FactSHEET

Understanding the Affordable Care Act

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Key Issues in the Final and Interim Final Rules on Establishing Exchanges and Expanding Medicaid under the Affordable Care Act

In March 2012, the Department of Health and Human Services (HHS) published two important Affordable Care Act regulations:

- Establishment of Exchanges and Qualified Health Plans
- Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010

Although these are final rules, HHS also included some sections that are "interim final," meaning they are open for public comment. Comments on the interim final provisions are due on May 11 for the exchange rule and May 7 for the Medicaid rule. They can be submitted via www.regulations.gov. Below is a summary of key points in the final rules and a summary of the provisions that are interim final and open for comment. Note that some content is included in both sets of regulations as it pertains to coordinated eligibility and enrollment for exchange and Medicaid coverage.

Exchanges

Final Rule

The final rule on exchanges includes strengthened standards for many exchange functions, including:

- **The initial open enrollment period**
  The initial open enrollment period for exchange coverage will be one month longer than initially proposed, running from October 1, 2013 to March 31, 2014.
- **The Navigator program**
  The final rule requires that each state have at least one community- or consumer-focused nonprofit serving as a Navigator—an entity that will help consumers understand and enroll in coverage options. The final rule also clarifies that individuals can't be paid by insurance companies to sell coverage while simultaneously serving as a Navigator and that states can't require Navigators to obtain insurance broker licenses. Finally, the rule requires that Navigators receive formal training before they serve consumers and that exchanges develop standards to prevent conflicts of interest in the Navigator program.

- **Exchange governing boards**
  The final rule requires every exchange governing board to have at least one consumer representative. It also maintains the standard from the draft rule that prohibits governing boards from having a majority of members with conflicts of interest (due to being insurers, brokers, etc.).

- **Stand-alone dental plans**
  The final rule extends new consumer protections to stand-alone dental plans offered through the exchange, such as a prohibition on annual and lifetime spending limits. These protections previously applied only to comprehensive medical coverage. The final rule also requires that the exchange consider the capacity of stand-alone dental plans in order to ensure that they have a sufficient number of providers before certifying them for sale in the exchange.

Interim Final Broker Provision Open for Comment

The rule also includes new provisions, which are open for comment until May 11, 2012, relating to health insurance brokers. These provisions, found in Section 155.220 of the rule, clarify that brokers, including web-based brokers, may help people enroll in qualified exchange plans and apply for premium tax credits and cost-sharing assistance. Although the rule leaves it up to each state to decide whether and how brokers will be involved in the exchange, the interim final rule lays out certain standards pertaining to the role of brokers. Specifically, it clarifies the following:

- Applications for premium credits and cost-sharing assistance must be processed through the exchange;
- Web-based brokers displaying exchange plans to consumers must show every exchange plan and all plan information that is available on the exchange website; and
- Any brokers who assist people with exchange plans and affordability programs must register with the exchange and receive special training.

What to Address in Comments

To ensure that there are adequate consumer protections when brokers, and specifically web-based brokers, assist consumers with exchange applications and coverage, advocates may want to provide comments on these provisions, addressing the need for the following:

- Standards regarding how exchange plan information is displayed by web-based brokers to ensure that plans are not displayed in a manner that could steer people into options that are not in their best interests;
- Safeguards to prevent consumers from having to pay more for exchange coverage if they obtain it through an in-person or web-based broker versus through the exchange website;
- Provisions to ensure that brokers, including web-based brokers, fully inform consumers of the availability of premium tax credits and cost-sharing assistance for exchange coverage; and
- Safeguards to protect the privacy of consumer information.

Medicaid and Exchange Eligibility Processes

Interim Final Eligibility Process Provisions Open for Comment

Interim final provisions in the Medicaid and exchange rules, which are open for comment, include new options for the process of determining eligibility for insurance affordability programs. The Affordable Care Act calls for a streamlined enrollment process that ensures that regardless of where people apply for coverage—through an exchange or through a Medicaid or CHIP agency—they should be promptly enrolled in the proper program. The Medicaid and exchange interim final rules, however, give states new options to bifurcate the eligibility determination process between different state and federal agencies (the exchange, Medicaid, CHIP, and HHS). Instead of requiring the exchange to make Medicaid eligibility determinations and enroll qualified applicants in the program, the interim final rules permit an exchange (state-based or federally facilitated) to "assess" whether a person is potentially eligible for Medicaid and then send the application to the Medicaid agency for a final determination. The rule also permits a state exchange to allow HHS to conduct premium tax credit eligibility determinations for the state and allows federal exchanges to contract with state agencies to perform eligibility determinations for any insurance affordability program.

The final and interim final Medicaid and exchange rules do include some consumer protections to promote a seamless eligibility determination process, such as:

- **The safeguarding of information**
  The interim and final rules include language to ensure that important personal information, including financial information and Social Security numbers, is properly protected.
- **Requesting only necessary applicant information**
  Applicants can only be required to provide information that is necessary for the eligibility and enrollment process.
- **Requesting applicant information only one time**
  Medicaid and CHIP agencies cannot request information or documentation that has already been provided to the exchange. If functioning in a bifurcated system, the exchange must transmit all applicant information that it gathers regarding those potentially eligible for Medicaid or CHIP to the Medicaid or CHIP agency.

What to Address in Comments

Even with the consumer protections described above, we are concerned that the new options to bifurcate the eligibility determination process may lead to a less seamless, less streamlined process. In order to ensure a seamless eligibility determination process under these new rules, advocates may want to provide comments addressing the need for the following:

- **Continuity of rules and procedures across agencies**
  It is important that all agencies involved in eligibility determinations for a state abide by the same rules and procedures when assessing or determining Medicaid and CHIP eligibility in order to ensure accurate and consistent eligibility determinations. This will help minimize the need for further verification once an application reaches the Medicaid agency and minimize the number of applicants who fall through the cracks.

- **Prior approval to bifurcate an eligibility determination process**
  In order to ensure that every state has a seamless and timely eligibility determination process, HHS should conduct a "readiness assessment." This readiness assessment would test eligibility systems and require that they demonstrate the capacity to efficiently enroll consumers in coverage even if they are using a divided eligibility process—a far more complicated method of evaluating eligibility than a single eligibility system—before HHS approves a system as compliant with the Affordable Care Act.

- **Increased transparency**
  It is important that states (and HHS, when applicable) make public interagency eligibility process agreements and verification plans. These plans will be crucial to the implementation of a seamless eligibility determination process, and they should be subject to public review. Moreover, in order to assert their rights, beneficiaries and their advocates will need a clear understanding of verification procedures and which agency is responsible for which step.

- **Stronger timeliness standards**
  The timeliness standards set out in the interim final rules are vague, requiring that eligibility be processed "promptly and without undue delay." The outside time limits for processing Medicaid applications—45 days for nondisability determinations, 90 days for disability determinations—remain unchanged from current rules. We would like to see modern timeliness standards and are interested in input regarding what these should be. (We might recommend that even when eligibility determination is bifurcated, an eligibility "assessment" must be conducted within three days, accounts must be transferred to the appropriate agency within one day, the appropriate agency must contact the applicant within three days if further information is needed, eligibility determinations for nondisability cases must be completed within 30 days, and disability cases must be completed within 60 days.) In addition, the rules seem to allow timeliness standards to reset when an application is transferred from one agency to another, which we believe would cause undue delay in determinations and should not be allowed.

The Medicaid rule is open for comment until May 7, 2012, and the exchange rule is open for comment until May 11, 2012. Please feel free to contact Families USA at stateinfo@familiesusa.org with any questions you have about these rules or the commenting process.