

Enrollee Transition Procedures

March 8, 2013
PMAC Meeting

Procedures and policy options for transition of employees due to PCIP transition, plan decertification, or life change events.



Topics for Discussion

- (1) What are the procedures for enrollee transition if a plan is decertified or if the enrollee has a qualifying life change event? If a SHOP plan is decertified, are employees granted a special open enrollment period?
- (2) What are the procedures for the transition of Pre-existing Conditions Insurance Plan (PCIP) enrollees to Exchange plans?
- (3) What are the enrollee communication procedures?
- (4) Options for AID consideration for PCIP and QHP transition:
 - a. Should AID develop continuity of care standards or require that issuers develop standards to be approved in the QHP review process?
 - b. Should there be a required continuity of network providers during a transition period?
 - c. Should enrollees in a decertified QHP be automatically enrolled into another QHP?
 - d. Should issuers be required to permit disenrollment in QHPs within a certain time frame?
 - e. Should SHOP purchasers be allowed to waive eligibility requirements if the employer was eligible in the previous enrollment period?

Background

After the exchange becomes operational, there are several events which could result in loss of health insurance coverage for QHP enrollees who will need to be transitioned to new plans. Enrollees will also be transitioning from the Pre-existing Conditions Insurance Plan (PCIP) to QHPs. This issue brief discusses the process for transitioning enrollees from QHPs or PCIP plans to new QHPs as well as potential continuity of care issues. AID seeks to align the PCIP and QHP transition processes where possible.

The PCIP program is part of the Affordable Care Act (ACA) and is an interim high-risk pool that covers individuals with pre-existing conditions who have not had coverage for at least six

months. Coverage through the PCIP program will end prior to plan year 2014, at which time enrollees will be able to purchase plans on the exchange; ACA provisions that go into effect for plan year 2014 do not allow denial of enrollment based on pre-existing conditions. HHS has indicated that there will be a forthcoming transition process:

Transition to the Exchanges (45 CFR § 152.45)

Prior to termination of the PCIP program, HHS will develop procedures to transition PCIP enrollees to the Exchanges, established under sections 1311 or 1321 of the Affordable Care Act, to ensure that there are no lapses in health coverage for those individuals.

QHPs may also be decertified or withdrawn in the course of ongoing or periodic monitoring or as the result of an adverse event reported to AID or FFE, potentially resulting in lost coverage to enrollees. AID has established tentative procedures that govern the QHP decertification / withdrawal process in the exchange as well as the transition of enrollees to new plans. These procedures were included in the AR Design Review Blueprint. Below is a brief summary of the procedures:

- When plans are decertified/withdrawn, carriers, affected consumers, and the FFE must all be notified. HBEPD will notify the carrier and work with CSD to notify consumers and facilitate enrollment into a different health plan. The issuer account will be updated and HBEPD will notify the FFE of the decertification.
- Issuers can appeal the decertification, and if successful, can have the plan reinstated. Consumers, the FFE, and the carrier will all be notified in this case. (Note that decertification is a final measure that results when issues cannot be resolved through other means such as corrective action plans).
- If there is a voluntary company/issuer withdrawal from the state or Exchange, the company must give the state 180 days notice. For individual plan withdrawal, the company must give the state 90 days notice.
- Arkansas will likely draft a QHP rule that will address certification, recertification, and decertification procedures. The policy and procedures in support of this rule will be completed and the rule published upon receipt of final rules from CMS.
- Plans can be decertified due to insolvency in collaboration with the Finance Division. Consumers have guaranty fund coverage up to \$300,000 per person in the case of issuer insolvency.

- AID currently sends notification to consumers enrolled in liquidated or withdrawn plans and is actively involved in helping consumers find replacement coverage.

