April 25, 2013

Recommendations of the Working Group on Eligibility, Enrollment, and Churn to the District of Columbia Health Benefit Exchange Authority

The purpose of this report is to outline the recommendations of the Eligibility, Enrollment, and Churn Working Group regarding a variety of open questions and/or issues that impact eligibility and enrollment rules, as well as the challenges enrollees may encounter as they transition between Medicaid and the Exchange.

Recommendations

1. **Issue 57: Extending the 90-Day Clock**
    a. **Charge:** Applicants are allotted 90 days to resolve any inconsistencies on their application if the information provided is not compatible with the Exchange's data verification. The Exchange may extend this 90-day period if the applicant can demonstrate a good faith effort has been made to obtain the required documentation. How should the District of Columbia Health Benefit Exchange (DC HBX) define good faith effort?
    b. **Recommendation:** The working group recommends that the Exchange allow individuals who make a good faith effort an additional 30 days, beyond the 90 mandated in Federal guidance, to resolve any inconsistencies with Exchange eligibility verification. Good faith effort is 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.

Commentary: This recommendation allows an individual to have more time if they need it, still applies a sense of urgency to sending in the documentation, and decreases the possibility of appeals. The group did identify that In-Person Assistors will play an important role in helping individuals compile the documentation needed to complete an eligibility determination. The Working Group recommends that the notice sent to an individual granting the additional 30 days should have language advising of potential tax liability and that In-Person Assistors are available to provide support.

2. **Issue 160: Frequency of Required Noticing on Reporting Changes**
    a. **Charge:** Enrollees in Insurance Affordability Programs (IAPs) are required to report any change to eligibility within 30 days of the event/change. The Exchange must provide

periodic electronic notifications regarding the requirements for reporting changes and an enrollee's opportunity to report any changes, unless the enrollee has declined to receive electronic notifications (§155.330(c)(2)). How frequently should DCAS send these notifications?

b. **Recommendation:** Working group recommends that electronic notices be sent to those individuals enrolled in IAPs twice a year reminding them to report any changes that may impact their eligibility. The recommended dates for these notices are March 31st and June 30th. These reminders are in addition to the language included in eligibility determination and redetermination notices of the individual's duty to report.

Commentary: This electronic reminder would most likely be an e-mail message to the individual, which would also appear in their secure inbox. There was no opposition to this recommendation.

3. **Issue 159: Auto-Termination of QHP Enrollment upon Medicaid Eligibility**
   a. **Charge:** The Exchange must redetermine eligibility for Exchange enrollment and IAPs if (1) an enrollee reports a change, or (2) the Exchange becomes aware of change via ongoing data verification efforts. One of the eligibility requirements for those receiving advance premium tax credits is that the individual does not have access to other minimum essential coverage, including Medicaid. If an individual is redetermined eligible for Medicaid, they would lose their APTC, but could remain in their QHP paying the full price of premium if they did not want to be covered under Medicaid. Should the Exchange automatically disenroll a customer from a QHP, unless the customer actively chooses otherwise, when he/she is determined eligible for Medicaid?
   b. **Recommendation:** Subject to a review of general counsel, the working group recommends that the Exchange terminate an enrollee's QHP upon notification of Medicaid eligibility in accordance with the effective dates described in 45 CFR §155.330(f); changes made before the 15th of the month would be effective the first day of the next month, changes made after the 15th would be effective the first day of the second month following the change. An individual can request to continue enrollment in their QHP, without any subsidies, before the scheduled automatic QHP termination date.

Commentary: There was no opposition voiced to this recommendation. However, the working group requests that all noticing to members clearly state the member's obligation to pay the entire premium for remaining in a QHP.

