

Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers. Summary of Proposed Rule

August 22, 2011

On August 17, 2011, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* a notice of proposed rulemaking (NPRM) implementing certain functions for the Health Insurance Exchanges established by Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) (together, these laws are referred to by the Department as the Affordable Care Act (ACA)).

The NPRM covers Exchange functions for determining eligibility for participation in the Exchange and for subsidies for insurance affordability, and standards for employer participation in the small business SHOP Exchanges. **Comments must be submitted by October 31, 2011.**

The NPRM is one of three NPRMs published on August 17, 2011, noted in the text box below. Health Policy Alternatives has prepared a summary of each of the three.

August 17, 2011 Rules Implementing Eligibility and Subsidy Provisions of the ACA

Medicaid: CMS issued an NPRM “Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010.” That proposed rule addresses the:

- Expansion of Medicaid eligibility in 2014 to non-elderly adults who are not otherwise eligible and who have income below 133 percent of the federal poverty level (FPL).
- Modifications of existing eligibility rules so that eligibility for Medicaid and CHIP would be simplified and coordinated with eligibility for the premium tax credits available through the Exchanges starting in 2014. These modifications require that Medicaid eligibility standards be based on Modified Adjusted Gross Income (MAGI).
- Changes regarding the Federal Medical Assistance Percentage (FMAP) for the newly eligible individuals.

Tax credits: The Internal Revenue Service (IRS) issued an NPRM “Health Insurance Premium Tax Credit,” That proposed rule addresses:

- Eligibility standards and computations for receipt of the sliding scale advance payment premium tax credits for individuals enrolled in qualified health plans (QHPs) in the Exchange;
- Year-end reconciliation provisions and information reporting requirement.

Exchanges: CMS issued an NPRM “Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers.” That rule provides standards and processes for Exchange functions for determining eligibility for participation in the Exchange, for subsidies for affordability, including Exchange implementation of the standards for Medicaid and Tax Credits proposed in the other two proposed rules. It also proposes standards for small employer participation in the Small Business Health Options Program (SHOP).

BACKGROUND

CMS reviews the relevant ACA provisions, its process of developing the proposed rules through consultation with stakeholders, and the structure of the proposed rule.

PROVISIONS OF THE PROPOSED REGULATIONS EXCHANGE FUNCTIONS (SUBPART D, PART 155)

The proposed rules add a new Subpart D to 45 CFR 155 for Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs.

CMS notes that it considered the option of having the Secretary of HHS determine eligibility for the advance payment of the premium tax credit, with other eligibility and enrollment functions residing in the Exchange, but proposes instead that the Exchanges perform all of the functions to ensure a seamless experience for applicants. It proposes to minimize opportunities for fraud and abuse **and seeks comments on further strategies in this regard**. CMS notes and references the companion NPRMs on the Medicaid program and the premium tax credits as related components of the implementation of the seamless eligibility approach.

Definitions and general standards for eligibility determinations (§155.300)

The proposed rule sets out a number of definitions, noting that “virtually all” are from other proposed regulations.

Eligibility standards (§155.305)

Enrollment in a QHP: CMS proposals that the Exchange determine an individual eligible for enrollment in a QHP through the Exchange if the individual meets the following three basic standards set out in the ACA.

First, the individual must be a citizen, national, or non-citizen lawfully present, and be reasonably expected to remain so for the period of enrollment. CMS notes that it intends to align the definitions for “lawful presence” with the rules for Medicaid and CHIP. **CMS seeks comments on the language about a reasonable expectation that the individual remain in the defined citizenship category, and for the period of enrollment.**

Second, the individual must not be incarcerated (except for incarceration pending disposition of charges.)

