DC HBX Authority
ME&E Subcommittee Meeting

July 12, 2012

DCAP: Connecting District Residents to Health Care and Human Services Benefits

Agenda

- Updates from other Subcommittees
  - Insurance
  - IT
  - Operations
  - Communications
- Discussion Questions
- Q&A

Other Subcommittee Updates

- **Insurance Subcommittee**
  - Working on QHP Requirements (including EHB selection), anticipate release of draft for public comment in August
  - Seeking stakeholder input on the Regulatory Authority approach and Plan Management process flows
  - Following up with NAIC on SERFF beta testing (updates for ACA Plan Management)
- **IT Subcommittee/PMO**
  - The Local Data Hub work group identifying POCs at OCTO and sister agencies
  - The ACEDS Transition Team is developing a workplan for legacy system modifications
  - The PMO is coordinating an update of specific planning documents for CCIIO
- **Operations Subcommittee**
  - Discussing polices and processes for the Call Center and Navigator program
  - Reviewing and updating Operating Model and Costs for the HBX
- **Communications Subcommittee**
  - Analyzing results of the Navigator Survey (with Operations Subcommittee)
  - Planning ongoing newsletters and marketing RFP for DCAS roll-out

Question 1 – "Backup" QHPs

The D.C. Access Project (DCAP) staff is thinking about how to handle existing enrollees who lose coverage in their current plan and fail to take action to select a new QHP. This may occur at:

1. annual enrollment
2. when their current QHP is decertified, or
3. when their Medicaid or BHP benefits are terminated.

45 C.F.R. 155.335(j) instructs that if the applicant was in a QHP and remains eligible at annual redetermination, he/she is to be kept in the same plan. However, the rules do not indicate the procedure when the same plan is not offered in the new benefit year. It also does not address scenario 2 or 3 above. **What are the suggestions of beneficiary advocates on how best to deal with these situations?**

Question 2 – Automatic Enrollments

45 C.F.R. 155.410(g) allows Exchanges to conduct automatic enrollments for good cause and in accordance with HHS guidance (not yet released). **What are the suggestions of beneficiary advocates regarding when automatic enrollment would be appropriate?** Your response should include responses to the following:

a. Should only certain plans be eligible for receiving auto-enrolled individuals?
b. Should individuals be able to move out of a plan in which they were auto-enrolled, effective the 1st of the month following the requested change? Should this be time-limited to only when the change is made within 30-days of the auto-enrollment?

Question 3 – Special Enrollment Periods

45 C.F.R. 155.420(d)(1) – (7) lists several circumstances under which an applicant can have a 60-day Special Enrollment Period (SEP) outside the usual Annual Enrollment. They are:

1) A qualified individual or dependent loses minimum essential coverage; (e.x. ESI or Medicaid)
2) A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;
3) An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
4) 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, or its instrumentalities as evaluated and determined by the Exchange. 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;
5) 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;
6) An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP. The Exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
7) A qualified individual or enrollee gains access to new QHPs as a result of a permanent move;

Additionally, 155.420(d)(9) allows an SEP for "exceptional circumstances." HHS may administratively proscribe certain circumstances, such as natural disasters, but there may also be discretion afforded the Exchanges. **From the perspective of beneficiary advocates, how should the Exchange exercise this discretion? Are there circumstances other than those listed that we should consider?**

Question 4 – QHP Effective Dates

Effective dates for QHP coverage are laid out in the final rule as follows:

a. In the event of a birth, adoption, or placement for adoption, coverage is effective on the date of the event, but APTC and CSR don't start until 1st of month after event. 155.420(b)(2)(i).

b. In the event of marriage or loss of Minimal Essential Coverage (including Medicaid), coverage is effective on the 1st day of the month following the marriage or loss of MEC. 155.420(b)(2)(ii).

c. Other than the situations described above, the basic coverage effectiveness rules make coverage effective on the 1st of the next month if an individual selects a QHP by the 15th of the prior month. 155.420(b)(1). Coverage is effective the 1st of the 2nd month following selection if that selection is made after the 15th of a month. Id.

With the exception of birth, adoption, or placement for adoption, 45 C.F.R. 155.420(b)(3) allows Exchanges to alter the above rules if all participating QHP issuers agree. However, if the new effective date is earlier than the 1st of the next month, the applicant still does not get the APTC until the 1st of the next month. **What is the perspective of beneficiary advocates as to earlier effective dates?**

Questions?

Appendix: Release Scope for DCAS

Release 1	Release 2	Release 3
ACA Required • Medicaid (MAGI only) • QHP Subsidies/Credits • Unsubsidized QHPs **Functionality Deployed:** • Customer Portal • Employer/Carrier functions • Verification (Federal Data Hub integration and Local Interfaces) • Eligibility & Enrollment • Plan Management • QHP/Medicaid Financial Management (Marketplace) • Contact Center • Consumer Marketing • "Basic" Case Management	*Federally Funded* • Remaining Medicaid (Non-MAGI) • Supplemental Nutrition Assistance Program (SNAP, also known as Food Stamps) including Employment and Training Program and Disaster Food Stamps (separate application process) • Temporary Assistance for Needy Families (TANF) including TANF Employment Program and TANF Diversion (one-time payment in lieu of ongoing benefits) • Refugee Cash and Medical Assistance *Locally Funded* • Program on Work, Employment and Responsibility (POWER) • Interim Disability Assistance • General Assistance for Children • Immigrant Children Health Care • DC Healthcare Alliance • Burial Assistance • Homeless "Intake" **New Functionality Deployed:** • "Full" Case Management • Human Services Financial Management	*Federal/Local* • Homeless Services Program • Strong Families Program (SFP) • Adult Protective Services (APS) • Family Violence Prevention Services • Teen Parent Assessment Program • Refugee Resettlement Services • Parent and Adolescent Support Services (PASS) • Emergency Rental Assistance Program (ERAP) • Low Income Home Energy Assistance Program (LIHEAP) *Non-DHS ("Optional")* • DOH: Women, Infants, and Children (WIC) • OSSE: Subsidized Child Care **New Functionality:** • N/A

Appendix: Release Schedule