CONSENSUS ELIGIBILITY, ENROLLMENT, & CHURN RECOMMENDATIONS

1. Income Change Non-Report Threshold

The District of Columbia Health Benefit Exchange will not require enrollees to report a change in income that is below a monthly average of $150 or $1,800 annually. All notice language sent to enrollees regarding the duty to report shall include the following language - "All changes in income will affect the amount of premium tax credit you are eligible for, and could impact your federal taxes, but you are not required to report a change in income below $150/month ($1,800 annually)."

2. Periodic Electronic Notices to Report

Periodic Electronic Notices to Report:

The District of Columbia Health Benefit Exchange will send electronic notifications regarding the duty to report changes relevant to enrollment in the Individual Marketplace or for tax credits to individuals who have consented to electronic notifications, on March 31 and June 30 of each calendar year. These reminders are in addition to the language included in eligibility determination and redetermination notices of the individual's duty to report.

3. Effective Date for Changes During Benefit Year

For those individuals enrolled in a QHP who experience a change in eligibility during a benefit year, but who do not lose their eligibility for enrollment in a QHP, the District of Columbia Health Benefit Exchange will implement eligibility changes determined on or before the 15th day of the month to be effective the first day of the following month. For those eligibility changes made on the 16th day or thereafter, the effective date of the change will be the first day of the second month following the date of the redetermination notice.

4. Default Online APTC Setting

The portion of the online system used by individuals to compare and select plans shall display a default APTC of eighty-five percent (85%) of the maximum APTC the individual is determined eligible for. The online system shall indicate that the amount can be changed to a higher amount, up to the maximum APTC for which the individual is eligible, or a lower amount.

5. Churn Mitigation

Establishment of Care Transition Plans by QHP Issuers:

QHPs in the District of Columbia Health Benefit Exchange shall implement policies that address transition care for enrollees in the midst of active treatment. Such policies must require that QHPs, upon request by the enrollee, allow non-participating providers to continue to provide health care services for the lesser of the remaining course of treatment or 90 days (except that such time limit is not applicable to maternity care). The transition policy shall be similar to that which was adopted by the Maryland Health Progress Act of 2013, as appropriate.

Counseling by In-Person Assisters and Brokers:

In-Person Assisters under contract with the District of Columbia Health Benefit Exchange shall counsel individuals about transition risk upon changes in program eligibility. The training available to In-Person Assisters and Brokers shall include information on risks associated with transitioning from one form of coverage to another during a course of active treatment.

6. Extension of Inconsistency Period for Good Faith effort:

Individuals who make a good faith effort shall be provided an additional 30 days, beyond the 90 mandated in 45 C.F.R. §155.315(f)(2)(ii), to resolve any inconsistencies with Exchange eligibility verification data sources. Good faith effort shall be defined as an individual requesting the additional 30 days from the Exchange either online, through the call center, in-person at a service center, or by mail.

7. Default Termination of QHP Coverage Based on Medicaid Eligibility

Default Termination of QHP Coverage Based on Medicaid Eligibility Determination:

The District of Columbia Health Benefit Exchange will terminate an enrollee's QHP enrollment upon notification of Medicaid eligibility with the effective date dependent on the date of the Medicaid eligibility determination. Determinations made on or before the 15th of the month would have a default termination effective the first day of the next month, determinations made after the 15th would have a default effective date of the first day of the second month following the determination. An individual can request to continue enrollment in their QHP, without any subsidies, before the scheduled default QHP termination date. Individuals will be advised of their default termination date in the redetermination notice sent following the Medicaid eligibility determination. Default terminations do not alter an individual's right to terminate under 45 C.F.R. §155.430.