Third, the individual must be a resident of the State that established the Exchange. CMS proposes to align the residency standard with Medicaid rules. That includes a provision allowing an individual to establish the intent to reside in the area for individuals in transitional situations. It does not require that the individual indicate that intent for an entire year. The proposal also references a series of additional Medicaid residency rules for special populations. CMS also proposes that, in cases where members of a household reside in different service areas served by

different Exchanges, they are permitted to enroll in the Exchange of the primary taxpayer or in the Exchange serving the area in which the individual(s) reside. **CMS seeks comments on whether it should consider standards for network adequacy for out-of-state dependents. CMS also notes that State Medicaid agencies continue to have flexibility with respect to residency of students, and seeks comments on whether different rules should be maintained or a unified approach adopted.**

Enrollment period: the Exchange would determine if the individual is eligible for application during a particular open enrollment or special enrollment period.

Eligibility for Medicaid and CHIP, or a Basic Health Program: the Exchange would determine an applicant eligible for Medicaid or CHIP, and enroll applicants into those programs, based on the applicable eligibility criteria. If the State is operating a Basic Health Program under the ACA in the service area of the Exchange, the Exchange would determine eligibility for that program based on eligibility criteria that would be established for such a program.

Eligibility for advance payments of the premium tax credit: The Exchange would determine eligibility of a primary taxpayer for advance payment of the premium tax credits provided under the ACA. (The Internal Revenue Service's (IRS) proposed rules for implementing the premium tax credit, also published on August 17, 2011, are summarized in a separate HPA summary; that summary should be consulted for a more detailed review of eligibility for the tax credit.) In general, consistent with the proposed IRS rules, the Exchange would determine the individual eligible if the individual:

- meets the conditions of eligibility for enrollment in a QHP noted above;
- is expected to have a household income of at least 100 percent of the FPL but not more than 400 percent of the FPL for the benefit year; and
- is not eligible for minimum essential coverage through another governmental- or employer-sponsored program or plan.

Non-citizens lawfully present in the United States, if ineligible for Medicaid due to the required five-year waiting period, are eligible for the advance payment tax credit even if their income is below 100% of the FPL.

The Exchange must calculate the amount of the advance payment tax credit in accordance with the proposed rules of the IRS. The individual must be actually enrolled in a QHP before the Exchange may approve advance payments to the issuer of the QHP. The Exchange may not determine a taxpayer eligible for an advance payment tax credit if HHS notifies the Exchange that, in a prior year, the taxpayer or spouse received advance payments but did not file a tax return for the year in which they received payments. Further, the Exchange must require application filers to provide the Social Security number (SSN) of the primary taxpayer if the application filer attests that the primary taxpayer has a SSN and filed a tax return for a prior year which would be used for verification of income and family size. CMS notes that this standard also applies for applicants for cost sharing reductions.

CMS highlights two differences between advance payments of the premium tax credit and Medicaid and CHIP. Eligibility for Medicaid and CHIP is based on current income, while eligibility for advance payments of the premium tax credit is based on annual income. And, unlike Medicaid and CHIP, the premium tax credit is paid on an advance basis and then reconciled based on the individual's tax return for the entire year.

CMS notes comments and concerns that have been raised about the impact of the annual basis for calculation of income for the premium tax credit, coupled with the reconciliation process. Some commented that coverage could be unaffordable for individuals who have substantial decreases in income over the course of the year, and others that the fear of large repayments could deter enrollment: both concerns could lower enrollment and impact the Exchange risk pool. CMS notes that the Exchanges can implement eligibility processes to emphasize accuracy, and processes to report changes in income during the course of the year **and CMS seeks comments on ways to achieve this outcome.**

Eligibility for cost sharing reductions: The Exchange would also determine eligibility for the income-related cost-sharing reductions provided under the ACA. In general, the Exchange would determine the individual eligible if the individual:

- meets the conditions of eligibility for enrollment in a QHP noted above;
- meets the requirements for the advance payments of the premium tax credits noted above; and
- is expected to have a household income that does not exceed 250 percent of the FPL for the benefit year.

The Exchange may provide cost-sharing reductions to individuals who are enrolled in a silver-level QHP, except in the case of Indians (who are subject to special eligibility standards for cost-sharing reductions reviewed below).

