Virginia Regulatory Town Hall

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Fast Track Proposed Regulation
Agency Background Document

Agency name	Department of Human Resource Management
Virginia Administrative Code (VAC) citation	1 VAC55-20
Regulation title	Commonwealth of Virginia Health Benefits Program
Action title	Update and clarify existing definitions, timeframes and general technical information regarding the State Health Benefits Program.
Date this document prepared	09/24/2013

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 14 (2010) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Brief summary

Please provide a brief summary (no more than 2 short paragraphs) of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes.

This amended regulation provides some technical corrections to definitions. It removes the authority of the State Advisory Council because that requirement was removed from the Code of Virginia. Additionally, due to a liberalization of the Health Insurance Portability and Accountability Act (HIPAA), the plan now allows the employee 60 days to add a newborn or an adopted child. This same liberalization allows new employees retroactive coverage as long as they enroll within 30 days of their employment date. The employee's coverage will be effective the first of the month coinciding with or following the date of employment. IRS section 125 had previously required this election to be on a prospective basis.

This amendment also removes the number of hours need to be worked to be eligible for the state health plan by removing those hours from the definition of a full-time employee. This amendment was made due to the uncertainty of the Affordable Care Act and when the employer mandate will become effective. The hourly requirement will be found in the guidance documents issued by the Department of Human Resource Management (DHRM).

Statement of final agency action

Please provide a statement of the final action taken by the agency including (1) the date the action was taken, (2) the name of the agency taking the action, and (3) the title of the regulation.

On April 3, 2013 the Department of Human Resource Management adopted updates and technical corrections to Commonwealth of Virginia Health Benefits Program 1 VAC55-20.

Legal basis

Please identify the state and/or federal legal authority to promulgate this proposed regulation, including (1) the most relevant citations to the Code of Virginia or General Assembly chapter number(s), if applicable, and (2) promulgating entity, i.e., agency, board, or person. Your citation should include a specific provision authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency/board/person's overall regulatory authority.

Section 2.2-2818 of the Code of Virginia Authorizes the Department of Human Resource Management to establish and administer the health insurance plan for state employees.

Purpose

Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Detail the specific reasons the regulation is essential to protect the health, safety or welfare of citizens. Discuss the goals of the proposal and the problems the proposal is intended to solve.

This amendment is made so that certain technical corrections to definitions can be made. The reference to the State Advisory Council is removed because it is no longer authorized under the Code of Virginia.

Due to changes in HIPAA, this amendment allows an employee 60 days to add a newborn or an adopted child. It also allows new employees retroactive coverage, as long as they enroll within 30 days of their employment date. The employee's coverage will be effective the first of the month coinciding with or following the date of employment. IRS section 125 had previously required this election to be on a prospective basis.

Furthermore due to the uncertainty surrounding the number of hours required for benefits under the employer mandate of the Affordable Care Act the amendment removes any references to the number of hours required for full-time eligibility under the state plan. This information will be placed in DHRM's guidance documents.

Rationale for using fast track process

Please explain the rationale for using the fast track process in promulgating this regulation. Why do you expect this rulemaking to be noncontroversial?

Please note: If an objection to the use of the fast-track process is received within the 30-day public comment period from 10 or more persons, any member of the applicable standing committee of either

house of the General Assembly or of the Joint Commission on Administrative Rules, the agency shall (i) file notice of the objections with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the normal promulgation process with the initial publication of the fast-track regulation serving as the Notice of Intended Regulatory Action.

The proposed amendments to this regulation will only make technical corrections, liberalize eligibility rules, and changes that are or will be required by the Code of Virginia or the Affordable Care Act.

Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. (Provide more detail about these changes in the "Detail of changes" section.) Please be sure to define any acronyms.

The proposed amendments do not substantively alter the existing regulation, except for the liberalization of coverage rules.

