Rhode Island Department of Health

NOTICE OF PUBLIC HEARING

The Director of the Rhode Island Department of Health has under consideration proposed amendments to the *Rules and Regulations Pertaining to the Rhode Island Health Benefits Exchange* [*R23-1-1-ACA*] pursuant to the authority conferred under §23-1-1 and Chapter 42-35 of the Rhode Island General Laws, as amended, and Executive Order 11-09 issued by Governor Lincoln Chafee on 19 September 2011. The purpose of the proposed regulations is to establish requirements for the operation of the Rhode Island Health Benefits Exchange (doing business as HealthSource RI) to carry out the functions of an Exchange in accordance with the Section 1311 of the federal Patient Protection and Affordable Care Act (ACA).

Notice is hereby given in accordance with the provisions of Chapter 42-35 of the Rhode Island General Laws, as amended, that the Director will hold a public hearing on the above mentioned matters, in the **AUDITORIUM** of the Rhode Island Department of Health (on the lower level of the Cannon Building), Three Capitol Hill, Providence, Rhode Island on **THURSDAY, 12 JUNE 2014 AT 9:30 AM** at which time and place all persons interested therein will be heard. The seating capacity of the room will be enforced and therefore the number of persons participating in the hearing may be limited at any given time by the hearing officer, in order to comply with safety and fire codes.

In the development of the rules and regulations, consideration was given to the following: (1) alternative approaches; (2) overlap or duplication with other statutory and regulatory provisions and (3) financial impact on small business. No alternative approach, duplication, or overlap was identified based upon available information.

For the sake of accuracy, it is requested that statements to be made relative to any aspect of the regulations, including alternative approaches or overlap, be submitted in writing at the time of the hearing or in electronic format prior to the hearing date to: Edward D'Arezzo, Interim Associate Director of Health at edward.d'arezzo@health.ri.gov or by calling (401) 222-1006.

Copies of the regulations are available for public inspection in the Cannon Building, Room #201, Rhode Island Department of Health, 3 Capitol Hill, Providence, Rhode Island, on the Secretary of State's website: http://www.sos.ri.gov/ProposedRules/, by calling 401-222-7767 or by e-mail to Bill.Dundulis@health.ri.gov.

The Department of Health is accessible to the handicapped. If communication assistance (readers/ interpreters/captioners) is needed, or any other accommodation to ensure equal participation, please call 401-222-7767 or RI Relay 711 at least three (3) business days prior to the meeting so arrangements can be made to provide such assistance at no cost to the person requesting.

Signed this 24th day of April 2014

Original signed by Michael Fine, MD

Michael Fine, M.D., Director of Health

RULES AND REGULATIONS PERTAINING TO THE RHODE ISLAND HEALTH BENEFITS EXCHANGE

[R23-1-1-ACA]

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

DEPARTMENT OF HEALTH

May 2014 (Proposed)

COMPILER'S NOTES:

Proposed Additions: The proposed regulations are new in their entirety. Therefore, changes are not specifically indicated.

INTRODUCTION

These *Rules and Regulations Pertaining to the Rhode Island Health Benefits Exchange* [R23-1-1-ACA] are promulgated pursuant to the authority set forth in RIGL §23-1-1 and Executive Order 11-09 issued by Governor Lincoln Chafee, pursuant to RIGL. §§ 42-62-16 et.seq., on 19 September 2011. Executive Order 11-09 created the Rhode Island Health Benefits Exchange (doing business as HealthSource RI) to carry out the functions of an Exchange in accordance with the federal Patient Protection and Affordable Care Act (ACA).

Section 1311 of the ACA provides legal authority for states to establish health insurance exchanges. Health insurance exchanges are designed to provide affordable health insurance to eligible individuals and small businesses through Qualified Health Plans. The Exchange will operate a Small Business Health Options Program (SHOP), which permits employers to obtain group health insurance coverage for their employees. Certain employers that purchase coverage through a SHOP are eligible for a federal small business premium tax credit

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to:

(1) Alternative approaches to the regulations;

(2) Duplication or overlap with other state regulations; and

(3) Significant economic impact on small business.

Based upon available information, no known alternative approach, duplication or overlap was identified.