Consistent with the ACA, the Exchange must use the following eligibility categories for determining cost sharing reductions:

- individuals with household income greater than 100 percent of the FPL and less than or equal to 150 percent of the FPL;
- individuals with household income greater than 150 percent of the FPL and less than or equal to 200 percent of the FPL; and
- individuals with household income greater than 200 percent of the FPL and less than or equal to 250 percent of the FPL.

CMS notes that additional information about the cost-sharing reductions will be provided in the future.

Eligibility determination process (§155.310)

CMS proposes rules for the Exchange eligibility determination process for enrollment and for eligibility for the insurance affordability provisions:

- The Exchange must accept applications in the form previously proposed in the Exchange proposed rules.
- The Exchange is prohibited from requiring individuals who are not seeking coverage for themselves, but are applying on behalf of others, from providing information on citizenship, status as a national, or immigration status. The Exchange may not require such an individual to provide a SSN except to fulfill the previously noted requirement of verification of prior year household income for purposes of determining eligibility of those who are applying.
- The Exchange must permit an applicant for enrollment in a QHP to decline an eligibility determination for the insurance affordability provisions (advance payment tax credits, cost-sharing subsidies, Medicaid or CHIP), but only if the individual declines the determination for all such programs. That means that the individual may not, for example, decline a Medicaid determination and seek only the advance payment premium tax credit.
- The Exchange must accept an application and make an eligibility determination at any time during the year. CMS notes that this does not supersede the enrollment periods provided in the prior Exchange and QHP proposed rules.

CMS proposes several special rules related to the advance payments of the premium tax credit, which primarily relate to compliance with the IRS' proposed rules for the premium tax credit.

- The Exchange must permit an enrollee to accept less than the full amount of the advance payment tax credit; CMS notes that this policy is designed to reduce the enrollee's risk of repayment at the time of the year-end tax reconciliation.
- The Exchange may provide the advance payment tax credit only if the primary taxpayer attests that he or she will comply with requirements set out by the IRS for filing a tax return for the benefit year, that, if married, the taxpayer will file a joint return, and that he or she will claim a personal exemption reduction for the applicants identified as family members.

When an Exchange determines an individual eligible for Medicaid or CHIP, it must notify the applicable State agency and transmit the relevant information to that State agency.

CMS proposes that the Exchange must provide an applicant with timely, written notice of eligibility determination of the insurance affordability provisions. CMS notes that the written notice is intended to provide an individual with a record of steps taken and remaining action needed to complete the process, along with information regarding appeal rights. CMS notes that this notice is not required at every step of the process, but only at the conclusion of the process, along with notices as needed if the Exchange needs more information. CMS notes that it anticipates proposing additional information requirements in future rulemaking.

CMS proposes to codify the rules for Exchange reporting to employers. The Exchange must notify an employer that an employee has been determined eligible for advance payments of the premium tax credit or cost-sharing reduction, based in part on the Exchange finding that the employer does not provide minimum essential coverage or coverage that is affordable (as

defined in the IRS' proposed rules for implementation of the premium tax credits). The Exchange must identify the employee when notifying the employer.

In the case of an individual who the Exchange determined to be eligible for enrollment in a QHP, but does not select a QHP during the specified enrollment period, and now seeks a new enrollment period, CMS proposes the following:

- If the individual is seeking a new enrollment prior to the date on which they would have otherwise been subject to an annual redetermination, the Exchange must receive an attestation whether the previously submitted eligibility information has changed.
- If the individual is seeking a new enrollment on or after the date on which they would have otherwise been subject to an annual redetermination, the Exchange would conduct a standard annual redetermination.

CMS notes that it considered requiring a new determination after a specific period of time, and solicits comments on the proposed approach.

Verification process related to eligibility for enrollment in a QHP (§155.315)

CMS notes that it proposes that the Exchange must verify applicant information, first relying on sources of electronic data, and then follow specific procedures when requesting documentation from applicants, including documentation from an applicant when information provided is not reasonably compatible with other information provided or available to the Exchange.