4. **Issue 35: Exchange action when an individual fails to select a new plan when existing plan is de-certified or not offered in the next benefit year**
   a. **Charge:** Enrollees who fail to respond to the annual enrollment notice and whose health plans will continue to be available in the next benefit year will be automatically re-enrolled (45 CFR §155.335(j)). However, there may be circumstances where an

enrollee's existing plan is decertified or not offered in the next benefit year. When a plan will no longer be available, the enrollee will receive notice that they must select a new plan. The Exchange must decide what happens if the individual fails to select a new plan.

b. **Recommendation:** The working group was split on a recommendation for this issue and unable to arrive at consensus. A review of the options discussed and the two positions which found working group support are presented below.

Commentary: The working group identified 3 options for those individuals enrolled in a QHP that is not offered in the next benefit year, and who fail to select a new plan during open enrollment. Under each option there will be noticing and appeal opportunities.

1) *No auto-enrollment*: Under this scenario, when an individual fails to select a plan during open enrollment after notification that their existing plan is no longer being offered and of their subsequent disenrollment, the Exchange will not auto-enroll into a new plan. While this option satisfied group members who were concerned with the Exchange making the assumption that an individual still wants coverage after not making a selection, other members were concerned that this option wasn't in line with Federal rules on auto-reenrolling those who fail to select when their plan is available and that it may result in disenrollment of individuals who may need additional assistance.

   This option did not receive any working group support.

2) *Special enrollment period/No auto-enrollment:* Do not auto-enroll the individual in a new plan, but allow a 60 day special enrollment period, starting with the first day coverage is lost, for those individuals who are disenrolled as a result of failing to select a new plan after decertification or a plan leaving the market. This option was presented as a compromise between options 1 and 3. This option would allow an individual additional time to make a selection when they realize coverage was lost and alleviated concerns of the Exchange making decisions on behalf of enrollees that they did not make themselves.

   This option received support from carrier representatives.

3) *Auto-enrollment if a similar plan is available*: Under this option, the Exchange would auto-enroll an individual who failed to select a new plan when their existing plan was no longer offered, only if there was a similar plan available. A similar plan is defined as same carrier, metal tier, and provider network. If there is no similar plan available, the Exchange would not auto-enroll, but would allow a 60 day special enrollment period starting on the first day coverage is lost. Working group members felt this option was in keeping with the heath reform's goals of expanding coverage and, since the group felt the population impacted by this rule would be small, would allow individuals who may be hard to reach to continue coverage. Other working group members expressed

concern about auto-enrolling an individual when that person had not selected a new plan option and thus exposing them to a potential financial liability.

This option was supported by the remaining working group members.

Additional Commentary: While not specifically the charge of this group, the working group also recommends that there should be no auto-enrollment during the initial enrollment; individuals not currently in a QHP must affirmatively choose a plan. The Exchange will send a notice to individuals who did not select a plan after application and eligibility determination reminding them to choose a plan. This notice should include information on In-Person Assistors to help those who are eligible to enroll in a plan.

5. **Issue 86: Special Enrollment for Exceptional Circumstances**
    a. **Charge:** The Exchange must provide an initial enrollment period and annual open enrollment periods during which individuals can enroll in or change QHPs. The initial enrollment period lasts from October 1, 2013 until March 31, 2014. After this initial period, all qualified individuals can enroll in or change plans between October 15 and December 7 each year and have their coverage effective on January 1 of the following year. Individuals who do not enroll in or change plans during these annual open enrollment periods can only do so at other times if they qualify for a special enrollment period. Federal guidance specifies most of the criteria to qualify for a special enrollment period, in addition to which federal guidance allows the Exchange to grant special enrollment periods if the individual meets other exceptional circumstances defined by the Exchange (45 C.F.R. §144.20(d)(1)-(9)). What should constitute "other exceptional circumstances" that would allow an individual to enroll in a Qualified Health Plan (QHP) during a special enrollment period?
    b. **Recommendation:** The working group recommends offering special enrollment periods under the following circumstances:
        i. Medicaid applicants who apply during an annual enrollment period, or during a special enrollment period, but do not receive notice of the determination of non-eligibility for Medicaid until after the enrollment period has ended, should be granted a special enrollment period. This special enrollment period would exclude Medicaid applicants who were denied due to their failure to timely provide the requested documentation.
        ii. A special enrollment period should be granted to qualified individuals whose 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 take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

iii. Offering a special enrollment period to an individual who missed the individual open 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 can't enroll through the SHOP, the individual's open enrollment period has passed. Some members of the group noted that this individual may qualify under other special enrollment periods, such as the one relating to the loss of minimum essential coverage.