8. Special Enrollment Periods for "Exceptional Circumstances"

The District of Columbia Health Benefit Exchange will consider it an exceptional circumstance, permitting a new special enrollment period, when an applicant or enrollee does not select a plan during Initial Enrollment, Open Enrollment, or an SEP granted on other grounds, due to one of the following circumstances if the individual does not otherwise qualify for an SEP under the categories in 45 C.F.R. §155.420(d)(1) – (8):

1) Based on the individual's self-attestation, he/she is eligible for Medicaid but the eligibility determination is pending paper verification of an eligibility factor and the individual is ultimately determined ineligible for Medicaid after the enrollment period has expired. The first day of the SEP shall be the date of the notice of Medicaid ineligibility. This SEP would exclude Medicaid applicants who were denied due to their failure to timely provide the requested documentation.

2) An individual misses the Individual Exchange enrollment period while waiting for their employer to be approved for the SHOP. Under this scenario, an individual's employer applies to participate through SHOP during the individual open enrollment period and is ultimately denied due to not meeting minimum participation requirements. By the time the employee is notified that he/she cannot enroll through the SHOP, the individual's enrollment period has passed.

3) The individual's enrollment or non-enrollment in a QHP was unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of a QHP issuer, or its instrumentalities as evaluated and determined by the D.C. Department of Insurance, Securities, and Banking. In such cases, the Exchange may trigger the SEP and take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

DRAFT 5-6-13

RESOLUTION OF THE EXECUTIVE BOARD
DISTRICT OF COLUMBIA
HEALTH BENEFIT EXCHANGE AUTHORITY

To establish a minimum threshold under which individuals in the Individual Exchange marketplace are not obligated to report changes in income.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq.*) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(1)) requires the Authority to establish an American Health Benefit Exchange for individuals and families and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, 45 C.F.R. § §155.330(b) requires individuals enrolled in the Individual Exchange to report changes that may impact their eligibility for enrollment or tax credits within 30 days of the change, but allows the Exchange to establish a minimum threshold related to income, under which the individual is not obligated to report a change; and

WHEREAS, on April 17, 2013, the Eligibility, Enrollment, and Churn Working Group deliberated the issue and reached a consensus recommendation.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following consensus recommendation presented by the Eligibility, Enrollment, and Churn Working Group:

Income Change Non-Reporting Threshold:

The District of Columbia Health Benefit Exchange will not require enrollees to report a change in income that is below a monthly average of $150 or $1,800 annually. All notice language sent to enrollees regarding the duty to report shall include the following language - "All changes in income will affect the amount of premium tax credit you are eligible for, and could impact your federal taxes, but you are not required to report a change in income below $150/month ($1,800 annually)."

I HEREBY CERTIFY that the foregoing Resolution was adopted on this _____ day of _____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____
Khalid Pitts, Secretary/Treasurer
District of Columbia Health Benefits Exchange Authority

DRAFT 5-6-13

RESOLUTION OF THE EXECUTIVE BOARD
DISTRICT OF COLUMBIA
HEALTH BENEFIT EXCHANGE AUTHORITY

To establish the frequency of electronic notifications regarding the duty to report changes relevant to eligibility for Individual Exchange marketplace enrollment or tax credits.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq.*) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(1)) requires the Authority to establish an American Health Benefit Exchange for individuals and families and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, 45 C.F.R. § §155.330(c)(2) requires the Exchange to send periodic electronic notices to individuals receiving tax credits, who have consented to electronic notifications, regarding their duty to report changes that may impact their eligibility; and

WHEREAS, on April 17, 2013, the Eligibility, Enrollment, and Churn Working Group deliberated the issue and reached a consensus recommendation.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following consensus recommendation presented by the Eligibility, Enrollment, and Churn Working Group:

Periodic Electronic Notices to Report:

The District of Columbia Health Benefit Exchange will send electronic notifications regarding the duty to report changes relevant to enrollment in the Individual Marketplace or for tax credits to individuals who have consented to electronic notifications, on March 31 and June 30 of each calendar year. These reminders are in addition to the language included in eligibility determination and redetermination notices of the individual's duty to report.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this _____ day of _____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____
Khalid Pitts, Secretary/Treasurer
District of Columbia Health Benefits Exchange Authority