Verification of citizenship, status as a national or lawful presence:

- If the applicant attests to citizenship and has a SSN, the Exchange would first submit the information to HHS, which would transmit it to the Social Security Administration (SSA.) CMS notes that it anticipates that the single, streamlined application it has proposed will contain the necessary information.
- If the applicant has documentation that can be verified through the Department of Homeland Security, or whose attestation cannot be verified by SSA, the Exchange would submit the information to HHS, which would submit it to the Department of Homeland Security (DHS). CMS notes that the proposed language supports the use of the DHS' Systematic Alien Verification for Entitlements (SAVE) system to satisfy this standard.
- If the Exchange is unable to verify an applicant's claim, CMS proposes it must follow procedures outlined below for all such inconsistencies except that the time frame for resolution is 90 days from the date that the notice of inconsistency is received (which is 5 days from the date on the notice unless the applicant shows that the notice was not received within 5 days.)

Verification of residency: CMS proposes that the Exchange accept an individual's attestation of residency as verification, unless the State Medicaid or CHIP agency chooses not to allow verification based solely on attestation, in which case the Exchange would follow the procedures for verification set out in the Medicaid proposed rule. In addition, if the information regarding residency is not reasonably compatible with other information available to the Exchange, the

Exchange may examine additional data sources, and must follow procedures outlined below for inconsistencies.

Verification of incarceration status: CMS proposes that the Exchange rely on electronic data sources approved by HHS to verify incarceration status, or accept the individual's attestation if such sources are not available. If the attestation is not reasonably compatible with other information available to the Exchange, it must follow the procedures outlined below for dealing with inconsistencies.

CMS solicits comments on what electronic data sources are available and should be authorized by HHS for Exchange purposes.

Inconsistencies: CMS proposes a process for dealing with situations in which an applicant attests to information related to several issues, including enrollment in a QHP, insurance affordability, citizenship, residency, and incarceration status, but that attestation is inconsistent with other data available.

- The Exchange must first make a reasonable effort to identify and address the causes of the inconsistency, such as contacting the information filer.
- If the Exchange is unable to resolve the inconsistency through this initial effort, it must notify the applicant, and provide a period of 90 days to present evidence or otherwise resolve the inconsistency. The Exchange may extend this period if the applicant demonstrates a good faith effort to obtain the required documentation.
- During this time period, the Exchange must proceed with all other aspects of the eligibility determination, and must ensure that advance payment tax credits are available during the resolution period, subject to an attestation by the primary taxpayer that he or she understands that any such payments during the resolution period are subject to reconciliation.

If the Exchange is unable to verify the applicant's attestation at the conclusion of this resolution period, it must determine the applicant's eligibility based on the data sources specified, notify the applicant, and implement the eligibility determination ten to thirty days from the date of the notice. CMS notes that it intends to address in the future the timing of such notices, and to coordinate the requirements with Medicaid. CMS further notes that all such determinations are subject to appeal.

Flexibility in information collection and verification: CMS proposes that it may approve an Exchange plan to modify the information collection and verification requirements provided that it finds that the modification would reduce administrative costs and burdens, maintain accuracy, minimize delay, not undermine coordination with Medicaid or CHIP, and continue to comply with specified standards.

Applicant information: An Exchange may not require an applicant to provide information beyond the minimum amount necessary to support the eligibility determination.

Verification process related to eligibility for insurance affordability programs (§155.320)

CMS proposes verification processes for eligibility determination for the premium tax credits and cost-sharing subsidies, complying in part with the requirements set out by the IRS in its proposed rules for implementation of the premium tax credits.