Commentary: The working group discussed, but did not reach consensus on offering a special enrollment period under exceptional circumstances to pregnant women. The carriers and other members of the working group raised concerns about adverse selection and voiced strong opposition to this special enrollment period. An alternative solution raised would be to allow pregnant women to purchase coverage through the Alliance. Other members of the group argued that the public health costs incurred by not obtaining pre-natal care are often higher than insuring this group and have other far-reaching economic and personal consequences, so becoming pregnant deserves special consideration. Commentary supporting a special enrollment period for pregnant women is attached in Appendix I.

6. **Issue 66: QHP Effective Date of Changes**
   a. **Charge:** The final Exchange eligibility rule requires that the Exchange redetermine eligibility based on periodic review of data sources and self-reported information. The Exchange can establish the last date of the month on which a redetermination made on a self-reported change becomes effective on the first day of the next month (except for birth/adoption) (45 CFR §155.330(f)(2)).
   b. **Recommendation:** For those individuals enrolled in a QHP who experience a change (except for birth/adoption) in eligibility (but who do not lose their eligibility for enrollment in a QHP), the working group recommends that changes made on or before the 15th of the month be effective the first of the following month. For those changes made on the 16th or thereafter, the effective date of the change will be the first day of the second month following the date of the change report.

7. **Issue 58: Non-Report Threshold for Income**
   a. **Charge:** Exchanges must require an enrollee in an IAP to report changes that may impact eligibility within 30 days of such change, but the Exchange may exempt from this reporting requirement income changes below a minimum threshold for such reporting (45 CFR §155.330(b)(3)).
   b. **Recommendation:** The working group recommends advising enrollees that they do not have to report a change in income that is below a monthly average of $150 or $1,800 annually. The working group would also like to add language to the notice that states, "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)."

Commentary: During the discussion the group weighed concerns of tax reconciliation with the burden to report, especially for those individuals with a fluctuating monthly income. Ultimately, $150 was chosen as a threshold that was easy to understand, low enough to protect against too much "clawback" at year-end, and will protect some individuals from having to report changes nearly every month. The Working Group also identified this issue as a place where the assistance of an In-Person Assistor will be critical.

8. **Issue 166: Default APTC Setting**
    a. **Charge:** Individuals are not obligated to take the full tax credit they may be eligible for as advance payments (§155.310(d)(2)(i)). When an individual is using the Exchange web portal to select a QHP, they will also be able to select the amount of APTC they would like to apply to their monthly premium. The Exchange will need to decide what default amount they would like to populate into the web tool an individual will use to adjust the APTC amount. The Exchange will provide educational support and the individual will have to attest that they understand the implications of the APTC. For example, should the default be 100% of APTC or something less than that? Individuals would be able to change the amount of APTC applied at any time.
    b. **Recommendation:** The working group recommends that the default setting of this web-based tool will be 85% of the total APTC amount available.

Commentary: The working group was concerned about the type of assistance available on website to help consumers understand the APTC and possible implications at tax time.

9. **Discussion of issues relating to churn between Medicaid and the Exchange**
    a. **Charge:** With ACA-defined income corridors for Medicaid and Exchange PTC/CSR eligibility, there are estimates that up to 35% of enrollees in Medicaid (0-200% FPL) and recipients of high subsidy Premium Tax Credits and Cost Sharing Reduction subsidies (200-400% FPL) will switch eligibility category every six months.[1] Similar findings were reached in analysis of income and participation simulations conducted by Alex Graves, PhD at Vanderbilt, with the assistance of Jonathan Gruber at MIT. [2] The working group identified 3 potential adverse impacts of churn: coverage gaps, discontinuity of care and access to providers, and change in the enrollee's cost-sharing for benefits. What can the Exchange do to help minimize the impact of churn?
    b. **Approach:** The working group discussed many possible reforms or initiatives that could address the issue of churn, but recognized that most could not realistically be