Issues

Please identify the issues associated with the proposed regulatory action, including:
1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions;
2) the primary advantages and disadvantages to the agency or the Commonwealth; and
3) other pertinent matters of interest to the regulated community, government officials, and the public.
If there are no disadvantages to the public or the Commonwealth, please indicate.

This regulatory action poses no disadvantage to the public or the Commonwealth. The proposed amendments to this regulation make technical corrections and changes that are or will be required by the Code of Virginia or the Affordable Care Act. Additionally, due to changes in HIPAA, this amendment allows an employee 60 days to add a newborn or an adopted child. It also allows new employees retroactive coverage, as long as they enroll within 30 days of their employment date. IRS section 125 had previously required this election to be on a prospective basis.

None of these changes pose a disadvantage to the public or the Commonwealth.

Requirements more restrictive than federal

Please identify and describe any requirement of the proposal which is more restrictive than applicable federal requirements. Include a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements or no requirements that exceed applicable federal requirements, include a statement to that effect.

There are no requirements that exceed applicable federal requirements.

Localities particularly affected

Please identify any locality particularly affected by the proposed regulation. Locality particularly affected means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.

No localities will bear a disproportionate impact from the proposed amendments.

Regulatory flexibility analysis

Pursuant to §2.2-4007.1B of the Code of Virginia, please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the proposed regulation.

There are no alternatives. Leaving the regulations as currently written would misalign changes in applicable federal and state rules that have occurred since the most recent update to the regulations. The proposed amendments will not have an adverse impact on small business.

Economic impact

Please identify the anticipated economic impact of the proposed new regulations or amendments to the existing regulation. When describing a particular economic impact, please specify which new requirement or change in requirement creates the anticipated economic impact. Please keep in mind that we are looking at the impact of the proposed changes to the status quo.

Description of the individuals, businesses or other entities likely to be affected (positively or negatively) by this regulatory proposal. Think broadly, e.g., these entities may or may not be regulated by this board	No economic impact
Agency's best estimate of the number of (1) entities that will be affected, including (2) small businesses affected. Small business means a business, including affiliates, that is independently owned and operated, employs fewer than 500 full-time employees, or has gross annual sales of less than $6 million.	No economic impact
Benefits expected as a result of this regulatory proposal.	Improved communication and compliance with state and federal law.

Projected cost to the <u>state</u> to implement and enforce this regulatory proposal.	No economic impact
Projected cost to <u>localities</u> to implement and enforce this regulatory proposal.	No economic impact
All projected costs of this regulatory proposal for <u>affected individuals, businesses, or other entities</u>. Please be specific and include all costs, including projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses, and costs related to real estate development.	No economic impact

Alternatives

Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in §2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.

The agency has determined that no alternative would achieve the purpose of this regulatory action.

Family impact

Please assess the impact of the proposed regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

This amendment will not have an impact on the family.

Detail of changes

Please list all changes that are being proposed and the consequences of the proposed changes. If the proposed regulation is a new chapter, describe the intent of the language and the expected impact. Please describe the difference between existing regulation(s) and/or agency practice(s) and what is being proposed in this regulatory action.

*If the proposed regulation is intended to replace an <u>emergency regulation</u>, please list separately (1) all differences between the **pre**-emergency regulation and this proposed regulation, and (2) only changes made since the publication of the emergency regulation.*

For changes to existing regulation(s) or regulations that are being repealed and replaced, use this chart:

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, intent, rationale, and likely impact of proposed requirements
20	N/A	Definitions	Added "Adverse experience adjustment" and removed "experience adjustment" as a technical correction to the name of the adjustment. Updated definition of "Basic statewide health plan" to be consistent with current terminology. Technical correction to change "impartial health entity" to match federal terminology "independent review organization." Updated definition of "part-time employee" for local employers to clarify that they must work more than 20 hours per week to be eligible for coverage.
40	N/A	State advisory council	The requirement was removed from the Code of Virginia
90	N/A	Impartial health Entity	Independent review organization matches the term used in the federal law. This is a technical correction
160	N/A	Establishing contribution rates and accounting for contributions and claims	Updated timeframe for notification to coincide with the end of the plan year instead of mid-year. "The department will notify a terminating local employer of any adverse experience adjustment within six-calendar months of the ~~time~~ end of the plan year in which the local employer terminates participation in the program."
230	N/A	Entrance into the health benefits program	Technical correction to remove incorrect language in order to comply with federal law. ~~Coverage will not be available to a new employee unless the employee is on the payroll a minimum of 16 calendar days.~~
240	N/A	Payment of contributions	Technical correction to clarify that local employer may be responsible for retired and COBRA employee contributions at the employer's discretion. ''The local employer ~~is~~ may be