Verification of minimum essential coverage: The Exchange must verify that the individual is not eligible for minimum essential coverage through an employer-sponsored plan or government program, using information obtained by submitting identifying information to HHS and the State agencies administering Medicaid, CHIP or a Basic Health Program. **CMS solicits comments about specific sources that could be utilized.**

Verification of household income and family/household size:

Data: the Exchange must request tax return data on modified adjusted gross income (MAGI) from the Secretary of the Treasury, through HHS, for all individuals whose income is counted in calculating household income for whom the Exchange has a SSN. If the identifying information does not match a tax record, the Exchange must proceed as identified above in dealing with inconsistencies. **CMS requests comments on how the Exchange can best use available data, and, in particular, on how to determine whether available tax information is representative of the likely situation for the year for which coverage is requested. CMS also notes that this proposal does not request the application filer to state their MAGI at the time of application, which CMS believes would deter application as it requires the applicant to have a copy of the relevant tax return at the point of application.**

Verification for Medicaid and CHIP: The Exchange must require an application filer to attest to household composition for Medicaid and CHIP. The Exchange would either accept that attestation, or, if it is not reasonably compatible with other information available, verify the attestation through electronic data sources. The Exchange may further request additional documentation if necessary. CMS notes that while the verification processes for Medicaid and CHIP are drafted separately from the processes for the premium tax credits and cost-sharing subsidies, it expects the Exchange to implement them in an integrated manner. The Exchange must verify MAGI-based income in accordance with procedures set out in Medicaid and CHIP rules.

CMS also notes that the verification policies are designed to limit the burden on application filers, and **solicits comments on how the process can work most smoothly for electronic and paper applications.**

Verification process for advance payments of the premium tax credit and cost-sharing reductions: CMS proposes a series of policies for Exchange verification for purposes of the premium tax credit and cost-sharing reductions.

- Family size: the Exchange must require the application filer to attest to household composition. The Exchange would either accept that attestation, or, if it is not reasonably

compatible with other information available, verify the attestation through electronic data sources. The Exchange may request additional documentation if necessary.

- Annual household income: the Exchange must compute annual household income based on the tax return data required, and require the application filer to attest whether it is an accurate projection for the benefit year. If the data are unavailable, or the application filer attests that it is not an accurate projection, the Exchange must direct the application filer to attest to projected household income. If that projection is not reasonably compatible with information computed by the Exchange, the Exchange is to proceed with its own computations.
- Increases in household income: if an application filer attests that annual household income has increased, or is reasonably expected to increase for the benefit year, and is not within the Medicaid or CHIP income standard, the Exchange would accept the application filer's attestation, or, if it is not reasonably compatible with other information available, the Exchange would verify the attestation through electronic data sources. The Exchange may request additional documentation if necessary.

Alternative verification process: CMS proposes an alternative process in cases in which an application filer who is not eligible for Medicaid or CHIP is attesting to a decrease in income or 20 percent or more, or when tax return data are unavailable, or in certain other situations. In those situations, the Exchange must first attempt to verify the attestation by using annualized data from MAGI-based income, and if that is unavailable, verify the attestation through electronic data sources. If that is unavailable, the Exchange must follow the procedures noted above for dealing with inconsistencies. If, at the conclusion of the 90 day period provided under those procedures, an application filer has not responded to a request for additional information, and the data sources that are available indicate that the individual is eligible for Medicaid or CHIP, the Exchange will not provide eligibility for advance payments of tax credits or cost-sharing reductions. In other situations in which the Exchange remains unable to verify the attestation, the Exchange is to proceed with eligibility based on the prior year tax information that is available.

Education and assistance: CMS proposes that the Exchange provide education and assistance to an application filer regarding the verification process, **and solicits comments as to strategies the Exchange can employ.** CMS intends to provide sub-regulatory guidance on this issue.

Verification related to enrollment in an eligible employer-sponsored plan: The Exchange must require the application filer to attest to whether the applicant is enrolled in an employer-sponsored plan. The Exchange would either accept that attestation, or, if it is not reasonably compatible with other information available, verify the attestation through electronic data sources. The Exchange may request additional documentation if necessary. The Exchange must verify an applicant's eligibility for qualified coverage in an eligible employer-sponsored plan for purposes of establishing eligibility for advance payments of the premium tax credits or cost-sharing reductions.