TABLE OF CONTENTS

	Page
INTRODUCTION	i
1.0 DEFINITIONS	1
2.0 GENERAL PROVISIONS	3
2.1 Purpose and Scope	4
2.2 Exchange Functions	4
2.3 Additional Guidance	4
2.4 Relation to Other Laws	
3.0 QUALIFIED HEALTH PLAN ELIGIBILITY AND ENROLLMENT	4
3.1 In General	4
3.2 Eligibility for Enrollment in a QHP Through the Exchange	4
3.3 QHP Selection	4
3.4 QHP Enrollment	4
3.5 Appeals	5
4.0 INITIAL OPEN ENROLLMENT, ANNUAL OPEN ENROLLMENT, AND SPECIAL ENROLLMENT PERIODS	5
4.1 In General	5
4.2 Initial Open Enrollment Period	5
4.3 Initial Open Enrollment Period Coverage Effective Dates	5
4.4 Annual Open Enrollment Period	5
4.5 Annual Open Enrollment Period Coverage Effective Dates	5
4.6 Special Enrollment Periods	5
5.0 ADVANCED PAYMENTS OF THE PREMIUM TAX CREDIT	7
5.1 In General	7
5.2 Eligibility for Advance Payments of the Premium Tax Credit	7
5.3 Individuals for Whom a Premium Assistance Amount Can be Provided	7
5.4 Special Rule for Non-Citizens Who are Lawfully Present Immigrants and Who Are Ineligible for Medicaid by Reason of Immigration Status	8
5.5 Calculation of Advance Payments of the Premium Tax Credit	8
5.6 Appeals	8
6.0 COST SHARING REDUCTIONS	8
6.1 In General	8
6.2 Eligibility Criteria	8
6.3 Provided Only to Enrollees in a Silver-Level Qualified Health Plan	8
6.4 Use of Eligibility Categories	9
6.5 Special Rule for Lawfully Present Immigrants Below 100% FPL	9

	Page
6.0 COST SHARING REDUCTIONS [cont.]	
6.6 Special Rules for Indians	9
6.7 Special Rule for Multiple Tax Households	9
6.8 Appeals	9
7.0 TERMINATION OF COVERAGE AND GRACE PERIODS	9
7.1 In General	9
7.2 Termination of Coverage Due to Non-Payment of Premium	9
7.3 Grace Period	10
7.4 Qualified Health Plan Issuers May Not Terminate Coverage	10
7.5 Involuntary Termination	10
7.6 Voluntary Termination	10
7.7 Notice	10
7.8 Effective Date of Termination	11
8.0 MINIMUM ESSENTIAL COVERAGE EXEMPTIONS	11
8.1 In General	11
8.2 Exchange Exemption Eligibility Determination	12
9.0 MINIMUM ESSENTIAL COVERAGE EXEMPTIONS	13
9.1 In General	13
9.2 Issuer Agreements	13
10.0 SHOP EXCHANGE	13
10.1 In General	13
10.2 Terms and Conditions	13
10.3 SHOP Enrollment	13
10.4 Agents and Brokers	13
10.5 SHOP Premium Aggregation	13
10.6 Due Date	13
10.7 Grace Period	13
11.0 APPEALS	14
11.1 Designation of Exchange Appeals Entity	14
11.2 Procedures for Appeals	14
12.0 EXCHANGE TRUST PAYMENTS	14
12.1 Establishment of Trust	14
12.2 Payments to the Trust	14
12.3 Overdue Accounts	14
12.4 Payment Deposits	15
12.5 Payments from the Trust	15

		Page
12.0	**EXCHANGE TRUST PAYMENTS** [cont.]	
12.6	Standards	15
12.7	Privacy and Security	15
13.0	**SEVERABILITY**	15

SECTION 1.0 DEFINITIONS

Wherever used in these Regulations, the following terms shall be construed as follows:

1.1 ***"Act"*** or ***"ACA"*** means the federal Patient Protection and Affordable Care Act (U.S. Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-152), and all rules promulgated thereunder.

1.2 ***"Advance Payments of the Premium Tax Credit" or "APTCs"*** means payments of the tax credits specified in 26 USC section 36B which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan through the Exchange.

1.3 ***"Annual Open Enrollment Period"*** means the period during which a qualified individual may enroll in coverage through the Exchange for an upcoming Benefit Year.

1.4 ***"Applicant***" means an individual who is seeking eligibility for him or herself or for members of his or her household through an application submitted to the Exchange for at least one of the following:

(a) Enrollment in a Qualified Health Plan;

(b) Advance payments of the premium tax credit and cost sharing reductions; or

(c) Medicaid or CHIP, if applicable; or

(d) An employer or employee seeking eligibility for enrollment in a Qualified Health Plan through the SHOP where applicable.

1.5 ***"Benefit Year"*** means a calendar year for which a health plan provides coverage for health benefits.

1.6 ***"Cost Sharing Reductions"*** means reductions in cost sharing for an eligible individual enrolled in a silver level plan, as defined by section 1302(d)(1)(B) of the ACA, in the Exchange or for an individual who is an Indian enrolled in a Qualified Health Plan through the Exchange

1.7 ***"Dependent"*** means any individual who is or who may become eligible for coverage under the terms of a Qualified Health Plan because of a relationship to a qualified individual or enrollee.

1.8 ***"Eligibility Appeals"*** means appeals from an eligibility decision made by the Exchange in accordance with 45 C.F.R. Subpart D, including:

(a) An initial determination of eligibility, including the amount of APTCs and the level of CSRs, made in accordance with standards specified in 45 C.F.R.. §§155.305(a) through (h);

(b) A redetermination of eligibility, including the amount of APTCs and level of CSRs, made in accordance with 45 C.F.R.. §§ 155.330 and 155.335;

(c) The failure by the Exchange to make such eligibility determination or redetermination in a timely manner; and

(d) A termination from QHP coverage or disenrollment from a QHP made by the Exchange in accordance with 45 C.F.R. §155.430.