			responsible for remitting such contributions for active, retired, and COBRA-participating employees." Technical correction to timeframe for employee elections under HIPAA Special Enrollments. "Coverage elections made for newborns, adoption or placement for adoptions are effective the date the child is born, adopted or placed for adoption, so long as the employee makes the coverage election within ~~31~~ 60 days of the event."
280	N/A	Commencement of local employer participation	Technical correction to clarify that school groups may choose later open enrolment periods. "Certain school groups may conduct their open enrollment in August and September."
290	N/A	Re-participation of local employers	Technical correction to clarify that a waiting period will be imposed on entire group, not individual employees. "~~Employees of l~~ Local employers seeking re-participation may be required to serve a waiting period."
320	N/A	Eligible employees	Removed reference to full time employee work hours due to lack of clarity under the Affordable Care Act. This information will be addressed in future guidance documents. "~~A full-time salaried employee is one who is scheduled to work at least 32 hours per week or carries a faculty teaching load considered to be full-time at his institution."~~ Added language to clarify that local employers are not subject to the caveat for receiving an immediate annuity. "For local employers, the immediate annuity requirement is not applicable as long as the retiree meets the age and service requirements imposed by the plan." Technical correction to eligibility criteria and timeframe

			for new hires to request coverage for adult incapacitated dependents. "The child must live with the employee as a member of the employee's household, be unmarried, and be dependent upon the employee for financial support." "_a) The enrollment form is submitted within ~~31~~ 30 days of hire;"
330	N/A	Enrollment form or enrollment action	Technical correction to timeframe for HIPAA Special Enrollments. "Coverage elections made on account of a newborn, adoption or placement for adoption are effective the date the child is born, adopted or placed for adoption, as long as the employee makes the coverage election within ~~31~~ 60 days of the event."
350	N/A	Membership	Technical correction to strike outdated language. ~~A woman with single membership under the program does have maternity coverage. However, the newborn child is covered only for routine hospital nursery care, unless the mother changes to dual or family membership within 31 days of the date of birth.~~ Technical correction to timeframes for qualifying mid-year event changes to align with federal law. "Within ~~31~~ no more than 60 days of a qualifying mid-year event. Any such change in membership must be on account of and consistent with the event." "C". Within ~~31~~ no more than 60 days of a cost and coverage change, as acknowledged by the department."
370	N/A	Effective date of coverage	Update to language regarding coverage effective dates to comply with federal and state laws. ''A. ~~General. Coverage and changes in coverage or membership are generally prospective, effective on the~~

			~~first day of the month following the month in which the enrollment action is received by the department's designee.~~ Newly eligible employees. Newly eligible employees (new hires) have up to 30 calendar days to enroll in a health plan and/or flexible spending account offered by the state. The 30-day countdown period begins on the first day of employment and ends 30 calendar days later. If the enrollment action is received within the 30 calendar day time frame, coverage will be effective the first of the month coinciding with or following the date of employment. There is no discretion allowed in this area. Coverage will always be effective in this manner. In no case will coverage begin before the eligible employee's first day of employment. B. ~~Date coverage begins. Coverage begins on the first day of the first full month of employment following the receipt of the employee's enrollment action. Employees who begin work on the first working day of the month are considered employed effective the first of the month. Thus, if an employee submits the completed enrollment action on or prior to the first working day of the month, coverage will be effective the first of the month in which employment commenced.~~ Qualifying Mid-Year Events. Employees who experience a qualifying mid-year event have 60 calendar days to make a consistent election change. The 60-day countdown period begins on the day of the event. Normally changes will be effective the first of the month following receipt of the enrollment