CMS notes that Exchanges will interact extensively with employees and their employers. HHS and the Departments of Treasury and Labor are working to coordinate the needed information that could be reported in order to make it easy and efficient for employers to report and

employees to access information. For example, Exchanges could provide a template for reporting. CMS is also considering a central database that employers could voluntarily populate. **CMS invites comments on the timing and reporting of information needed.**

Additional verification for immigration status for Medicaid and CHIP: The Exchange must also implement specific verification procedures for immigration status required under Medicaid and CHIP, including whether the individual meets the immigration status and five-year waiting period for Medicaid and CHIP. CMS notes that eligibility for Medicaid that is restricted to emergency services is not considered eligibility for Medicaid for purposes of establishing eligibility for the Exchange.

Eligibility redetermination during a benefit year (§155.330)

CMS proposes that the Exchange must redetermine eligibility if it receives and verifies new information.

Requirement for individual to report changes: The Exchange must require individuals enrolled in a QHP (with or without advance payments of premium tax credits or cost-sharing reductions) to report changes with respect to eligibility for enrollment in a QHP within 30 days of the change. The Exchange must verify such information in accordance with the previously noted verification processes. **CMS solicits comments on whether the Exchange should offer an enrollee an option to be periodically reminded to report any changes that have occurred.**

Requirement for Exchange to periodically examine certain data sources: The Exchange must periodically examine data sources to identify two changes: death and eligibility determinations for Medicaid and CHIP. CMS proposes that the Exchange have additional flexibility to identify and act on other changes that effect eligibility, subject to approval by HHS of as part of the Exchange plan. CMS notes that it considered directing the Exchange to use additional electronic data sources to determine changes in an enrollee's situation, and **solicits comments on whether and how it should approach additional data matching.**

Redetermination and notification of eligibility: If an Exchange verifies updated information, it must redetermine the enrollee's eligibility and notify the enrollee, and the enrollee's employer (if applicable).

Effective dates: In general, changes resulting from a redetermination are effective on the first day of the month following the date of the notice to the enrollee of the change. CMS proposes that the Exchange may, with approval from HHS, establish a reasonable point in a month (such as the 15th of the month) after which a change would be the first day of the second month following the date of the notice. **CMS solicits comments on whether this approach should require HHS approval, and whether there should be a uniform standard for all Exchanges.** In the case of a redetermination that results in an individual becoming ineligible to continue enrollment in a QHP in the Exchange, the Exchange must maintain the enrollment without advance payment of premium tax credit or cost-sharing reductions for a full month following the month in which the notice is sent. CMS notes that this does not require the individual to retain

that coverage, and CMS solicits comments on this approach, as well as other approaches to minimizing coverage gaps.

Annual eligibility redetermination (§155.335)

CMS proposes that Exchanges redetermine eligibility on an annual basis. **CMS solicits comments on whether the procedures proposed for redetermination of eligibility should satisfy the annual redetermination, and whether that should be a federal or Exchange standard.**

Updated income and family size information: in the case of an enrollee who requests an eligibility determination for insurance affordability programs, the Exchange must request updated tax return information and conduct electronic data matching regarding MAGI-based income. **CMS solicits comments on whether and how to approach additional data matching.**

Notice to the enrollee: The Exchange must provide an annual redetermination notice to the enrollee, including the data used in the initial eligibility determination, any updated information obtained through data matching, and the projected eligibility determination for the upcoming year. **CMS solicits comments on the content of such a notice.**

Changes reported by enrollees, verification, and redetermination: The Exchange must require an enrollee to report any changes with respect to the information provided in the notice within 30 days. The Exchange must verify any changed information using the same procedures as at initial application, including the procedures for dealing with inconsistencies. The Exchange must require the enrollee to sign and return the notice within 30 days. If it is not returned, the Exchange proceeds as outlined below. The Exchange must redetermine eligibility after the 30 day period using the information provided, notify the enrollee, and notify the enrollee's employer if applicable. CMS notes that this is designed as one strategy proven to minimize the risk of individuals losing coverage when they remain eligible. CMS recognizes that advance payments of premium tax credits are subject to reconciliation by Treasury, and **solicits comments on strategies to improve the accuracy of determinations, and steps to ensure that redetermination minimizes the burden on individuals, QHPs and the Exchange.**

Renewal of coverage: If an enrollee remains eligible for coverage in a QHP, the enrollee remains in the QHP selected the previous year unless the enrollee takes action to select a new QHP within an enrollment period or terminate coverage in the QHP.