1.9 ***"Enrollee"*** means a qualified individual or qualified employee enrolled in a QHP.

1.10 ***"EOHHS"*** means the Rhode Island Executive Office of Health and Human Services.

1.11 ***"Exchange"*** means the Rhode Island Health Benefits Exchange, doing business as HealthSource RI.

1.12 ***"Exchange Appeals"*** means all Rhode Island Health Benefits Exchange-related appeals, including Eligibility Appeals, Exemption Appeals, Large Employer Appeals, and SHOP Appeals, as defined in these Regulations.

1.13 ***"Exemption Appeals"*** means appeals from a determination of eligibility for an exemption from the Individual Responsibility Penalty (IRP) made by the Exchange in accordance with §1311(d)(4)(H) of the ACA, or an appeal related to the failure by the Exchange to make such exemption eligibility determination or redetermination in a timely manner.

1.14 ***"Federal Regulations"*** means the regulations promulgated under the Act at 45 C.F.R. Parts 155, 156 and 157.

1.15 ***"FPL"*** means the most recently published federal poverty level guidelines available as of the first day of the annual open enrollment period for coverage offered through the Rhode Island Health Benefits Exchange.

1.16 ***"HHS"*** means the U.S. Department of Health and Human Services.

1.17 ***"Indian"*** has the same meaning as the definition of Indian given in 45 C.F.R. §155.300.

1.18 ***"Individual Responsibility Penalty"*** means the tax penalty associated with the failure of certain individuals to carry minimum essential coverage in accordance with §5000A of the Internal Revenue Code.

1.19 ***"Initial Open Enrollment Period"*** means the period during which a qualified individual may enroll in coverage through the Exchange for coverage during the 2014 benefit year.

1.20 ***"Issuer Agreement"*** means the agreement between the QHP issuer and the Exchange that satisfies all applicable requirements of the federal regulations.

1.21 ***"Lawfully Present"*** has the same meaning given to the term in 45 C.F.R. §152.2.

1.22 ***"Limited Cost Sharing Plan"*** means, with respect to a QHP at any level of coverage, the variation of such QHP described in 45 C.F.R. §156.420(b)(2).

1.23 ***"Premium"*** means the payment required to be paid for an enrollee to participate in a Qualified Health Plan.

1.24 ***"Qualified Employee"*** means an individual employed by a qualified employer who has been offered health insurance coverage by such qualified employer through the SHOP.

1.25 ***"Qualified Employer"*** means an employer that is eligible to participate in the SHOP Exchange and elects to make available health coverage to its employees through the SHOP Exchange.

1.26 ***"Qualified Health Plan" or "QHP"*** means a health plan that has in effect a certification that it meets the standards described in 45 C.F.R. Part 156 Subpart C and such additional standards that may be prescribed, issued or recognized by the Exchange in accordance with the process described in 45 C.F.R. Part 155 Subpart K.

1.27 ***"Qualified Individual"*** means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a Qualified Health Plan in the individual market.

1.28 ***"RIGL"*** means the General Laws of Rhode Island, as amended.

1.29 ***"Shared Responsibility Payment"*** means the assessment on certain nonexempt individuals who, for each month during the taxable year, must have minimum essential coverage or make a payment as described in §1.5000A-1 and §1.5000A-4.

1.30 "***SHOP Appeals***" means appeals by employers or employees of determinations of eligibility for the SHOP Exchange made by the Exchange in accordance with 45 CFR §155.715, including the failure of the Exchange to make such eligibility determinations in a timely manner.

1.31 ***"SHOP Exchange"*** means the Small Business Health Options Program in accordance with §1311(b)(1)(B) of the ACA and 45 C.F.R. Part 155 Subpart H through which a qualified employer may provide its employees and their dependents participation in one or more QHPs.

1.32 ***"Special Enrollment Period"*** means a period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a Qualified Health Plan through the Exchange outside of the initial and annual open enrollment periods

1.33 ***"These Regulations"*** mean all parts of Rhode Island *Rules and Regulations Pertaining to Pertaining to the Rhode Island Health Benefits Exchange* [R23-1-1-ACA]

1.34 ***"Trust"*** means the HealthSource RI Trust established by the Exchange.

1.35 ***"Zero Cost Sharing Plan"*** means, with respect to a QHP at any level of coverage, the variation of such QHP described in 45 C.F.R. §156.420(b)(1).

SECTION 2.0 GENERAL PROVISIONS

2.1 **Purpose and Scope.** The purpose of these Regulations is to establish certain rules governing.