Transition Challenges and Considerations

Plan transitions could result in continuity of care issues because they could involve changes in provider network, prescription coverage, or premium amount. The transition process and enrollment period timelines could also result in loss of coverage. There are several challenges to consider in the transition process:

- **Network coverage** – Will the same network exist in the new QHP? The FFE portal may have some tools to help consumers ensure that they are choosing plans that cover their service area but may not be able to assist consumers in determining that they can access the same provider network. Note that the PCIP program service area is statewide but the QHP service area requirement is not.
- **Enrollment Period** – If plans on the exchange are decertified, a special enrollment period will have to be facilitated among several parties including the FFE and HBEPD. However, one option to consider is to automatically enroll consumers in another QHP. PCIP enrollees will be notified of the end of the PCIP program and will be able to obtain coverage in the normal enrollment period.
- **Scope of benefits and limitations** – Benefit coverage among QHPs will be similar due to the minimum Essential Health Benefits (EHBs) but the cost sharing and service limitations may be different. Benefits covered under the PCIP program are not as broad as the benefits covered under QHPs. Continuity of medical treatments or pharmacy coverage may be at risk in the transition process.
- **Premium Changes** – Recipients transitioning from the PCIP program to QHPs will likely see a premium increase due to different premium rating factor requirements (i.e. age) in the exchange as well as an increased scope of benefits. Premiums could also vary among QHPs and consumers may not be able to transition to a plan with the same premium. PCIP premiums range from \$150.00 through \$650.00 per month in Arkansas.
- **Navigators / consumer outreach** – During the transition period it will be especially important that Navigators and In-Person Assisters are equipped to assist consumers in transitioning from the PCIP program or QHPs. There will need to be a process to provide

advanced communication to these parties so that they can provide specialized staff or can be adequately prepared to answer consumer questions.

- **Post-transition appeal resolution** – If consumers are transitioning from one plan to another, they may have had pending grievances or appeals with the previous plan issuer.
- **SHOP plans** –45 CFR § 155.715 (g) outlines the process for employer withdrawal from SHOP and states that the SHOP exchange will ensure that each QHP terminates the coverage of employer’s qualified individuals enrolled in QHPs and that each of the enrollees are notified of the termination and provided other information about potential sources of coverage. (See Attachment D).

In the case of a SHOP plan decertification or other loss of minimum essential benefit coverage at the minimum required value through the SHOP employer plan, employees must be granted a special enrollment period pursuant to proposed rule 45 CFR §155.725 during which they can enroll in another QHP offered in the *SHOP Exchange*.¹

- **Multi-State OPM Plans (MSP)** – MSPs must meet QHP requirements but are permitted a phase-in period where the plans initially do not have to meet the state service area requirements and can offer plans within partial service areas. OPM urges the plans to comply with state service area standards will possible and HHS will review the plans for discriminatory service area configurations. However, this could present continuity of care challenges in the first few years if the service area offering is not clear to consumers. MSPs must comply with QHP requirements for providing notice to enrollees in the case of decertification.²

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¹ Proposed rule 45 CFR §155.705 requires employers to choose only one QHP to offer to employees, so AID may wish to provide comment on potential transition issues if a SHOP plan were to become decertified in plan year 2014, since employees are only allowed to enroll in the SHOP Exchange during the special enrollment periods.

² OPM Final Rule 45 CFR § 800

Options for AID Consideration

1. Should AID develop continuity of care standards or require that issuers develop standards to be approved in the QHP review process?

Some states are requiring that issuers provide minimum transition coverage and/or transition plans. For example, Delaware is requiring that issues provide a transition plan and requires that the issuer cover medical treatments in progress for the lesser of 90 days or until the treating provider releases the patient from care. Delaware also has specific requirements for pharmacy and mental health treatment. (See Attachment A: Delaware Continuity of Care Standards). Maryland is postponing continuity of care requirements until 2015 but has developed recommendations for issuers and will monitor continuity of care issues in 2014. (See Attachment B: Maryland Continuity of Care Recommendations). AID could develop continuity of care standards or allow issuers to develop transition plans to be approved in the QHP review process.

2. Should there be required continuity of network providers during a transition period?

Enrollees transitioning to a new QHP may be enrolling in a plan with a different provider network which could result in access and continuity of care issues. AID could require continuity of network providers for a minimum time period at in-network rates or could require that transition plans submitted by issuers include network considerations in the continuity of care plan.

