DC Health Benefit Exchange Authority

Executive Board IT & Eligibility Working Committee

Meeting Minutes

Friday, May 3, 2013

Location: teleconference

Call-in Information: 1-877-668-4493 Access code: 641 170 303

I. Opening Remarks
Leighton Ku, Chairman

Introduced himself as the Chairman of the Working Committee. This meeting is to discuss work from the Eligibility, Enrollment & Churn Working Group.

Noted that Henry Aaron is on vacation and unable to participate. Kevin Lucia and Leighton Ku are the two other Committee Members and are both present. Board member Wayne Turnage also joined as Chair of the Working Group.

II. Discussion of issues relating to eligibility, enrollment and churn

A. Wayne Turnage, Chairman of the Enrollment, Eligibility and Churn Working Group turned the time over to Alex Alonso, HBX staff, to review the consensus agreements from the working group.

Alex Alonso reviewed the consensus items *(list inserted for ease of reading)*

Consensus Recommendations

1. ***Inconsistency Extension 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.

2. ***Periodic Notice 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.*
3. ***Auto-Termination 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.*
4. ***Auto-Enrollment Recommendation:*** *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. ***SEP Recommendations:*** *The working group recommends offering special enrollment periods under the following circumstances:*

a) *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.*
b) *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.*
c) *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.

6. ***Effective Date 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. ***Non-Report Threshold 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)."*
8. ***Default APTC Recommendation:*** *The working group recommends that the default setting of this web-based tool will be 85% of the total APTC amount available.*
9. ***Churn Recommendations:*** *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[1]. These requirements have been summarized in one page, appended to this report. 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.*

Chairman Ku noted that he intends to suggest some word changes on one item in the consensus recommendations for the sake of clarity. Specifically, in item

#7, he proposes to change the last phrase from "but you are not required to report a change in income below $150/month ($1,800 annually)." to "but you are not required to report a change in annual income below $1,800 (or an average of $150 in monthly income)."

Discussion and consideration of the non-consensus items from the Eligibility, Enrollment and Churn Working Group:

Chairman Ku asked Alex to provide a quick overview of the three non- consensus items.

1. Pregnancy Special Enrollment Period – Medicaid extends to 300% of poverty for pregnant women, but there was still concern by some group members who sought a special enrollment period for pregnancy. National Women's Law Center was championing this and was joined by some other consumer advocates. On the other side were carrier representatives who were concerned about adverse selection.

DISCUSSION: Committee Members discussed with Alex Alonso the rules that govern coverage of newborns. It was explained that coverage is retroactive to date of birth. Alex Alonso also verified that the Federal Government does not consider pregnancy a rationale for a special enrollment period and that, after the infant is born that this also triggers a special enrollment period and that the coverage period goes back to the date of birth. The Committee Members recognized the sensitivity of this issue, but also noted that the overall goal of the ACA is for people to obtain coverage before they are in need of services. While they recognized that pregnancy is a special event, we also recognized that there are other important health events (e.g., having an accident, a diagnosis of cancer or another serious illness) for which there are no special enrollment periods. If we permitted special enrollment periods for all of these, we would create a serious adverse selection problem that would drive rates up and discourage people from enrolling when they are healthy. After a long discussion, all three Board Members agreed that a special enrollment period for pregnancy was not needed at this time. As with most decisions made this year, they also agreed this issue should be closely monitored to see if there is a problem. If there is, we could act in the future.

2. **Churn:** Alex Alonso described this problem of the concern regarding people who will flip back and forth – or churn – between Medicaid and private health insurance on the Exchange. This raises real concerns about continuity of care for patients. In the Working Group's deliberation of these issues, professional facilitator Jon Kingsdale laid out a series of policies that could mitigate churn. Several weren't

logistically possible for 2014 and were set aside for that reason by the Working Group. One was focused on requiring QHPs, as a condition of certification, make a good faith effort to sign up the 11 federally qualified health centers in DC as part of their networks.

Consumer groups were in favor of this, however, the carriers and one of the FQHCs indicated that not all the FQHC's have experience working with commercial insurers and might not want to contract with them. Carriers didn't like it as a mandate, but say they will make this effort without that. Carriers opposed this recommendation.

DISCUSSION: Committee members highlighted that via the network adequacy discussions earlier this year, the Board – at the advice of the network adequacy working group – took a wait and see approach to the essential community provider (ECP) issue, preferring to see if there was a problem before enacting rigid policies. There is also recognition that for some closed panel plans, there need to be special accommodations if such policies are put in place. It was also noted that the federal law takes a similar approach of encouraging carriers to include ECPs, but it doesn't mandate specific thresholds. The Committee Members discussed the need to strongly encourage carriers to contract with these key community providers and agreed on the important of continuing to deliver that message to the insurers. It was also noted that "good faith effort" is a difficult concept to enforce.

In the end, the Committee Members agreed to stick with the Board's previous policy of watching what happens in 2014 and if carriers aren't contracting with essential community providers, that would be the right time to consider a heightened standard or a contracting requirement, or "any willing provider". That will take time to study and understand its ramifications.

3. **Auto-enrollment when a plan no longer exists, but a similar plan does:** Alex Alonso described the options considered by the Working Group:

Options:

i. no auto-enrollment in this scenario – no one supported this.
ii. a special enrollment period of 60 days. The individual would have been dropped from their old plan on Dec 31, but would have 60 days to select a new plan. That received support from carriers.
iii. Auto enrollment in a similar plan if available. Similar is defined as being the same carrier, the same metal tier, and the same provider network. This option was supported by other members of the group,

but not the carriers. If no similar plan, then you'd still get the new 60 day special enrollment period.

DISCUSSION: Committee Chairman Ku proposed a combined alternative that incorporates parts of the bottom two options described above. His preferred approach would be to auto enroll an individual in this circumstance into a similar plan, but then provide them a new 60-day special enrollment period so they can switch to a different plan if they don't like the similar plan into which they have been enrolled. He noted that this formulation would ensure continuous coverage. He also emphasized that this is likely to be a rare occurrence as people will get multiple notifications from their plan if it is being terminated. This protection is really here for the hopefully very small minority of people who ignore those communications. There was also discussion that a policy like this mirrors similar actions that are taken in Medicaid in the District today.

The Committee Members agreed with the auto-enrollment policy put forward by Chairman Ku. Exchange staff were provided the flexibility needed to draft the proposal given that it was not presented in writing.

III. Closing remarks, adjournment

Chairman Leighton Ku concluded the meeting by highlighting that we have an upcoming Board meeting on May 9th where these issues will be presented and voted upon and he and the other Committee Members encouraged members of the public with opinions on these issues to please come forward and make your voices heard.

IV. Votes

V. Closing Remarks and Adjournment