(a) Individual eligibility for enrollment in a Qualified Health Plan;

(b) Individual eligibility for receipt of advance payments of the premium tax credit and cost sharing reductions;

(c) Enrollment of qualified individuals in a Qualified Health Plan;

(d) Initial open enrollment, annual open enrollment and special enrollment periods for qualified individuals;

(e) Premium payments and termination of coverage for qualified individuals;

(f) Eligibility for Minimum Essential Coverage exemptions;

(g) The operation of a SHOP Exchange, including enrollment of qualified employers and qualified employees into qualified health plans;

(h) A mechanism for handling all Rhode Island Health Benefits Exchange Appeals; and

(i) Establishment of a trust to facilitate the collection and payment of premiums to qualified health plan issuers and the receipt of payments for such products and services as may be offered by and/or through the Exchange related to the goals of improving the health, wellbeing and outcomes of all Rhode Islanders.

2.2 **Exchange Functions.** The Exchange carries out the functions described in 45 C.F.R. Part 155 Subpart C.

2.3 **Additional Guidance.** Policies and procedures for implementation of these Regulations may be established in manuals and other documents promulgated by the Exchange.

2.4 **Relation to Other Laws.** Nothing in these Regulations shall preempt or otherwise conflict with any applicable state and federal laws and rules.

SECTION 3.0 QUALIFIED HEALTH PLAN ELIGIBILITY AND ENROLLMENT

3.1 **In General.** Section 1311 of the ACA establishes exchanges to facilitate the purchase of qualified health plans. Section 1311 and its implementing regulations, 45 C.F.R. §155.305 and 45 C.F.R. §155.400, respectively, establish eligibility requirements and requirements for enrollment in a Qualified Health Plan.

3.2 **Eligibility for Enrollment in a QHP Through the Exchange.** The Exchange shall determine an applicant eligible for enrollment in a Qualified Health Plan if he or she meets the following requirements:

(a) *Citizenship, status as a national, or lawful presence.* Is a citizen, or national of the United States, or is a non-citizen who is lawfully present in the United States and is reasonably expected to be a citizen, national or a non-citizen who is lawfully present for the entire period for which enrollment is sought.

(b) *Incarceration*. Is not incarcerated, other than incarceration pending the disposition of charges.

(c) *Residency*. Meets the applicable residency standards as defined in 45 C.F.R. §155.305 (a)(3).

3.3 **QHP Selection.** The Exchange shall accept a Qualified Health Plan selection from an applicant determined eligible for enrollment in a QHP. The Exchange shall notify the issuer of the applicant's selected QHP and transmit information necessary to enable the QHP issuer to enroll the applicant.

3.4 **QHP Enrollment.** Enrollment of a qualified individual in a QHP shall be limited to the initial open enrollment period, annual open enrollment period, or a special enrollment period.

3.5 **Appeals.** An applicant has the right to an appeal of an eligibility determination based on subpart 3.2 and pursuant to the appeals process as described in §11.0 of these Regulations and as may be set forth in the *"0110 Complaints and Hearings"* regulations promulgated by EOHHS.

SECTION 4.0 INITIAL OPEN ENROLLMENT, ANNUAL OPEN ENROLLMENT, AND SPECIAL ENROLLMENT PERIODS

4.1 **In General.** Section 1311 of the ACA and its implementing regulations, 45 C.F.R. §§155.410 and 155.420, establish requirements for initial open enrollment, annual open enrollment, and special enrollment periods for Qualified Health Plans.

4.2 **Initial Open Enrollment Period.** The initial open enrollment period as established by the Exchange shall last from October 1, 2013 and through March 31, 2014.

4.3 **Initial Open Enrollment Period Coverage Effective Dates.**

(a) To make coverage effective, qualified individuals must select a Qualified Health Plan and submit the balance of the first month's payment in full in accordance with dates established by the Exchange.

4.4 **Annual Open Enrollment Period.**

(a) *Benefit Year 2015 and Beyond*. For 2015 and subsequent benefit years, the Exchange will establish the annual open enrollment period and shall provide a minimum of one hundred twenty (120) days advance public notice prior to its first day.

(b) Annual Open Enrollment Periods as established by the Exchange shall last a minimum of thirty (30) days.

4.5 **Annual Open Enrollment Period Coverage Effective Dates.**

(a) Qualified individuals must select a QHP and the Exchange must receive the first month's premium in full in order to make coverage effective.

(b) *Benefit Year 2015 and Beyond.* The Exchange shall establish a deadline relative to the Annual Open Enrollment Period by which a qualified individual's first month's premium must be received in order to make coverage effective as of the first day of the benefit year.

4.6 **Special Enrollment Periods.** The Exchange shall provide special enrollment periods lasting a minimum of sixty (60) days and consistent with 45 C.F.R. §155.420 during which qualified individuals may enroll in Qualified Health Plans and enrollees may change Qualified Health Plans.