			action. C. ~~Exceptions. With prior approval from the department, coverage may be allowed to commence on an earlier date in limited circumstances when prior coverage is unavailable; for example, a new employee who has moved out of the service area of an HMO.~~ Terminations required by the plan. Employees can only provide coverage for family members who meet the health plan's eligibility definition."</u>
380	N/A	Leaves of absence	Technical correction to update language regarding leave with full pay. "~~Nothing special must be done to maintain coverage.~~ No action is required." Added reference to LTD-working to clarify that LTD-working employees continue in active coverage. "LTD-working employees continue in active coverage until the end of the month in which the employee transitions to LTD-not working." Technical correction to timeframe for qualifying mid-year event changes. "An employee enrolled in an alternative health benefits plan who moves out of the plan's service area while on a leave of absence may change to another plan offered by the department in his new location by taking an enrollment action within ~~31~~ 60 days of the date of the move; Employees may change from single to dual or family membership within ~~31~~ 60 days of returning from leave without pay if the employee dropped dual or family membership during the leave or if there was a qualifying mid-year event during the leave."
390	N/A	Termination of coverage	Technical correction to add language that specifies state employees, dependents and

			beneficiaries. "Coverage ends on the date of a participant's death. Coverage for family members of state employees continues until the end of the month following the month in which the participant died. 1. A surviving state beneficiary may enroll in the state retiree group if: a. The state dependent is eligible for an annuity under the VRS death-in-service provision;" "Survivors of deceased state employees who are not eligible for an annuity from VRS can nonetheless be covered under the State Health Benefits Program if they had coverage at the time the employee died. To continue coverage, the state family member must apply within 60 days of the employee's death."
400	N/A	Termination of employment	Technical correction to remove language that no longer applies. "~~Terminating employees may also have the option of converting to a non-group policy. The carrier will send the employee a letter offering non-group coverage. The employee will have 30 days after the date of the letter to reply in order for coverage to be continuous.~~"
410	N/A	Suspension and reinstatement	Technical corrections to remove outdated information and to clarify when the state contribution applies when employees are suspended or reinstated. "Coverage generally continues with the state contribution through the end of the month in which the suspension began. However, if the suspension was effective on or before the first work day of the month, there will be no coverage for that month unless the employee is reinstated in time to work half of the work days in the month. For example, if a suspension is

			effective on April 19, the employee will have coverage with the state contribution through the end of April. If the suspension is effective April 1, the employee ~~will have no~~ must pay the entire cost of coverage ~~in April~~ for the month of April. By the same token, if the suspension is effective April 2 and the employee's first workday in April is April 3, the employee will not have ~~coverage~~ the state contribution in April. ~~If the employee is reinstated in time to work half of the workdays in the month following the month in which the suspension began, there will be continuous coverage with the state contribution.~~ 2. If the employee is suspended pending court action or pending an official investigation, the suspension may go beyond one pay period. In these cases, coverage will continue with the state contribution to the end of the month in which the suspension began. If the employee is reinstated in time to work half of the workdays of the month following the month in which the suspension began, there would be no break in coverage. Suspension beyond that period should be handled in the same way as a leave without pay with no employer contribution. The employee may waive coverage or remain in the group by paying the full monthly contribution~~s~~ to the employer in advance. Group coverage may continue until a court decision is issued or the official investigation is completed, or up to a period of 12 months, whichever is less. 3. If the employee is reinstated with back benefits, the