DRAFT 5-6-13

RESOLUTION OF THE EXECUTIVE BOARD
DISTRICT OF COLUMBIA
HEALTH BENEFIT EXCHANGE AUTHORITY

To establish effective dates for eligibility redeterminations resulting from changes reported during the benefit year.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq.*) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(1)) requires the Authority to establish an American Health Benefit Exchange for individuals and families and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, 45 C.F.R. §155.330(f)(2) permits the Exchange to determine a reasonable point in a month after which an eligibility change captured through a redetermination will not be effective until the first day of the second month after the redetermination is made; and

WHEREAS, on April 17, 2013 the Eligibility, Enrollment, and Churn Working Group deliberated on this topic and reached a consensus recommendation.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following consensus recommendation presented by the Eligibility, Enrollment, and Churn Working Group:

For those individuals enrolled in a QHP who experience a change in eligibility during a benefit year, but who do not lose their eligibility for enrollment in a QHP, the District of Columbia Health Benefit Exchange will implement eligibility changes determined on or before the 15th day of the month to be effective the first day of the following month. For those eligibility changes made on the 16th day or thereafter, the effective date of the change will be the first day of the second month following the date of the redetermination notice.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this _____ day of _____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____
Khalid Pitts, Secretary/Treasurer
District of Columbia Health Benefits Exchange Authority

DRAFT 5-6-13

RESOLUTION OF THE EXECUTIVE BOARD
DISTRICT OF COLUMBIA
HEALTH BENEFIT EXCHANGE AUTHORITY

To establish a default setting for the amount of advanced payment of premium tax credit displayed to users during plan selection.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq.*) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(1) & (10)) requires the Authority to establish an American Health Benefit Exchange for individuals and families, including establishing a website for individuals to shop for Qualified Health Plans, and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, 45 C.F.R. §155.310(d)(2) requires the Exchange to allow qualified individuals to take less than the full amount of advance payment of premium tax credits (APTC) for which he or she is determined eligible;

WHEREAS, 26 C.F.R. 1.36B-4 permits individuals whose premium tax credit (calculated at the time of income tax filing for the benefit year) exceeds the amount taken as an APTC to receive the remaining amount of the credit due as an income tax refund; and

WHEREAS, on April 17, 2013, the Eligibility, Enrollment, and Churn Working Group deliberated on this and reached a consensus recommendation.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following consensus recommendation presented by the Eligibility, Enrollment, and Churn Working Group:

The portion of the online system used by individuals to compare and select plans shall display a default APTC of eighty-five percent (85%) of the maximum APTC the individual is determined eligible for. The online system shall indicate that the amount can be changed to a higher amount, up to the maximum APTC for which the individual is eligible, or a lower amount.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this _____ day of _____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____
Khalid Pitts, Secretary/Treasurer
District of Columbia Health Benefits Exchange Authority

DRAFT 5-6-13

DRAFT FOR EXECUTIVE BOARD CONSIDERATION
RESOLUTION OF THE EXECUTIVE BOARD
DISTRICT OF COLUMBIA
HEALTH BENEFIT EXCHANGE AUTHORITY

To require Qualified Health Plan (QHP) issuers to establish polices that address transition of care for enrollees in the midst of active treatment at the time of transition into a QHP.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq.*) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(1) & (19)) requires the Authority to establish an American Health Benefit Exchange for individuals and families and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, there is a consensus among public health researchers that a substantial portion of individuals in the Individual Exchange marketplace will experience changes in eligibility during the benefit year causing them to move or "churn" between Medicaid, and coverage in a Qualified Health Plan (QHP);

WHEREAS, on April 17, 2013, the Eligibility, Enrollment, and Churn Working Group discussed strategies to address "churn" and developed consensus recommendations.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following consensus recommendations presented by the Eligibility, Enrollment, and Churn Working Group:

Establishment of Care Transition Plans by QHP Issuers:

QHPs in the District of Columbia Health Benefit Exchange shall implement policies that address transition care for enrollees in the midst of active treatment. Such policies must require that QHPs, upon request by the enrollee, allow non-participating providers to continue to provide health care services for the lesser of the remaining course of treatment or 90 days (except that such time limit is not applicable to maternity care). The transition policy shall be similar to that which was adopted by the Maryland Health Progress Act of 2013, as appropriate.