(a) *Triggering Events*. The Exchange will allow a qualified individual or enrollee, and, when specified below, his or her dependent, to enroll in or change from one QHP to another if one of the triggering events defined in 45 C.F.R. §155.420(d) occurs. The Exchange shall also have the authority to define other triggering events not otherwise specified in 45 C.F.R. §155.520(d).

(b) *Effective Dates*

(1) *General.* Except as specified in §4.6(b)(2) of these Regulations, the Exchange shall establish a monthly deadline by which a qualified individual enrolling during a Special Enrollment Period must select a QHP and the Exchange must receive the first month's premium in order to make coverage effective on the first day of the following month. The Exchange shall make coverage effective on the first day of the second following month for a qualified individual not meeting the monthly deadline.

(2) *Special Effective Dates.*

i. *In the case of birth, adoption, or placement for adoption, the Exchange must ensure that coverage is effective on the date of the birth, adoption, or placement for adoption.*

ii. *In the case of marriage or in the case where a qualified individual or dependent loses minimum essential coverage, the Exchange must ensure coverage is effective on the first day of the following month.*

SECTION 5.0 ADVANCED PAYMENTS OF THE PREMIUM TAX CREDIT

5.1 **In General**. Section 1401 of the ACA creates new section 36B of the Internal Revenue Code (the Code), which provides for a premium tax credit for eligible individuals who enroll in a QHP through an Exchange. Section 1402 of the ACA establishes provisions aimed at reducing the cost-sharing obligations of certain eligible individuals enrolled in a QHP offered through an Exchange, including standards for determining Indians eligible for certain categories of cost-sharing reductions. The ACA and its implementing regulations, found in 45 C.F.R. §155.305, authorize the Exchange to determine qualified individuals' eligibility for Advance Payments of the Premium Tax Credits. In order to qualify for Advance Payments of Premium Tax Credits, an applicant must meet both the eligibility requirements to enroll in a Qualified Health Plan as described at §3.0 of these Regulations and the eligibility requirements for the advance payment of a premium tax credits as described in this subpart. An applicant determined eligible for a premium assistance amount may elect not to take the full monthly premium assistance amount for which he or she is determined eligible. The amount of the premium tax credit the applicant should have received over the course of the benefit year will be reconciled when the applicant files a tax return for that year.

5.2 **Eligibility for Advance Payments of the Premium Tax Credit.** The Exchange shall find an applicant eligible for advance payments of the premium tax credit if the Exchange determines that he or she meets the following criteria:

(a) He or she is expected to have a household income, as defined in section 36B(d)(2) of the Internal Revenue Code, of greater than or equal to 100 percent of the FPL and less than 400 percent of the FPL for the benefit year for which coverage is requested; and

(b) He or she plans to file a federal tax return, and, if married to file a joint return, for the benefit year;

(c) He or she may not be claimed by another tax filer as a tax dependent under Section 151 of the Internal Revenue Code.

5.3 **Individuals for Whom a Premium Assistance Amount Can be Provided.** An applicant will be eligible for a premium assistance amount only for a month that one or more members of the tax filer's family (the tax filer or the tax filer's spouse or tax dependent) meet the following criteria:

(a) Are enrolled in one or more QHPs; and

(b) Are not eligible for minimum essential coverage as defined in 26 C.F.R. §1.36B-2(c) other than individual market coverage described in 5000A(f)(1)(C) of the Internal Revenue Code.

5.4 **Special Rule for Non-Citizens Who are Lawfully Present Immigrants and Who Are Ineligible for Medicaid by Reason of Immigration Status.** In accordance with 45 C.F.R. 155.305(f)(2), lawfully present immigrants who are ineligible for Medicaid based on immigration status and whose household income is below one hundred percent (100%) of the FPL shall be eligible for an APTC if they meet all other eligibility requirements for advance payments of the premium tax credit.

5.5 **Calculation of Advance Payments of the Premium Tax Credit.** The Exchange shall calculate any applicant's advance payment of the premium tax credit in accordance with the requirements of 26 C.F.R. §1.36B-3.

5.6 **Appeals.** An applicant has the right to an appeal of an eligibility determination based on this section and pursuant to the appeals process as described in §11.0 of these Regulations and as set forth in the *"0110 Complaints and Hearings"* regulations promulgated by EOHHS..

SECTION 6.0 COST SHARING REDUCTIONS

6.1 **In General.** Section 1401 of the ACA and its implementing regulations, 45 C.F.R. §155.305, establish eligibility requirements for an applicant to receive cost sharing reductions. To receive cost sharing reductions, an applicant must meet the eligibility requirements to enroll in a Qualified Health Plan as described in §5.0 of these Regulations, the eligibility requirements for the advance payments of a premium tax credit as described at §5.2 of these Regulations and the eligibility requirements as described in §6.2 of these Regulations.