[1] See Sommers & Rosenbaum, "*Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges",* Health Affairs, Vol. 30, No. 2, February, 2011.
[2] Graves, *Tabulations of the Survey of Income and Program Participation,* with computing support and consultation from Jonathan Gruber, Ph.D., Professor of Economics at MIT.

considered at this late date for 2014. The group did discuss a variety of shorter term strategies to address churn that could be implemented for 2014.

c. **Recommendation:** The group reached consensus that the Exchange should require that carriers implement policies that address transitions of care for enrollees in the midst of active treatment. These policies require that carriers, upon request by the member, allow non-participating providers to continue to provide health care services for the lessor of the remaining course of treatment or 90 days (except for maternity care). The group recommends the Exchange impose requirements on issuers similar to those imposed by legislation adopted in Maryland for transitions of care[3]. These requirements have been summarized in one page, appended to this report as Appendix II. The group also recommends that the Exchange require navigators/brokers to obtain training and provide counseling to beneficiaries, when selecting a QHP or Medicaid MCO, about transition risk upon change in eligibility.

   The group did not reach consensus on, but did have majority support for requiring that, as a condition of certification, issuers make a good faith effort to contract with all of the larger FQHCs. After 2014, this issue should be re-examined by the Exchange, using data on the impact of churn and the adequacy of QHP provider networks. Dissenting opinion to this recommendation is attached as Appendix III.

Commentary: Additional reforms discussed that could not be implemented for 2014, are outside of the purview of this working group, or did not receive support, are described below:

i. The working group recommends that Medicaid MCOs be encouraged by the District to participate as QHPs, so that enrollees can stay in the same plan as they move from one coverage program to another. The working group understands that this is not feasible for 2014 because DHCF just completed the contracting process for its MCOs.
ii. The working group recommends that when an individual has moved from Medicaid to the Exchange and is getting an episode of care covered under the transition of care requirement described above, that Medicaid cover the enhanced cost-sharing of that episode of care. Operational implications of this recommendation still need to be assessed by the Medicaid program.
iii. The working group recommends that the Exchange evaluate in 2014 and 2015 the size and nature of the disruption in care due to churn, with the benefit of data and experience from 2014, and then consider solutions appropriate to the nature of the problems experienced. Solutions discussed ranged from a hardship fund to assist with increased cost-sharing in selected circumstances to changes in plan formularies to assure availability of maintenance drugs on tier-1 and 2, but the working group recommends that the nature and size of the problems first be studied.

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[3] State of Maryland, *Maryland Health Progress Act of 2013, House Bill 228* (State of Maryland, 2013), available online at http://mgaleg.maryland.gov/2013RS/bills/hb/hb0228T.pdf , pages 70-77.

iv. Due to the existing limitation of care and disease management in Medicaid MCOs, the group did not support establishing linkages among the care management staff of Medicaid MCOs and QHPs.

v. The group identified, but did not discuss the following:

   a. A premium assistance or subsidy program funded by the District to ease the financial transition from Medicaid to the Exchange at 200% of FPL
   b. Instead of switching pregnant women to a Medicaid plan, allow pregnant women to remain on the QHP with premium assistance.
   c. A "Bridge" program, such as California has proposed, to give former Medicaid MCO enrollees premium savings by positioning MMCOs as the lowest-priced silver plans.

Support for Special Enrollment Period for Pregnant Woman
The National Women's Law Center
Legal Aid Society of D.C.

We strongly support special enrollment periods for pregnant women. The public health benefits of ensuring that all women have access to affordable prenatal care are numerous and outweigh concerns about adverse selection.

