GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES

Economic Security Administration

Meeting Title: Medicaid Expansion and Eligibility (ME&E) Subcommittee Meeting

Date/Time: Thursday July 12th , 2012 / 10:00 AM to 12:00 PM

Location: Department of Human Services (DHS)
645 H St NE, 4th Floor Conference Room

Attendees:

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Agenda:

1. Subcommittee Updates
2. Discussion Questions
    1. "Backup" QHPs
    2. Auto Enrollment
    3. Special Enrollment Periods
    4. QHP Effective Dates
3. Q&A

Subcommittee Updates

- Trey provided an update on the other HBX Authority Subcommittees (see presentation for details):
    - Insurance
    - IT/PMO
    - Operations
    - Communications

Discussion Questions

1. <u>"Backup" QHPs</u> – What should happen when existing enrollees who lose coverage fail to pick a new QHP?
    - Q: if we auto-enroll in a new plan, won't carriers be concerned that they will not be paid?
        - A: We are working to understand whether a QHP is obligated to pay claims prior to receipt of the first premium payment ("binder payment"). There is also a 90-day grace period for enrollees that have paid premiums in the past but start to fall behind. Failure to pay for 90 days straight causes retroactive denial of claims and the right of a provider to bill the client directly.
    - Q: If one of these enrollees does nothing and then gets sick, who pays the cost for their care? Which cost is higher, automatically enrolling them or paying for their uninsured care (through emergency rooms, etc)?
        - A: They would be just like any other uninsured person. The cost/benefit trade-off is not currently known. It is also not easily comparable. The cost of uncompensated care is borne by all of the insured, but the cost of an auto-enrolled individual is concentrated on whatever plan they are auto-enrolled in.
    - Q: Can we distinguish between people whose plan was decertified vs people who lost coverage through a change in circumstance?
        - A: Probably – this will be a **design consideration**.
        - Comment: Disability Services is leaning towards auto-enrolling everyone possible, to provide better services and reduce overall costs.
        - Comment: If a plan is still offered and the enrollee does not take action, we have to auto enroll them.

- Q: For Medicaid enrollees who lose coverage and need to enroll in a QHP, who tells them about their special enrollment period?
    - A: DHS/ESA will send a notice.
- Q: Can the government make someone incur a cost without their permission? That is what auto-enrollment would do.
    - A: Perhaps the application should ask permission to auto-enroll before it is submitted. This would be a **design consideration**.
    - Comment: the senior community does not always understand notices and won't be using the computer system. Clear communication to partner organizations will be important.
    - Comment: It is hard enough to find people when we want to give them something. It will be even harder when we want them to incur a debt.
- Q: Can we create a new special enrollment period when someone who was dropped from Medicaid needs coverage? For example, they walk into a community-based organization seeking help because their doctor said they are no longer covered.
    - A: Question #3 is about Special Enrollment Periods and the District's ability to define "exceptional circumstances" that also warrant a SEP. We can consider this as one of those scenarios.
    - Comment: The HIV/AIDS population often finds out that they no longer have coverage when they can no longer get their medication.
- Q: There is a 60-day SEP when coverage is lost. When should it start? (we are also asking CCIIO for guidance on this)
    - Option: If it is when they are notified, they will have more time to select a plan and avoid a gap in coverage
    - Option: If it starts when coverage ends, there will almost certainly be a gap in coverage.

2. Auto Enrollment – When would automatic enrollments be appropriate, and should enrollees be able to move out of auto-enrolled plans?
    - Q: Expected guidance will state that if you are auto-enrolled in a plan, you can change to another plan at the same carrier. Is this sufficient?
        - A: (group consensus) we should let these auto-enrollees switch to any plan at any carrier in the first 30 days
    - Q: If we auto-enroll someone who was previously in Medicaid, cost will be an issue – should we enroll them in the lowest-cost plan?
        - A: (no consensus)
    - Q: Can we provide "wraparound" coverage for people who lose Medicaid? This would cover 30 days while they are transitioning to the BHP.
        - Comment: we should auto-enroll this population (under 200% FPL) in the BHP because it is their only option (persons eligible for the BHP are not eligible for APTC/CSRs).