6.2 **Eligibility Criteria**. The Exchange will determine an applicant eligible for cost-sharing reduction if he or she:

(a) Is expected to have household income, as defined in 36B(d)(2) of the Internal Revenue Code, that does not exceed two hundred and fifty percent (250%) of the FPL for the benefit year for which coverage is requested; and

(b) Meets the eligibility criteria for enrollment in a QHP; and

(c) Meets the eligibility criteria for an advance payment of a premium tax credit.

6.3 **Provided Only to Enrollees in a Silver-Level Qualified Health Plan**. With the exception of Indians, the Exchange will provide cost-sharing reductions only to enrollees who enroll in a silver-level Qualified Health Plan as defined by section 1302(d)(1)(B) of the ACA.

6.4 **Use of Eligibility Categories.** The Exchange will use the CSR eligibility categories set forth in 45 C.F.R. §155.305(g).

6.5 **Special Rule for Lawfully Present Immigrants Below 100% FPL.** The Exchange will follow the federal rule set forth in 26 CFR 1.36B-2 for lawfully present immigrants with income below one hundred percent (100%) FPL who are eligible for a cost-sharing reduction.

6.6 **Special Rules for Indians.** The Exchange will follow the special rules for Indians as set forth in 45 C.F.R. § 155.350.

(a) The Exchange will find Indians with expected household income equal to or less than three hundred percent (300%)of the FPL, who are eligible for an APTC, and who enroll in a QHP, eligible for a zero cost-sharing plan.

(b) The Exchange will find Indians who apply for an insurance affordability program eligible for the limited cost-sharing plan regardless of their income level.

6.7 **Special Rule for Multiple Tax Households.** To the extent that enrollment in a QHP includes individuals who expect to be in different tax households, the Exchange will apply only the category of eligibility last listed below for which all the individuals covered by the policy would be eligible:

(a) No cost sharing reduction.

(b) Limited cost-sharing reduction plan (for Indians)

(c) Category 3 cost-sharing reduction plan (for 201% FPL to 250% FPL)

(d) Category 2 cost-sharing reduction plan (for 151% FPL to 200% FPL)

(e) Category 1 cost-sharing reduction plan (for 100% FPL to 150% FPL)

(f) Zero cost-sharing reduction plan (for Indians below 301% FPL)

6.8 **Appeals.** An applicant has the right to an appeal of an eligibility determination based on this section and pursuant to the appeals process as described in §11.0 of these Regulations and as set forth in the *"0110 Complaints and Hearings"* regulations promulgated by EOHHS.

SECTION 7.0 TERMINATION OF COVERAGE AND GRACE PERIODS

7.1 **In General.** Section 1412(c)(2) of the ACA, and its implementing regulation 45 C.F.R. § 156.270, establish a three-month grace period for non-payment of premium before coverage will be terminated for a qualified individual who is receiving advance payment of premium tax credits and has made at least one full month's premium payment during the benefit year. 45 C.F.R. §155.430 establishes procedures for termination of QHP coverage.

7.2 **Termination of Coverage Due to Non-Payment of Premium.** The Exchange shall establish a standard policy for the termination of coverage of enrollees due to non-payment of premiums. This policy for the termination of coverage:

(a) Must include the grace period for enrollees receiving advance payments of the premium tax credits; and

(b) Must be applied uniformly to enrollees in similar circumstances.

7.3 **Grace Period.**

(a) *Individuals receiving an advance premium tax credit*. The Exchange shall provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year.

(b) *Exhaustion of grace perio*d. If an enrollee receiving advance payments of the premium tax credit exhausts the 3-month grace period without paying all outstanding premiums, the Exchange shall terminate the enrollee's coverage. Coverage is terminated with retrospective effect to the first day of the second month of non-payment.

(c) The QHP issuer must continue to pay claims during the first month of the grace period and may pend claims during the second and third months of the grace period.

(d) The Exchange has the authority to extend a Grace Period as described in §7.3(a) of these Regulations on a case-by-case basis.

7.4 **Qualified Health Plan Issuers May Not Terminate Coverage.** Qualified Health Plan issuers may not unilaterally terminate coverage. If a Qualified Health Plan issuer believes coverage should be terminated, it must request a termination from the Exchange, in a manner prescribed by the Exchange.

7.5 **Involuntary Termination.** The Exchange may promptly initiate termination upon any of the following events:

(a) The enrollee is no longer a qualified individual as determined based on information submitted by the enrollee or information obtained by the Exchange.

(b) The enrollee dies.

(c) Non-payment of premiums, after the exhaustion of any applicable grace period pursuant to §§ 7.3(a) and (b) of these Regulations.

(d) The QHP terminates or has been decertified, which constitutes a loss of Minimum Essential Coverage. The qualified enrollee will be given an opportunity to enroll in a new QHP pursuant to special enrollment periods set forth in §4.6(a) of these Regulations.

(e) The qualified individual selects a different QHP during an open or special enrollment period.

7.6 **Voluntary Termination.** The Exchange shall terminate enrollment at any time upon the request of an enrollee. Effective termination dates for voluntary termination shall be established by the Exchange.