A special enrollment period for pregnant women will ensure women have access to important prenatal care they may forgo if they remain uninsured. Prenatal care remains the primary way that problems are identified and addressed during pregnancy. Women who do not receive adequate prenatal care are at much higher risk for preterm births, which are the leading cause of death and disability among newborns. In spite of recent improvements, the U.S.'s infant mortality rate remains significantly higher than the average for Organization for Economic Security and Development nations.[1]

Additionally, pre-term births are extremely costly both within and outside of the health care system. The cost of hospitalization for a pre-term or low-birth weight infant averaged $15,100 in 2001, while the hospitalization costs associated with extremely preterm infants averaged $54,600.[2] Total societal costs are even higher -- according to the Institute of Medicine, in 2005 the economic burden associated with preterm birth was at least $26.2 billion annually, or $51,600 per infant born preterm.[3] Special enrollment periods for pregnant women will ensure that women have an opportunity to seek affordable prenatal care, reducing poor health outcomes and costly preterm births. Because the birth or adoption of a child triggers a special enrollment period, a preterm infant not eligible for other coverage will likely be enrolled in a plan through the health benefits exchange. Allowing an uninsured or underinsured woman a special enrollment period once she knows she is pregnant will reduce costs associated with caring for preterm infants.

Allowing a special enrollment period for pregnancy would also improve continuity of care. Once a woman discovers she is pregnant, she should be able choose a plan that is right for her and her family both during and after pregnancy. If women are only able to enroll in a new plan once the child is born, this could disrupt care during the post-partum period.

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[1] Congressional Research Service, "The U.S. Infant Mortality Rate: International Comparisons, Underlying Factors, and Federal Programs," 12 Apr. 2012, available at: http://www.fas.org/sgp/crs/misc/R41378.pdf
[2] Russell RB, et al, *Pediatrics*¸2007 Jul; 120(1):31-9, "Cost of Hospitalization for Preterm and Low Birth Weight Infants in the United States".
[3]The Institutes of Medicine, "Preterm Birth: Causes, Consequences, and Prevention," 2006, available at: http://www.iom.edu/~/media/Files/Report%20Files/2006/Preterm-Birth-Causes-Consequences-and-Prevention/Preterm%20Birth%202006%20Report%20Brief.pdf

One concern about creating a special enrollment period for pregnant women would be adverse selection into exchange coverage as women could wait until they become pregnant to enroll in coverage. However, numerous provisions of the ACA encourage women to enroll in coverage during regular enrollment periods, including the individual shared responsibility payments. The pool of potentially uninsured women who may become pregnant will therefore be therefore lower than in the current insurance marketplace.

Lastly, the Medicaid program's eligibility rules treat pregnancy as a time in a woman's life when it is particularly important to hold health coverage, with income-related eligibility levels that are higher for pregnant women than for other eligibility categories. This means that for many pregnant women in DC, their options for coverage will change when they become pregnant. Additionally, should the Treasury Department finalize their proposed rules governing minimum essential coverage in such a way that all states' pregnancy-related Medicaid coverage not be considered minimum essential coverage, pregnant women may still be eligible for advanced premium tax credits and could potentially face a penalty if they do not enroll in another form of MEC. During a period when a woman's eligibility and coverage options may be changing so drastically, it is important that she is able to have control over her health care and have the full range of options available to her so she can make a decision about what coverage is appropriate for her and her family. Given the uncertain nature of the final Treasury rules, it is also important that pregnant women have the chance to enroll in an exchange plan that is considered minimum essential coverage if they choose to do so.

Signed,

The National Women's Law Center

Legal Aid Society of D.C.

Summary of Maryland Health Progress Act of 2013[1]

On request, a receiving carrier or MCO must accept a preauthorization from a relinquishing carrier, MCO, or third-party administrator (TPA) for treatment for covered services for the lesser of the course of treatment or 90 days and for the duration of the three trimesters of a pregnancy and the initial postpartum visit. At the request and with the consent of an enrollee, a carrier, MCO, or TPA must provide a copy of a preauthorization to the receiving carrier or MCO within 10 days of receipt of the request. Carriers and MCOs may perform their own utilization review at the end of this period.

