RESPONSE TO TERMS OF CLEARANCE
IN THE NOTICE OF OFFICE OF MANAGEMENT AND BUDGET (OMB) ACTION

Request for Review If You Have Been Denied of Premium Assistance

A. Background

On May 20, 2009, OMB approved an emergency clearance request for an information collection request (ICR) entitled *Request for Review If You Have Been Denied Premium Assistance* (Application). The OMB control number is 0938-1062, and the expiration date is 11/30/2009. Notice for this emergency ICR appeared in 74 Federal Register 20483 (May 4, 2009). In the terms of clearance of its Notice, OMB stated: "By the next submission, the Department will be prepared to describe how it uses all of the data collected to carry out program objectives." This document describes how the information requested in the Application will enable Centers for Medicare & Medicaid Services (CMS) to carry out its larger mission of providing health care for as many people as possible by specifically fulfilling the statutory mandate set forth in the American Recovery and Reinvestment Act of 2009 (ARRA) (P.L. 111-5).

ARRA provides for premium assistance and expanded eligibility for health benefits under the Consolidated Omnibus Budget Reconciliation Act of 1986, commonly called COBRA, and other comparable state continuation coverage programs. This premium assistance is not paid directly to the covered employee or the qualified beneficiary, but instead is in the form of a tax credit for the group health plan, the employer, or the insurer. An individual must be an "assistance eligible individual" to be eligible for the premium assistance. If eligible, these individuals pay only 35 percent of their COBRA premiums to the plan and the remaining 65 percent is paid through the tax credit. Eligible individuals can start getting the premium assistance as of the first day of coverage beginning on or after February 17, 2009.

An "assistance eligible individual" is a "qualified beneficiary[1]" who:

- Is eligible for COBRA continuation coverage at any time during the period beginning September 1, 2008 and ending December 31, 2009;
- Elects COBRA coverage; and
- Has a qualifying event for COBRA coverage that is the employee's involuntary termination during the period beginning September 1, 2008 and ending December 31, 2009.

If an individual requests treatment as an assistance eligible individual and the group health plan, employer or insurer denies him or her premium assistance, the Secretary of Health and Human Services must provide for expedited review of the denial upon application to the Secretary in the form and manner the Secretary provides. The Secretary is required to make a determination within 15 business days after receipt of an individual's application for review.

1 In general a "qualified beneficiary" is an individual who was covered by a group health plan on the day before a qualifying event occurred that caused him or her to lose coverage. A qualified beneficiary must be a covered employee, the employee's spouse or former spouse, or the employee's dependent child.

The *Request for Review If You Have Been Denied Premium Assistance* (the "Application") is the form that will be used by individuals to file their expedited review appeals. Each individual must complete all information requested on the Application for CMS to begin reviewing his or her case. An individual's case cannot be reviewed if sufficient information is not provided on the Application, or cannot be obtained upon request.

The information provided on the Application will be used by CMS to make a determination regarding the applicant's eligibility for premium assistance. In cases where information is lacking, answers on the Application may provide solid leads for further research. CMS will make its determination within the 15-business day time frame required under section 3001(a)(5) of ARRA. CMS's determination upon review of the denial will be de novo and serve as the final determination of the Secretary. A reviewing court is required to grant deference to the Secretary's determination.

B. Use of Information

The information requested in the Application will better enable CMS to determine whether each individual is qualified for premium assistance. ARRA provides CMS an extremely tight time frame to render a decision: 15 business days. To reach a decision, CMS must not only apply a new statute--ARRA--to the varying facts of each case, but must interpret how ARRA interacts with either 1. complicated federal COBRA laws; or 2. the applicable laws of one of any number of State continuation coverage programs. Obtaining the specific information requested in the Application as soon as possible will enable CMS to use the short 15 days of time available to it more effectively by focusing on disputed or difficult facts or legal issues rather than researching basic facts or contact information that might be more easily within reach of each Applicant. Below we discuss the specific need for questions.

<u>Applicant's Information</u>
The basic contact information will allow CMS to reach applicants for any one of a number of questions that could arise (e.g., to find missing information or resolve complicated issues of fact that may arise in different cases or questions arising from the form.)

<u>Date of termination of employment</u>
To qualify under ARRA, the employee must be terminated within a certain time period (September 1, 2008 through December 31, 2009.)