7.7 **Notice.** The Exchange will provide an enrollee written notice of an involuntary termination that shall include the basis of the termination at least thirty days prior to the effective date of the termination.

7.8 **Effective Date of Termination.**

(a) *Voluntary terminations.*

(1) Upon a voluntary termination request submitted at least fourteen (14) days prior to the end of the month coverage shall be terminated at the end of the month. Coverage shall be terminated at the end of the following month if the termination request is submitted less than fourteen days prior to the end of the month.

(2) The Exchange may grant a different termination date if the request is submitted at least fourteen (14) days prior to the proposed termination date.

(3) The Exchange has discretion to grant an earlier termination date, on a case by case basis.

(4) If the enrollee requests coverage termination due to eligibility for Medicaid, coverage will terminate the day before Medicaid coverage begins.

(b) *Involuntary terminations.*

(1) If the enrollee is no longer a qualified individual as determined upon receipt of information from the enrollee or information obtained by the Exchange, coverage will terminate on the last day of the month following the month in which the Exchange sent the enrollee notice of an eligibility redetermination. In such a case, the enrollee may request an earlier termination date, pursuant to §7.8(a) of these Regulations.

(2) If the coverage is terminated for non-payment pursuant to §7.5(c) of these Regulations.

(3) If the enrollee dies, coverage terminates on the day of the death. Premiums will be refunded by the Exchange to the estate for the remainder of the month.

(4) If the enrollee changes Qualified Health Plans, the existing Qualified Health Plan coverage terminates the day before the new coverage begins.

(5) If the Qualified Health Plan terminates or is decertified, coverage will terminate the day the Qualified Health Plan terminates or is decertified, unless the enrollee is granted an earlier termination date pursuant to §7.8(a) of these Regulations .

SECTION 8.0 MINIMUM ESSENTIAL COVERAGE EXEMPTIONS

8.1 **In General.** Section 5000A of the Internal Revenue Code of 1986, as added by the ACA, requires that for each month during the taxable year, a non-exempt individual must have

minimum essential coverage, as defined under the law, or pay a shared responsibility payment.

(a) The Exchange is authorized to issue exemptions to the minimum essential coverage requirement.

(b) The Exchange may rely on HHS for this purpose until the Exchange establishes the procedures necessary to make such a determination.

(c) The Exchange call center and web site shall provide information to consumers regarding the exemption eligibility process.

8.2 **Exchange Exemption Eligibility Determination.** Any application for an exemption from the minimum essential coverage requirement submitted to the Exchange will be determined by the Exchange promptly and without undue delay.

(a) To the extent applicable, the Exchange will use information already available to it, so as not to request duplicate information from the applicant.

(b) An exemption applicant who has a Social Security number must provide such number.

(c) An individual who is not seeking an exemption for himself or herself need not provide a Social Security number, except as required by 45 C.F.R. §155.610(e)(3).

(d) Once the applicant's eligibility for an exemption is approved pursuant to exemption eligibility standards as defined in 45 C.F.R. §155.605, the Exchange will send the applicant a notice that will serve as the certificate of exemption. The notice will instruct the application to retain the certificate as proof of exemption. If the exemption is denied, the Exchange will send the applicant a notice containing instructions on how to appeal the denial.

(e) If the Exchange determines the applicant eligible for an exemption, the Exchange will transmit to the Internal Revenue Service the individual's name, Social Security number, exemption certificate number, and any other information required by the Internal Revenue Service.

(f) The Exchange will attempt to verify information provided by the applicant in compliance with the requirements of 45 C.F.R. §155.615.

SECTION 9.0 AGREEMENTS WITH ISSUERS

9.1 **In General.** The Exchange shall establish a certification process for all participating QHP Issuers.

9.2 **Issuer Agreements.** All QHP Issuers must enter an Issuer Agreement with the Exchange describing the issuer's obligations with regard to offering products and/or services on the Exchange.

(a) Issuer Agreements shall be negotiated on an annual basis and formed in advance of the Annual Open Enrollment Period for the upcoming benefit year.

(b) QHPs offered through the Exchange pursuant to an Issuer Agreement may vary from year to year.

SECTION 10.0 SHOP EXCHANGE

10.1 **In General.** Section 1311(b)(1)(B) of the ACA and its implementing regulations, 45 C.F.R. Subpart H provide for the establishment of a Small Business Health Options Program (SHOP) Exchange that is designed to assist qualified employers and facilitate the enrollment of qualified employees into qualified health plans.

10.2 **Terms and Conditions.** To become an employer eligible to participate in the SHOP Exchange, employers must register with the Exchange and accept the terms and conditions for participation. The SHOP Exchange may from time to time modify such terms and conditions for participation in the SHOP Exchange.

10.3 **SHOP Enrollment.** A qualified employer or a qualified employee shall submit a signed application for coverage prior to receiving coverage through the SHOP Exchange. All signatures required from a qualified employer or a qualified employee to complete an enrollment application may be obtained electronically. Any such electronic signature is valid and the legal equivalent of a signature obtained in another form.