Also on request, carriers and MCOs must, for certain specified conditions, allow nonparticipating providers to continue health care services for the lesser of the course of treatment or 90 days and for the duration of the three trimesters of a pregnancy and the initial postpartum visit. Eligible conditions include acute or serious chronic conditions, pregnancy, mental health conditions, substance use disorders, and any other agreed-upon condition. The receiving carrier or MCO must pay the nonparticipating provider the rate and use the method of payment the carrier or MCO would normally pay and use for similar participating providers. The nonparticipating provider may decline the rate or method by giving 10 days' prior notice to the enrollee and the receiving carrier. Separate provisions specify continuity-of-care requirements for treatment in progress for dental services. For both health care and dental services, an enrollee is not subject to balance billing, and cost sharing for an enrollee may not exceed the cost sharing that would apply if the enrollee were receiving the services from a participating provider.

With respect to benefits covered under Medicaid fee-for-service (FFS), the continuity-of-care requirements do not apply to an enrollee transitioning from a carrier to Medicaid but do apply when an enrollee is transitioning from Medicaid to a carrier, but only for behavioral health and dental benefits authorized by a TPA. Continuity-of-care requirements apply to contracts issued or renewed on or after January 1, 2015.

The Commissioner and the Secretary of Health and Mental Hygiene are each authorized to adopt regulations to enforce continuity-of-care requirements. The Commissioner, the Secretary, and MHBE must collaborate to determine the data necessary to assess the implementation and efficacy of the continuity-of-care policies and develop a process to evaluate and monitor continuity of care. On request of the Commissioner, the Secretary, or MHBE, carriers, MCOs, and health care providers must provide the requisite data.

[1] State of Maryland, Maryland Health Progress Act of 2013, House Bill 228 (State of Maryland, 2013), available online at http://mgaleg.maryland.gov/2013RS/bills/hb/hb0228T.pdf , pages 70-77.

Recommendations for Addressing Churning between Medicaid and the Exchange

The undersigned organizations are deeply concerned about the potential impact that churning between Medicaid and exchange coverage will have on low-income consumers in the District. National research has shown that a large number of Medicaid and tax credit subsidy recipients are likely to experience a change in eligibility each year.[1] If not managed properly, transitions between different types of coverage can lead to harmful gaps in coverage and disruption of care.

The District has a number of long-term options to reduce and ease these transitions that we look forward to considering in future years. However, there are important steps the District can take to mitigate the impact of churning in the first year of exchange operation.

Consensus Care Continuity Recommendation

We support the consensus recommendation to require carriers to cover treatment that is in progress or preauthorized by the relinquishing coverage provider at the time an enrollee transitions for the remaining course of treatment or up to 90 days, whichever is shorter. This requirement allows consumers to continue treatment with their existing provider and pay in-network cost-sharing rates for that provider's services, even if that provider is not in the new health plan's network. We believe that Maryland's continuity of care protections, included with the working group report, provide an important model for the District. The board should adopt this general model while examining the specifics of Maryland's approach to ensure that its detailed policies provide adequate protection for transitioning District residents.

Additionally, when implementing these care continuity protections, we urge the board to ensure that transitioning consumers are clearly informed of their ability to receive coverage for preauthorized or in-progress treatment as soon as they are found eligible for exchange coverage. The board should ensure that this transitional coverage is easy to request so that consumers do not have to jump over hurdles to continue their scheduled treatment from their existing providers under their new health plan. For example, transitioning consumers should be able to make such a request after their previous coverage has ended, as long as they do so within the specified 90-day window.

We also look forward to future conversations with the Department of Health Care Finance on ways to promote affordability and ease the cost-sharing burden for individuals with preauthorized or ongoing treatment moving from Medicaid to the exchange.