Administration of advance payment premium tax credit and cost-sharing reductions (§155.340)

If an Exchange determines that an applicant is eligible for advance payments of the premium tax credit or cost-sharing reduction, or that eligibility has changed, it must transmit required eligibility and enrollment information to HHS, and notify and transmit to the issuer of the QHP information needed to implement any adjustments, including the dollar amount of the individual's advance payment and the individual's cost-sharing reduction category. **CMS seeks**

comments on the information needed by HHS to support monitoring, evaluation, and program integrity, and how the interaction can work as smoothly as possible.

The Exchange must also report information related to employer responsibilities. If an individual is eligible for advance payment of the premium tax credit or cost-sharing reduction based in part on a finding that an employer does not provide minimum essential coverage or affordable coverage, then the Exchange must provide this information to HHS. If an enrollee for whom advance payments of the premium tax credits or cost-sharing reductions are made notifies the Exchange that he or she has changed employers, the Exchange must report the information to HHS. If such an enrollee disenrolls from a QHP through the Exchange during a benefit year, the Exchange must notify HHS, which will transmit the information to the Secretary of the Treasury, and notify the individual's employer. The Exchange must comply with reporting requirements proposed by the Treasury Department in implementing the premium tax credits.

Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-Existing Conditions Insurance Program (§155.345)

CMS proposes standards for coordination to implement a streamlined, simplified system for eligibility determination and enrollment. The Exchange must enter into agreements with Medicaid and CHIP agencies necessary to fulfill the requirements. CMS anticipates that Medicaid and CHIP eligibility determinations will be conducted in cooperation with those agencies, and will utilize a single eligibility system or shared eligibility service.

Responsibilities related to individuals potentially eligible for Medicaid based on other information or through other coverage groups: the Exchange must perform what CMS calls a "screen and refer" function for applicants requesting eligibility for insurance affordability programs to determine if the applicant is potentially eligible for Medicaid based on factors not otherwise considered in these proposed rules, such as disability, and transmit to the State Medicaid agency identifying information and all other information submitted by the applicant. If the applicant is otherwise eligible for advance payments of premium tax credits and cost-sharing reductions, the Exchange must provide the applicant with such payments and reductions until the Medicaid or CHIP program notifies the Exchange that the applicant is eligible for such program. CMS notes that under the IRS' proposed rules for the premium tax credits, such an individual does not lose eligibility for the tax credit for such months even if retroactively made eligible for Medicaid.

The Exchange must also provide an opportunity for an applicant who is not automatically referred to the State Medicaid agency to request a full screening of eligibility for Medicaid by such agency. If an applicant makes such a request, the Exchange must submit all relevant information to the State Medicaid agency.

Determination of eligibility for individuals submitting applications directly to an agency administering Medicaid, CHIP, or the Basic Health Program: The Exchange must establish procedures to ensure that when an application is submitted directly to an agency administering Medicaid, CHIP, or a Basic Health Program, and the applicant is determined ineligible based on the applicable MAGI income standard, that an eligibility determination is conducted for

enrollment in a QHP and advance payments of tax credits and cost-sharing reductions. Such procedures cannot require the Exchange to duplicate any of the findings already made, and must provide that the same process is used for such applicants regardless of the agency that initially receives the application. CMS encourages States to develop integrated IT systems, and expects that States will utilize common or shared eligibility systems or services across the Exchange and Medicaid. Exchanges must use a secure electronic interface to exchange data, and may use model agreements established by HHS.