			employer should refund the employee the amount of the employer contribution during the period the employee paid the full premium. ~~Single membership should be reinstated retroactive to the date the employee was removed from the group up to a limit of 60 days. Retroactive dual or family membership will be available up to a maximum period of 60 days.~~ Previous coverage elections, including dual and family memberships, will be reinstated retroactively. B. Termination and grievance reinstatement. 1. Employees who are terminated and file a grievance shall be treated as terminated employees and may elect extended coverage or nongroup coverage. In the event such an employee is reinstated with back pay, ~~he will be given single membership retroactive up to 60 days. Retroactive dual or family membership will be available up to a maximum period of 60 days.~~ previous health and FSA elections will be reinstated retroactively. Appropriate contributions must be made to cover the period."
430	N/A	Coordination of benefits	Technical corrections to coordination of benefits rules. ~~Employees are required to notify the plan administrator that they or a covered dependent are enrolled under another plan. If a plan participant is eligible for coverage under two or more plans, the plans involved will share the responsibility for the participant's benefits according to these rules.~~ New employees will receive and be required to respond to a Coordination of

			Benefits (COB) inquiry letter following enrollment in the health plan. Employees should notify the plan administrator if coverage changes during employment for them or a covered dependent. If a plan participant is eligible for coverage under two or more plans, the plans involved will share the responsibility for the participant's benefits according to these rules. 1. If the other coverage does not have COB rules substantially similar to your health plan's, the other coverage will be primary. 2. ~~If a covered person is enrolled as the employee under one coverage and as a dependent under another, generally the one that covers him or her as the employee will be primary.~~ The plan that covers a person as an active employee, that is an employee who is neither laid off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan. 3. If a covered person is the employee under both coverages, generally the one that covers him or her for the longer period of time will be primary. 4. If the dependent is covered as a dependent on their

			parent(s) plan and they are also covered as a dependent on their spouse's plan, the spouse's plan is primary. 5. If the covered person is enrolled as a dependent child under both coverages (for example, when both parents cover their child), typically the coverage of the parent whose birthday falls earliest in the calendar year will be primary. 6. Special rules apply when a covered person is enrolled as a dependent child under two coverage and the child's parents are living apart. Generally, the coverage of the parent or step-parent with custody will be primary. However, if there is a court order that requires one parent to provide health care for the child, that parent's coverage will be primary. If there is a court order that states the parents share joint custody without designating that one parent is responsible for medical expenses, the parent whose birthday falls earliest in the plan year will be primary. 7. If a covered active employee or employee's dependent is also covered by Medicare, the coverage provided by the employer is primary (unless Medicare eligibility is due to End Stage Renal Disease and the coordination period has been exhausted). 8. If a covered retiree, survivor, LTD participant or their covered dependent is eligible for Medicare, the Medicare-eligible member is not eligible for coverage under your health plan (except during an End Stage Renal Disease

			coordination period. ~~B. If the other health benefit plan contains a coordination of benefits provision establishing the substantially same order of benefit determination rules as the ones in this section, the following will apply in the order of priority listed:~~ ~~1. The plan that lists the person receiving services as the enrollee, insured or policyholder, not as a dependent, will provide primary coverage. There is one exception. If the person is also entitled to Medicare, and as a result of federal law Medicare is (i) secondary to the plan covering the person as a dependent; and (ii) primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering the person as other than a dependent.~~ ~~2. Primary coverage for an enrolled child will be the plan which lists the parent whose month and day of birth occurs earliest in the calendar year as an enrollee, insured, or policyholder, except in the following circumstances:~~ ~~a. When the parents are separated or divorced, primary coverage will be the plan that covers the child as a dependent of the parent with custody. The plan of the husband or wife of a remarried parent with custody may provide primary coverage if the remarried parent with custody does not have a plan that covers the child.~~