Counseling by In-Person Assisters and Brokers:

DRAFT 5-6-13

In-Person Assisters under contract with the District of Columbia Health Benefit Exchange shall counsel individuals about transition risk upon changes in program eligibility. The training available to In-Person Assisters and Brokers shall include information on risks associated with transitioning from one form of coverage to another during a course of active treatment.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this _____ day of _____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____
Khalid Pitts, Secretary/Treasurer
District of Columbia Health Benefits Exchange Authority

DRAFT 5-6-13

DRAFT FOR EXECUTIVE BOARD CONSIDERATION
RESOLUTION OF THE EXECUTIVE BOARD
DISTRICT OF COLUMBIA
HEALTH BENEFIT EXCHANGE AUTHORITY

Allows a good faith extension of the period to resolve eligibility factor inconsistencies for eligibility or enrollment in the Individual Exchange marketplace

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq.*) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(1)) requires the Authority to establish an American Health Benefit Exchange for individuals and families and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, 45 C.F.R. §155.315(f)(3) allows Exchanges to extend the 90-day period provided to individuals to resolve inconsistencies regarding eligibility factors between data sources available to the Exchange and the individual's self-attestation when there has been a good faith effort; and

WHEREAS, on April 17, 2013, the Eligibility, Enrollment, and Churn Working Group deliberated the issue and reached a consensus recommendation;

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following consensus recommendation presented by the Eligibility, Enrollment, and Churn Working Group:

Extension of Inconsistency Period for Good Cause:

Individuals who make a good faith effort shall be provided an additional 30 days, beyond the 90 mandated in 45 C.F.R. §155.315(f)(2)(ii), to resolve any inconsistencies with Exchange eligibility verification data sources. Good faith effort shall be defined as an individual requesting the additional 30 days from the Exchange either online, through the call center, in-person at a service center, or by mail.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this _____ day of _____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____
Khalid Pitts, Secretary/Treasurer
District of Columbia Health Benefits Exchange Authority

DRAFT 5-6-13

RESOLUTION OF THE EXECUTIVE BOARD
DISTRICT OF COLUMBIA
HEALTH BENEFIT EXCHANGE AUTHORITY

To establish default termination rules for Individual Exchange marketplace enrollees who are determined eligible for Medicaid.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq.*) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(1)) requires the Authority to establish an American Health Benefit Exchange ("Exchange") for individuals and families and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, according to 26 U.S.C. §36B(c)(2)(B), individuals eligible for Minimum Essential Coverage are not eligible for the Advanced Premium Tax Credits used to lower premium costs for coverage in the Individual Exchange marketplace;

WHEREAS, according to 26 U.S.C. §5000A(f))(1)(A)(ii), Medicaid coverage is considered Minimum Essential Coverage;

WHEREAS, 45 C.F.R. §155.330(d)(ii) requires the Exchange to proactively and regularly monitor Medicaid eligibility determinations;

WHEREAS, the Authority is establishing a unified eligibility determination system in partnership with the Department of Health Care Finance (State Medicaid Agency) and will have knowledge of Medicaid eligibility determinations;

WHEREAS, Medicaid coverage in the District of Columbia offers a comprehensive benefit package at little or no cost-sharing for the enrollee; and

WHEREAS, on April 17, 2013 the Eligibility, Enrollment, and Churn Working Group deliberated regarding this situation and reached a consensus recommendation.

