Title of Rule:	Children's Basic Health Plan, Senate Bill 07-097 adds an income disregard of 2.5 % for families that are over-income. Senate Bill 07-211 expands presumptive eligibility to include children.
Rule Number:	MSB 07-09-19-B
Division / Contact / Phone:	Children's Basic Health Plan / Kristy Wilson / (303)866-3291

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   Senate Bill 07-097 will add an income disregard of 2.5 % for families that are over-income. Senate Bill 07-211 will expand presumptive eligibility to include children.

2. An emergency rule-making is imperatively necessary

   ☒ to comply with state or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

   Senate Bill 07-097 will add an income disregard of 2.5 % for families that are over-income. Senate Bill 07-211 will expand presumptive eligibility to include children.

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2007);
   Senate Bill 07-097 and Senate Bill 07-211

Initial Review		Final Adoption	
Proposed Effective Date	**01/01/2008**	Emergency Adoption	**12/14/2007**

DOCUMENT #03

Title of Rule:	Children's Basic Health Plan, Senate Bill 07-097 adds an income disregard of 2.5 % for families that are over-income. Senate Bill 07-211 expands presumptive eligibility to include children.
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REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The class of persons that will be affected and benefit from this proposed rule change are Children's Basic Health Plan program clients.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The population affected by this rule change will now receive immediate medical service because of presumptive eligibility.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   Costs associated with implementing this eligibility change have been fully addressed in the fiscal note submitted to the legislature and appropriated by the General Assembly.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   This rule is needed to comply with new legislation, SB 07-097 and SB 07-211.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   At this time there are no less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There were no alternative methods considered for the proposed rule.

50 DEFINITIONS

50.1 “Applicant” shall mean a person applying or re-applying for benefits on behalf of a child and/or themselves.

50.2 “Benefit Year” or “Plan Year” shall mean the term of the employer sponsored insurance as determined by the employer.

50.3 “Child” means a person who is less than nineteen years of age.

50.4 “Cost sharing” shall mean payments, such as copayments or enrollment fees that are due on behalf of the enrollee.

50.5 “Department” shall mean the Colorado Department of Health Care Policy and Financing.

50.6 “Effective Date” shall mean the first day of the employer sponsored insurance, or ESI, benefit year.

50.7 “Employer contribution” shall mean the amount of the employer sponsored insurance premium that is paid by the employer.

50.8 “Employer Sponsored Insurance” or “ESI” shall mean a medical benefit plan provided by an employer that meets the minimum required benefit coverage required by the Department.

50.9 “Enrollee” shall mean an eligible person who is enrolled in the Children’s Basic Health Plan including the premium assistance program.

50.10 “Essential Community Provider” means a healthcare provider that:

A. Has historically served medically needy or medically indigent patients and demonstrates a commitment to serve low-income and medically indigent populations who make up a significant portion of its patient population, or in the case of a sole community provider, serves medically indigent patients within its medical capability; and

B. Waives charges or charges for services on a sliding scale based on income and does not restrict access or services because of a client's financial limitations.

50.11 “Evidence of Coverage” or “EOC” shall mean any certificate, agreement, or contract issued to an enrollee from time-to-time by an MCO setting out the coverage to which the enrollee is or was entitled under the Children’s Basic Health Plan.

50.12 “Family” shall mean a group of people who are related by blood, marriage or other legally recognized domestic relationship, live in the same household and receive at least 50% of their support from the household.

50.13 “Grievance Committee” shall mean a conference with the Department or its Designee in which a contested decision regarding an applicant or enrollee is reexamined.

50.14 “Managed Care Organization” or “MCO” shall mean:

A. A carrier which meets the definition in §10-16-102 (8), C.R.S. with which the Department contracts to provide health care or dental services covered by the Children's Basic Health Plan; or,

B. Essential community providers and other health care and dental service providers with whom the Department contracts to provide health care services under the Children's Basic Health Plan using a managed care model.

50.15 "Opt-in" shall mean an eligible person's election to enroll in the premium assistance program.

50.16 "Opt-out" shall mean an eligible person's election to disenroll from the premium assistance program.

50.17 "Premium Assistance" shall mean a component of Children's Basic Health Plan, under which the Department pays part of the insurance premium for a Children's Basic Health Plan eligible enrollee's employer sponsored insurance, ESI.