			~~b. Despite subdivision 2 a of this subsection, if there is a court order that requires one parent to provide hospital or medical/surgical coverage for the child, primary coverage will be that parent's plan. If the specific terms of a court decree state that the parents will share joint custody and the court decree does not state that one of the parents is responsible for health care expenses of the child, then the rule set forth in the first sentence of subdivision 2 of this subsection, the birthday rule, will apply.~~ ~~3. If subdivisions 1 and 2 of this subsection do not apply, primary coverage will be the plan that has covered the participant for the longest uninterrupted period of time. There are two exceptions to this rule:~~ ~~a. The benefits of the plan that covers the person as a working employee (or the employee's dependent) will be determined before those of the plan that covers the person as a laid-off or retired employee (or the employee's dependent).~~ ~~b. The benefits of the plan that covers the person as an employee (or the employee's dependent) will be determined before those of the plan that covers the person under a right of continuation pursuant to federal or state law.~~ ~~C. If a plan does not have a coordination of benefits provision establishing substantially the same order of benefit determination rules as the ones in this section, that plan will be the primary~~

			~~coverage.~~ ~~D. If, under the priority rules, the state plan is the primary coverage, participants will receive unreduced benefits for covered services to which they are entitled under this plan.~~ ~~E. If the other plan is the primary coverage, the participant's benefits will be reduced so that the total benefit paid under this plan and the other plan will not exceed the benefits payable for covered services under this plan absent the other plan. In calculating benefits that would have been paid under this plan absent the other plan, any reduction in benefits for failure to receive a referral will not be considered. Benefits that would have been paid if the participant had filed a claim under the primary coverage will be counted and included as benefits provided. In a calendar year, benefits will be coordinated as claims are received.~~ ~~F. When a health benefit plan provides benefits in the form of services, a reasonable cash value will be assigned to each covered service. This cash value will be considered a "benefit payment."~~ ~~G. At the option of the plan administrator, payments may be made to anyone who paid for the coordinated services the participant received. These benefit payments by the administrator are ones that normally would have been made to the employee or on the employee's behalf to a facility or provider. The benefit payments made by the administrator will satisfy the obligation to provide benefits~~

			~~for covered services.~~ B. When your health plan is the primary coverage, it pays first. When your health plan is the secondary coverage, it pays second as follows: 1. The plan administrator calculates the amount your health plan would have paid if it had been primary coverage, then coordinates this amount with the primary plan's payment. Your health plan's payment in combination with the other plan's payment will never exceed the amount your health plan would have paid if it had been your primary coverage. 2. Some plans provide services rather than making a payment (i.e., a group model HMO). When such a plan is the primary coverage, your health plan will assign a reasonable cash value for the services and that will be considered the plan's primary payment. You health plan will then coordinate with the primary plan based on that value. 3. In no event will your health plan pay more in benefits as secondary coverage than it would have paid as primary coverage. ~~H~~ C.. If the administrator provided primary coverage and discovers later that it should have provided secondary coverage, the administrator has the right to recover the excess payment from the employee or any other person or organization. If excess benefit payments are made on behalf of the employee, the employee must cooperate with the

			administrator in exercising its right of recovery. ~~I~~ D. Employees are obligated to supply the plan administrator all information needed to administer this coordination of benefits provision. This must be done before an employee is entitled to receive benefits under this plan. Further, the employees must agree that the administrator has the right to obtain or release information about covered services or benefits received. This right will be used only when working with another person or organization to settle payments for coordinated services. The employee's prior consent is not required."
460	N/A	Alternative health benefits plans	Technical correction to clarify that "separating employees" refers to "state" employees. A separating state employee who defers retirement will not be eligible to enroll in a retiree medical plan when the former employee seeks retirement benefits.
9988	N/A	FORMS	Technical corrections to update revision dates, remove obsolete forms, and add forms that are used. Adoption Agreement (rev. 02/13). Health Benefits Program Application (rev. ~~0/00~~01/13). Enrollment Application/Waiver Form SHBP (rev. ~~3/01~~07/13). ~~Name/Address Change.~~ Extended Coverage Notice.

			State Health Benefits Program Appeal Form.

If a new regulation is being promulgated, use this chart:

Section number	Proposed requirements	Other regulations and law that apply	Intent and likely impact of proposed requirements

Enter any other statement here