Access to Essential Community Providers

The group also discussed, but did not come to a recommendation on, how to align provider networks between Medicaid and the commercial plans sold on the exchange to ensure continuous care for transitioning individuals. The conversation focused on the District's federally qualified health centers (FQHCs), but did not address the many other essential community providers (ECPs) that provide critical services to low-income District residents.

D.C. has numerous ECPs that focus on providing high-quality health care to low-income District residents. These providers include FQHCs, other health centers that focus on serving low-income, underserved populations, family planning clinics, Ryan White providers, and others. For the purpose of implementing the Affordable Care Act's exchange ECP requirements, the US Department of Health and Human Services has produced a non-exhaustive list of such providers for all states and the District, which can be found here: https://data.cms.gov/dataset/Non-Exhaustive-List-of-Essential-Community-Provide/ibqy-mswq. Including a sufficient number of ECPs in exchange plan networks is required under the ACA and is crucial to ensuring that low-income consumers get the care they need, even as income fluctuations may make them eligible for exchange coverage.

A number of states[2] and the federally-facilitated exchange[3] have set specific standards to ensure that QHPs include a sufficient number of ECPs in their networks. For example, Connecticut is requiring its QHPs to contract with at least 75 percent of ECPS in each county and at least 90 percent of FQHCs. Minnesota is requiring that all health plans offer contracts to any essential community providers within their service area, an approach also known as "any willing provider".[4]

We urge the Health Benefit Exchange Executive Board to consider a combination of these approaches. The Board should require QHP issuers to offer contracts to any willing ECP in the District. The Board should also consider following the example of the federally facilitated exchange and several state-based exchanges in developing a threshold level of ECP inclusion that all open-panel QHPs must meet, in addition to the "any willing provider" requirement. Within this standard, policies should be in place to ensure that a variety of ECPs across categories such as hospitals, FQHCs, other clinics, and other ECPs are included in each QHP network. The federally facilitated exchange has adopted such a policy, as outlined in this letter from HHS to issuers:
http://cciio.cms.gov/resources/regulations/Files/2014_Letter_to_Issuers_04052013.pdf.

The implementation of these policies together will ensure a robust network of low-income-focused providers for QHPs, while addressing the concerns raised by carriers and providers in the working group. ECPs that are not interested in contracting with commercial plans can decline such contracts under this any willing provider model. Carriers can apply their provider certification standards to the ECPs and will not have to contract with an ECP that does not meet these standards.

We believe this approach is the best way to ensure that low-income D.C. residents have access to the care they need from familiar providers without interruptions in treatment, and strongly urge the Health Benefit Exchange Executive Board to consider its adoption.

Sincerely,

Families USA

AARP DC

Legal Aid Society of D.C.

D.C. Coalition on Long Term Care

[1] Matthew Buettgens, Austin Nichols, and Stan Dorn. *Churning Under the ACA and State Policy Options for Mitigation* (Washington, D.C.: Urban Institute, 2012) available online at http://www.urban.org/UploadedPDF/412587-Churning-Under-the-ACA-and-State-Policy-Options-for-Mitigation.pdf.

[2] For more information on other state exchange approaches to ensuring adequate contracting with ECPs, see pages 7 -8 of *Consumer-Friendly Standards for Qualified Health Plans in Exchanges: Examples from the States* (Washington, D.C.: Families USA, 2013) available online at http://familiesusa2.org/assets/pdfs/health-reform/Consumer-Friendly-Standards-in-Exchange-Plans.pdf.

[3] ECP standards for QHPs in the federally facilitated exchange are outlined in pages 7-10 of CCIIO's Letter to Issuers on Federally-Facilitated and Partnership Exchanges, available online at http://cciio.cms.gov/resources/regulations/Files/2014_Letter_to_Issuers_04052013.pdf.

[4] Claire McAndrew. *Consumer-Friendly Standards for Qualified Health Plans in Exchanges: Examples from the States* (Washington, D.C.: Families USA, 2013) available online at http://familiesusa2.org/assets/pdfs/health-reform/Consumer-Friendly-Standards-in-Exchange-Plans.pdf.