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following consensus recommendation presented by the Eligibility, Enrollment, and Churn Working Group:

Default Termination of QHP Coverage Based on Medicaid Eligibility Determination:

The District of Columbia Health Benefit Exchange will terminate an enrollee's QHP enrollment upon notification of Medicaid eligibility with the effective date dependent on the date of the

Medicaid eligibility determination. Determinations made on or before the 15th of the month would have a default termination effective the first day of the next month, determinations made after the 15th would have a default effective date of the first day of the second month following the determination. An individual can request to continue enrollment in their QHP, without any subsidies, before the scheduled default QHP termination date. Individuals will be advised of their default termination date in the redetermination notice sent following the Medicaid eligibility determination. Default terminations do not alter an individual's right to terminate under 45 C.F.R. §155.430.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this _____ day of _____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____
Khalid Pitts, Secretary/Treasurer
District of Columbia Health Benefits Exchange Authority

DRAFT 5-6-13

DRAFT FOR EXECUTIVE BOARD CONSIDERATION
RESOLUTION OF THE EXECUTIVE BOARD
DISTRICT OF COLUMBIA
HEALTH BENEFIT EXCHANGE AUTHORITY

To define "exceptional circumstances" permitting a Special Enrollment Period.

WHEREAS, the Health Benefit Exchange Authority Establishment Act of 2011, effective March 4, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 *et seq.*) ("Act") created the District of Columbia Health Benefit Exchange Authority ("Authority"), an independent authority of the Government of the District of Columbia, and its governing Executive Board;

WHEREAS, §5 of the Act (D.C. Official Code §31-3171.04(a)(1) & (9)) requires the Authority to establish an American Health Benefit Exchange for individuals and families, including the establishment of enrollment periods, and §7 of the Act (D.C. Official Code §31-3171.06(a) & (b)) authorizes the Executive Board to take necessary lawful action to implement provisions of the Affordable Care Act of 2010 ("ACA") (P.L. 111-148 & P.L. 111-152);

WHEREAS, 45 C.F.R. §155.420(d)(1) – (8) establishes a series of circumstances in which QHPs must permit qualified individuals to receive a 60-day special enrollment period (SEP) to enroll in the Individual Exchange marketplace outside an Open Enrollment Period;

WHEREAS, 45 C.F.R. §155.420(d)(9) permits the Exchange to define "exceptional circumstances" establishing additional SEPs; and

WHEREAS, on April 17, 2013, the Eligibility, Enrollment, and Churn Working Group deliberated on this topic and reached consensus recommendations to the Executive Board;

NOW, THEREFORE, BE IT RESOLVED that the Executive Board hereby approves the following consensus recommendations presented by the Eligibility, Enrollment, and Churn Working Group:

The District of Columbia Health Benefit Exchange will consider it an exceptional circumstance, permitting a new special enrollment period, when an applicant or enrollee does not select a plan during Initial Enrollment, Open Enrollment, or an SEP granted on other grounds, due to one of the following circumstances if the individual does not otherwise qualify for an SEP under the categories in 45 C.F.R. §155.420(d)(1) – (8):

1) Based on the individual's self-attestation, he/she is eligible for Medicaid but the eligibility determination is pending paper verification of an eligibility factor and the individual is ultimately determined ineligible for Medicaid after the enrollment period has expired. The first day of the SEP shall be the date of the notice of Medicaid ineligibility. This SEP would exclude Medicaid applicants who were denied due to their failure to timely provide the requested documentation.

2) An individual misses the Individual Exchange enrollment period while waiting for their employer to be approved for the SHOP. Under this scenario, an individual's employer applies to participate through SHOP during the individual open enrollment period and is ultimately denied due to not meeting minimum participation requirements. By the time the employee is notified that he/she cannot enroll through the SHOP, the individual's enrollment period has passed.

3) The individual's enrollment or non-enrollment in a QHP was unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of a QHP issuer, or its instrumentalities as evaluated and determined by the D.C. Department of Insurance, Securities, and Banking. In such cases, the Exchange may trigger the SEP and take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this _____ day of _____, 2013, by the Executive Board of the District of Columbia Health Benefit Exchange Authority in an open meeting.

_____
Khalid Pitts, Secretary/Treasurer
District of Columbia Health Benefits Exchange Authority