<u>Date employer stopped paying for health insurance</u>
The date that an employer stops paying for health insurance may determine the date when that individual becomes eligible to receive benefits under ARRA.

<u>Applicant's relationship to employee and names of dependents</u>
Continuation coverage is generally available not only to a terminated employee, but to his or her dependents--including a spouse. Each of these individuals separately may or may not elect continuation coverage or apply for ARRA benefits. Each may even have--or elect for the future

if offered--a different health plan than the others. Because different facts may result in a different determination as to whether an individual is eligible for premium assistance or not, it is important that CMS know the exact person the case involves. Not all employees whose work provides the link to premium assistance may share the same last name as their dependents. Yet, facts about that employment are central to whether a dependent qualifies for premium assistance (e.g., the employee must be involuntarily terminated within a specific time period). If CMS found it essential to confirm an employee's work history to determine whether his or her dependent qualifies for premium assistance, its research would be significantly slowed down if it did not have the name of that employee at hand.

Eligibility: Questions 1 through 4

These questions go to the heart of eligibility of an applicant for continuation coverage and premium assistance. As grouped together--and as underscored by the note following the four questions--these questions enable individuals to determine if there is a possibility that they could receive premium assistance. Individuals who answer no are alerted to this possibility and also provided a helpdesk number to seek more information.

Involuntary termination: Question 5, a - f

ARRA's benefit is only available to those individuals and their dependents who are involuntarily terminated. Answers to subquestions under Question 5 provide information that will help CMS to, if not conclusively determine that an individual does not qualify for ARRA on the basis that the employee was not "involuntarily terminated," focus its research in the area.

Jurisdiction: Questions 6 and 7

ARRA specifies that individuals denied premium assistance should request an expedited review from either CMS or the Department of Labor (Labor). All determinations regarding ERISA plans (private employers with 20 or more employees) will be handled by Labor and appeals regarding public sector (state and local government with 20 or more employees) employer plans, federal government and State continuation coverage laws will be handled by CMS. These two questions allow CMS to decide whether it has jurisdiction to consider the applicant's case or whether the applicant should be referred to Labor.

Continuation coverage: Question 8, a - e

Continuation coverage is closely linked to premium assistance and these questions elicit critical information. Premium assistance is provided to help individuals with the cost of continuation coverage and, accordingly, cannot be provided when an individual is no longer eligible for continuation coverage. The information in this question will allow CMS to determine whether the continuation coverage has expired. (For instance, some States provide for only three months of continuation coverage.) If an individual indicates that he or she was denied continuation coverage, he or she can provide additional information for CMS to consider. The time that an individual receives notice that he or she is eligible for continuation coverage may impact the timing of his or her eligibility not only for continuation coverage but for the premium assistance (e.g., when eligibility would start or how long it would last).

Premium Assistance: 9 a-c, 10, 11

CMS is to review cases in which individuals have been denied premium assistance. These questions allow CMS to determine whether it needs to further research a case. While an explicit denial is not required in all cases, an applicant cannot be eligible for the premium assistance if he or she has other group health coverage or Medicare. Nor can applicants who have waived their right to premium assistance receive it. The time that an individual receives notice that he or she is eligible for premium assistance may impact the timing of his or her eligibility for the premium assistance (e.g., when eligibility would start or how long it would last.)

Information about employer, plan sponsor, parent company, and/or insurance, HMO or benefits administrator

The information here is highly critical for two reasons: 1. CMS may often need to obtain more information about the case from the involved entities; and 2. CMS needs to inform the involved entities as to the outcome of its determination (i.e., whether the applicant is eligible for premium assistance or not).

Additionally, please note that individuals generally need not fill out more than two sections. In the vast majority of cases, the employer will be sponsoring the plan so the applicants will not need to fill out plan sponsor information. Additionally, we (unfortunately) do not anticipate that there will be many parent companies or purchasers around to possibly be held responsible for any continuation coverage, so in all likelihood not many applicants will need to fill out that section either.

Other information

This information may be critical for cases. For instance, there may be witnesses who saw the circumstances in which an employee was terminated. In cases in which the facts are disputed, CMS could contact those people.

Signature

It is a universal practice to require individuals to verify the truth of their statements. This signature also allows CMS to further research the case.