50.18 "Presumptive Eligibility" shall mean children and pregnant women who have applied and appear to be eligible for the Children's Basic Health Plan shall be presumed eligible and may receive immediate temporary medical coverage.

50.19 "Primary Beneficiary" shall mean the employer sponsored insurance, or ESI, policy holder.

50.20~~19~~ "Subsidy" shall mean the amount paid by the Department to assist a Children's Basic Health Plan eligible person in purchasing coverage under an eligible health plan available through another coverage entity, including employer sponsored insurance, ESI.

50.21~~0~~ "Woman" shall mean a female age 19 or over.

100 ELIGIBILITY

110 INDIVIDUALS ASSISTED UNDER THE PROGRAM

110.1 To be eligible for the Children's Basic Health Plan, an eligible person shall:

A. 1. Be less than 19 years of age; or

2. Be a pregnant woman

B. Meet one of the following categories:

1. A citizen or national of the United States, the District of Columbia, Puerto Rico, Guam, the United States Virgin Islands, the Northern Mariana Islands, American Samoa, or Swain's Island; or

2. An alien or immigrant who entered the United States at least five years prior to the date of application and who is:

a. Lawfully admitted for permanent residence under the U.S. Immigration and Nationality Act; or

b. Paroled into the United States for at least one year under Section 212(d)(5) of the U.S. Immigration and Nationality Act; or

c. Granted conditional entry under Section 203(a)(7) of the U.S. Immigration and Nationality Act; or

3. An alien who arrived in the United States on any date who is:

a. Lawfully residing in Colorado and is an honorably discharged military veteran; or

1. A spouse of such military veteran; or

2. An unremarried surviving spouse of such military veteran; or

3. An unmarried dependent child of such military veteran.

b. Lawfully residing in Colorado and is on active duty in the United States Armed Forces, excluding military training; or

1. A spouse of such individual; or

2. An unremarried surviving spouse of such individual; or

3. An unmarried dependent child of such individual.

c. Granted asylum under Section 208 of the U.S. Immigration and Nationality Act; or

d. Refugee under Section 207 of the U.S. Immigration and Nationality Act; or

e. An individual with deportation withheld:

1. Under Section 243(h) of the U.S. Immigration and Nationality Act, as in effect prior to September 30, 1996; or

2. Under Section 241(b)(3), as amended by P.L. 104-208 of the U.S. Immigration and Nationality Act.

f. A Cuban or Haitian entrant, as defined under Section 501(e)(2) of the U.S. Refugee Education Assistance Act of 1980; or

g. An individual who:

1. Was born in Canada and possesses at least 50 percent American Indian blood; or

2. Is a member of an Indian tribe, as defined in 25 U.S.C. Section 450(b)e.

h. Admitted into the United States as an Amerasian immigrant under Section 584 of the U.S. Foreign Operations, Export Financing, and Related Programs Appropriation Act of 1988, as amended by P.L. 100-461; or

i. A lawfully admitted, permanent resident, who is a Hmong or Highland Lao veteran of the Vietnam conflict; and

C. Be a resident of Colorado; and

D. Have family income less than or equal to 200% of the Federal Poverty Level, adjusted for family size.

~~E. The person described in section 110.1.A.2. shall be presumed eligible for the Children's Basic Health Plan if their self reported income meets the income guidelines as described in section 110.~~

E~~F~~. Failure to complete an application or to provide required documentation in Section 130 will result in the denial of the incomplete application or individual applicant (s).

120 INSUFFICIENT ACCESS TO OTHER HEALTH COVERAGE

120.1 To be eligible for the Children's Basic Health Plan, an eligible person shall not:

A. Be covered under a group health plan or under health insurance coverage excluding Consolidated Omnibus Budget Reconciliation Act (COBRA); or

B. Have had within the three months prior to application, comparable (as defined in Title XXI of the Social Security Act, Section 2103) health coverage through an employer where the employer contributes at least fifty percent of the premium cost for the individual unless the individual lost health coverage due to a change in or loss of employment, or the employer no longer offers coverage; or

C. Be a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State of Colorado; or

D. Be eligible to receive assistance under Title XIX of the Social Security Act; or

E. Be an inmate of a public institution or a patient in an institution for mental diseases.

130 DOCUMENTATION

130.1 To be eligible for the Children's Basic Health Plan, an eligible person shall provide the following:

A. Verification of earned income for the family of the applicant if money has been earned within 30 days of the date of application. Verification may include one of the following:

1. Current wage stubs; or

2. A written document from an employer; or

3. A phone call to an employer (if permitted by applicant); or

4. Self-employment section of application, ledgers or receipts for self-employed applicants.

140. REDETERMINATION

140.1 Eligibility shall be redetermined when twelve (12) months have passed since the last eligibility determination.

150 CALCULATION OF FAMILY INCOME

150.1 Income includes all employment, self-employment, and unearned income, with the following exceptions:

A. College grants and scholarships;

B. Grants from non-profit, tax-exempt, charitable foundations specifically for cost sharing;

C. Child support and foster care payments;

D. Food stamps and Women, Infants, and Children (WIC) payments;

E. Assistance provided by non-profit organizations, if the assistance is need-based (i.e. the cost of meals at a soup kitchen);

F. Settlements;

G. Stipends;

H. College loans;

I. Medical care provided for free or if a third party made the payments;

J. Payments by credit life or disability insurance;

K. Proceeds of a loan;

L. Disaster relief assistance;

M. Tax refunds;

N. Moving expenses paid by employer for relocation;

O. Income of children less than 19 years of age; and

P. Children's Basic Health Plan premium assistance program payments

150.2 Verification of earned income may be provided through the submission of documents as described in section 130.1 A. Verification of earned income shall be provided for the month of application or the month prior to the month of application, if the verification is not yet available for the application month. Estimated income may be used to determine eligibility if the applicant provides income verification for any part of the application month.

150.3 The following are allowable deductions to income for the same month income is provided:

A. Day and elder care expenses;

B. Expenses for medical services, prescriptions or durable medical equipment;

C. Child support payments;

D. Alimony payments; and

E. Health insurance premiums.

F. For families that are over income, the Department may apply a 2.5% income disregard on or after March 1, 2008.

160 PREMIUM ASSISTANCE

160.1 To be eligible for the Children's Basic Health Plan premium assistance program, an eligible person shall meet all eligibility requirements for the Children's Basic Health Plan program, as described in Section 110, Individuals assisted under the program and Section 120, Insufficient access to other health coverage.

160.2 To be eligible for the Children's Basic Health Plan premium assistance program, an eligible person shall submit documentation required for enrollment in the Children's Basic Health Plan as described in Section 130, Documentation. An eligible person shall also submit the following prior to premium assistance enrollment;

A. Employer sponsored insurance form; and

B. United States Internal Revenue Services Form W-9: Request for Taxpayer Identification and Certification; and

C. Verification of employer sponsored insurance enrollment.

160.3 To be determined eligible for the Children's Basic Health Plan premium assistance program, an eligible persons' employer shall contribute to the employer sponsored insurance premium at a level determined to be cost effective by the Department.

160.4 Eligibility for the Children's Basic Health Plan premium assistance shall be redetermined consistent with section 140, Redetermination, based on employer benefit year.

160.5 A person who has applied for the Children's Basic Health Plan premium assistance program and is determined ineligible shall use the eligibility appeals process as described in section 600, Appeals Process.

170 PRESUMPTIVE ELIGIBILITY

170.1 An eligible person may apply for presumptive eligibility for immediate temporary medical services through designated presumptive eligibility sites.

To be eligible for presumptive eligibility, an applicant household's declared income shall not exceed 200% of federal poverty level and he/she shall be a United States citizen or a documented immigrant of at least five years.

Presumptive eligibility sites shall be certified by the Department of Health Care Policy and Financing to make presumptive eligibility determinations. Sites shall be re-certified by the Department of Health Care Policy and Financing every 2 years to remain approved presumptive eligibility sites.

The presumptive eligibility sites shall attempt to obtain all necessary documentation to complete the application within ten business days of application.

The presumptive eligibility site shall forward the application to the county within five business days of being completed. If the application is not completed within ten business days, on the eleventh business day following application, the presumptive eligibility sites shall forward the application to the appropriate county.

The presumptive eligibility period will be no less than 45 days. The presumptive eligibility period will end on the last day of the month following the completion of the 45 day presumptive eligibility period. The county or medical assistance (MA) site shall make an eligibility determination within 45 days from the date of application. The effective date of eligibility will be the date of application.

A presumptive eligible person may not appeal the end of a presumptive eligibility period.

170.2 Presumptively eligible clients may appeal the county or medical assistance (MA) site's failure to act on an application within 45 days from date of application or the denial of an application. Appeal procedures are outlined in Section 600.