3. Special Enrollment Periods – What other circumstances should trigger a special enrollment period (SEP)?
    - Refer to question #1 – create a SEP when someone was dropped from Medicaid, did not realize it, and seeks help?

- Q: Could the fourth point (see presentation, slide 6) be used when people did not understand that they are losing coverage? "A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS…"
    - Comment: Carriers will be concerned about what protections they have
- Q: Can the fifth point (see presentation, slide 6) be used when someone is pressured or tricked into enrollment in a "predatory" carrier, who is not actually a QHP? This would likely be outside of the Exchange, so it might need to be a special circumstance: "An enrollee adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee."
    - A: This seems like a different scenario and should be considered a SEP special circumstance
    - Comment: This should be public information, but only QHP changes are required to be publicized
- Q: What is the difference between "adoption" and "placement"
    - "Placement" just means all of the paperwork is not complete yet - but the child is in a new home
    - Comment: we need to avoid overlapping coverage with CFSA. Applicants sometimes mention that they have a child in their home, but they sometimes fail to mention that it is a foster child.
    - Comment: this should be a **design consideration**. We should ask applicants and check for paperwork (even if it is still in progress). Otherwise, we need to contact Child Protective Services.
- If an applicant happens to apply for Medical Assistance on a day that falls within an enrollment period, and it takes a while for their Medicaid application to be completed (supplying documentation, etc), should they still be able to enroll in a QHP if they are denied Medicaid after the enrollment period ends?
    - A: (group consensus) this seems like a good scenario for a SEP
    - Comment: this is NOT a "rolling" enrollment period – it only applies if they requested Medicaid during an enrollment period.
    - Comment: if they did not supply the required documentation for their Medicaid application in a timely manner, they won't get the SEP (unless they win an appeal).

4. <u>QHP Effective Dates</u> – should the Exchange consider changes to the effective dates as stated by the ACA?
    - NOTE: APTC and CSRs can only be effective on the 1st of a month because of IRS rules. If a child is born (or other life event occurs) in the middle of a month, the family must pay "full freight" until the 1st.
    - What are the options for making the coverage dates earlier?
        - Option: give enrollees until the 20th or so (instead of only until the 15th) to get coverage by the 1st of the next month. This squeezes the time needed to complete the enrollment, but prevents families enrolling on the 16th from waiting a month and a half.

- Option: for full freight QHPs only, make coverage effective earlier. For example, if they enroll between the 1st and the 15th, make coverage effective on the 21st. If enrolling after the 16th, make coverage effective in the middle of the next month (instead of waiting till the 1st). These would each be a pro-rated amount for the remainder of the month. NOTE this would not apply to APTC/CSR, which MUST be effective on the 1st of a month.
- Comment: Carriers are split on this issue. Many want to wait and see how 2014 goes.

- Q: What are carriers concerned about?
  - A: They don't offer coverage until an enrollee has paid, and they want to give enrollees more time to pay. If they enroll on the 14th and coverage is supposed to go into effect on the 20th, there are only 6 days.
  - Comment: Carrier may like the second option, in which they can be paid for partial months.

OTHER QUESTIONS

- Q: From CFSA – if we remove a child from a home, how soon can we remove them from their current plan and enroll them in FFS (assuming the family was on a QHP)? Today, the MCOs allow CFSA kids to still get prescriptions, etc under the old plan (even though the child is no longer in the household) until the FFS switch is complete. This has to happen in the future, otherwise CFSA will have to cover the costs of the medication.
  - A: The Policy Task Force will work on this, and it will be a **design consideration**.
- Q: How do we handle cases in which someone is in the hospital when their coverage changes? Could there be an exception in which the cost of their hospital stay is paid by their starting coverage until that say in over? This is especially concerning if the hospital is not covered by the new plan.
  - A: The Policy Task Force will work on this, and it will be a **design consideration**.

Action Items:

Group	Description	Assigned To	Target Date
ME&E	Follow up on open questions above	All	6/14 (next meeting)

Next Steps:

1. Next ME&E Subcommittee Meeting scheduled for August 9th, 2012