CMS proposes standards for coordination between the Exchange and the Pre-Existing Condition Insurance Program (PCIP) that will be phased-out as the Exchanges are implemented in 2014, in order to ensure that PCIP enrollees do not experience a lapse in coverage. **CMS solicits comments on additional responsibilities that should be assigned Exchanges as part of this process.**

Special eligibility standards and process for Indians (§155.350)

Indians are subject to special rules for cost-sharing under the ACA. Indians with household income at or below 300 percent of the FPL may not be subject to any cost sharing in any QHP. Further, a QHP may not impose cost-sharing on any Indian (regardless of income) for services furnished directly by the Indian Health Service, an Indian tribe, tribal Organization, or Urban Indian Organization, or through referral under contract health services. CMS proposes to codify these requirements by requiring an Exchange to determine if an applicant meets the requirements. To the extent that an applicant attests to status as an Indian, the Exchange must verify the attestation by using any of the previously noted relevant documentation under the proposed rules, relying on electronic data sources available, and following the procedures for dealing with inconsistencies identified earlier. **CMS solicits comments on the availability and usability of electronic data sources, as well as best practices for documentation related to Indian status.**

Right to appeal (§155.355)

CMS proposes that an Exchange must include notice of the right to appeal, and instructions on how to file an appeal, in any determination notice.

EMPLOYER INTERACTIONS WITH EXCHANGES AND SHOP PARTICIPATION (PART 157)

Basis and scope (§157.10)

CMS sets out the statutory authority for the proposed rules and the scope, which is to establish requirements for employers in connection with the Exchanges.

Definitions (§157.20)

CMS defines “qualified employee,” “qualified employer” and “small employer” through reference to previous regulatory provisions.

Eligibility of qualified employers to participate in a SHOP (§157.200)

CMS proposes general provisions for small employer participation in a Small Business Health Options Program (SHOP) and notes that it mirrors and complements previously proposed rules for a SHOP in the Exchange NPRM. Only qualified employers may participate, and a qualified employer may continue participating if it ceases to be a small employer solely because of an increase in the number of employees, so long as it meets other eligibility criteria. Multi-State employers may participate in multiple SHOPS. CMS notes, however, that it does not exempt an employer from the size standard: if an employer has more than 100 employees divided among multiple SHOP service areas, such an employer is still a large employer.

Qualified employer participation process in a SHOP (§157.205)

A qualified employer must comply with the requirements, timelines and processes for the SHOP. A qualified employer must:

- make coverage in a QHP available through the processes developed by the SHOP;
- disseminate information to qualified employees about the process to enroll in a QHP in the SHOP; CMS notes that the SHOP may assist qualified employers;
- submit any contribution toward the premium of a qualified employee according to the appropriate standards and processes;
- provide employees hired outside the initial or annual open enrollment with a specified period to enroll in the SHOP;
- provide the SHOP with information about employees or individuals whose eligibility to purchase coverage has changed; and
- adhere to the annual employer election period to change program participation for the next plan year. CMS notes that an employer may begin participating in a SHOP at any time, but once the employer begins participating, it must adhere to the annual employer election period.

CMS proposes that, if a qualified employer does not take action during the annual employer election period, the employer would continue to offer the same plan, coverage level, or plans selected the previous year, if such options remain available.

CMS seeks comments regarding the feasibility of these processes and implications for small employers and their employees.

COLLECTION OF INFORMATION REQUIREMENTS

CMS notes that it recognizes that the proposed rule contains items subject to the Paperwork Reduction Act, and that it intends to estimate the burden of compliance as part of future rulemaking.

SUMMARY OF PRELIMINARY REGULATORY IMPACT ANALYSIS

CMS notes that the analysis of benefits and costs in this proposed rule is linked to the detailed Preliminary Regulatory Impact Analysis (PRIA) evaluating the impact of the previously published NPRM on Establishment of Exchanges and Qualified Health Plans and related NPRM on Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (Premium Stabilization). A summary of that PRIA was provided by HPA in its July 15, 2011 summary of those proposed rules and is available on request.