10.4 **Agents and Brokers.** The SHOP Exchange shall establish a process by which a qualified employer or qualified employee may designate an insurance agent or broker to act on his or her behalf in interactions with the SHOP Exchange.

(a) In order to enroll qualified employers and qualified employees through the SHOP Exchange, the agent or broker must be certified to participate in the SHOP Exchange and must have established an account with the SHOP Exchange.

(b) A qualified employer or qualified employee may designate an agent or broker electronically.

10.5 **SHOP Premium Aggregation.** The SHOP Exchange shall provide each qualified employer with a bill on a monthly basis that identifies the employer contribution, the employee contribution, and the total amount that is due to the Qualified Health Plan issuers from the qualified employer. The SHOP Exchange shall also collect from each employer the total amount due and make payments to Qualified Health Plan issuers in the SHOP for all enrollees.

10.6 **Due Date.** The SHOP Exchange shall establish a monthly deadline by which premium payments must be received in order to make coverage effective on the first day of the following month. Payments received after the deadline described in this subsection will make coverage effective on the first day of the second following month.

10.7 **Grace Period.** Qualified employers shall have a thirty-day premium non-payment grace period. If full payment is not received by the end of the grace period, the SHOP Exchange may automatically terminate coverage retrospective to the last day for which coverage has been paid.

SECTION 11.0 APPEALS

11.1 **Designation of Exchange Appeals Entity.** Any Exchange eligibility appeals other than Large Employer Appeals may be accepted, processed and adjudicated by EOHHS if, at such time as the appeal is filed, the Exchange has in effect a memorandum of agreement (MOA) designating EOHHS as the entity responsible for such appeals.

11.2 **Procedures for Appeals Delegated to EOHHS by MOA**. Specific requirements relating to the acceptance, processing, and adjudication of appeals by EOHHS shall be as set forth in the "*0110 Complaints and Hearings*" regulations promulgated by EOHHS.

SECTION 12.0 EXCHANGE TRUST PAYMENTS

12.1 **Establishment of Trust.** The Exchange shall establish the Trust for the following purposes:

(a) Collecting health and dental insurance premium payments from qualified employers and qualified individuals;

(b) Remitting premium payments to QHP issuers on behalf of enrollees who participate in QHPs offered through the Exchange;

(c) Performing functions ancillary to the collection and payment of premiums to qualified health plan issuers and the receipt of payments for such products and services as may be offered through the Exchange; and

(d) Carrying out any other functions that are reasonably necessary in furtherance of the foregoing and in accordance with the establishment and maintenance of the Trust.

12.2 **Payments to the Trust.** Qualified individuals and qualified employers may remit premium payments to the Exchange to maintain participation in a QHP in accordance with all requirements under the Act and the Federal Regulations.

(a) Premium payments may be made in advance of the coverage month to which the payment applies.

(b) The monthly premium payment deadline shall be established by the Exchange.

(c) Premium payments will be applied against open premium lines in chronological order, beginning with the oldest outstanding premium payment.

(d) Payments may be received by the Trust from qualified individuals and employers for such products and services as may be offered through the Exchange.

12.3 **Overdue Accounts**. Individuals and Employers will be considered overdue when they have not paid a monthly bill in full by the designated due date.

(a) Overdue accounts will receive a late notice including the payment amount overdue, any applicable grace period as defined in §8.3 or §10.11 of these Regulations, and the expected coverage termination date.

(b) Late notices will be mailed and delivered electronically into the individual's or employer's account.

12.4 **Payment Deposits.** All premium payments described in §12.2 of these Regulations will be deposited into one or more bank accounts, held in the name of the Trust, and maintained at a bank branch located in the State of Rhode Island and insured by the Federal Deposit Insurance Corporation.

12.5 **Payments from the Trust.** Upon receipt the reconciliation of accounts among and between the Exchange and a QHP issuer, the Trust will remit premium payments to the QHP issuer in accordance with the issuer agreement and pursuant to procedures set forth by the Exchange. The Trust shall receive any such funds as may be permitted under state and federal law and regulation and remit to the Exchange.

12.6 **Standards.** All activities of the Trust must be performed in accordance with all applicable standards under the Federal Regulations and the Act including, without limitation, the oversight and financial integrity requirements of Section 1313 of the Act.

12.7 **Privacy and Security.** All activities of the Trust shall conform with all applicable state and federal laws pertaining to the privacy and security of financial and confidential health information including, without limitation, those standards described in 45 C.F.R. §§ 155.260(a)-(g) and 155.270(a) and (b) of the Federal Regulations relating to conducting electronic transactions.

SECTION 13.0 SEVERABILITY

13.1 If any provisions of these Regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these Regulations which can be given effect, and to this end the provisions of these Regulations are declared to be severable.

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