3. Should enrollees in a decertified QHP be automatically enrolled into another QHP?

There is some precedent in Medicare Advantage for automatically transitioning enrollees to a new plan when the former plan is no longer active. This would ensure that there are no lapses in coverage. Facilitating this transition through the FFE could present challenges and result in diminished consumer choice. One option is that AID could give enrollees a time period for which to enroll in a new plan through a special open enrollment period and could then be automatically enrolled after the expiration of the enrollment period.

4. Should issuers be required to permit disenrollment in QHPs within a certain time frame?

Because the transition period may cause confusion for consumers, it is likely that some consumers will enroll in a plan that they later realize did not meet their expectations. A



change period could help consumers get enrolled in a more satisfactory plan and prevent nonpayment of premiums. Facilitating this process through the FFE could present challenges, although there is already a requirement that consumers be granted a special enrollment period if a consumer enrolls in a plan due to “error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS.”³

³ 45 CFR 155.420(d)(4)

Attachment A: Delaware Continuity of Care Standards

Continuity of Care: A QHP issuer must have a transition plan for continuity of care for those individuals who become eligible or lose eligibility for public health programs. The Continuity of Care Transition Plan must include a transition period for prescriptions, including how the plan specifically addresses mental health pharmacy. In such instances, the new plan is responsible for executing the Transition plan. Transition plans are not applicable for individuals who voluntarily disenroll in a QHP, do not enroll in another QHP, but are still not eligible for Medicaid/CHIP.

- For treatment of a medical condition or diagnoses that is in progress or for which a preauthorization for treatment has been issued, the QHP issuer/plan must cover the service for a lesser of: a period of 90 days or until the treating provider releases the patient from care.
- A continuity/transition period of at least 60 days must be provided for medications prescribed by a provider. If the QHP uses a tiered formulary, the prescribed medication must be covered at tier comparable to the plan from which the individual was transitioned.
- For mental health diagnosis, a continuity/transition period of at least 90 days must be provided by the QHP for medications prescribed by the treating provider for the treatment of the specific mental health diagnosis. The prescribed medication must be covered at a tier comparable to the plan from which the individual transitioned.

Attachment B: Maryland Continuity of Care Recommendations

- Maryland Health Benefits Exchange (MHBE) should raise awareness and educate consumers about their continuity of care rights and options in 2014.
- Individual and small group health plans in the Maryland market should accept the prior authorization determinations from relinquishing plans for a specified time period—the lesser of the course of treatment or 90 days, or through delivery and the postpartum visit for pregnant women.
 - Consideration should be given as to whether this should apply to the large group market.
 - Coverage should be for covered benefits at the receiving health plan's rates.
 - Health plans should be encouraged to adopt this policy prior to 2015, and it should be required for 2015.
- Individual and small group health plans in the Maryland market should allow new enrollees within specified courses of treatment to receive care from out-of-network

providers for 90 days or through delivery and the postpartum visit for pregnant women. This should apply only to out-of-network providers who were rendering the specified treatments at the time of the enrollees' transition to new plans.

- Consideration should be given to the courses of treatment for conditions where continuity is especially important, such as pregnancy. Other such conditions should be reviewed in the legislative process.
- Coverage should be for covered benefits.
- A treating provider should be reimbursed at the rate established under existing law for an out-of-network provider.
- Consideration should be given as to whether this should apply to the large group market
- Health plans should be encouraged to adopt this policy prior to 2015, and it should be required for 2015.
- MHBE should begin collecting data during open enrollment and develop a process to evaluate and monitor continuity of care on an ongoing basis, focusing on the newly eligible population and trends in disparities.

Attachment C: 45 CFR § 155.420 Special enrollment periods.

(a) *General requirements.* The Exchange must provide special enrollment periods consistent with this section, during which qualified individuals may enroll in QHPs and enrollees may change QHPs.

(b) *Effective dates.* (1) *Regular effective dates.* Except as specified in paragraphs (b)(2) and (3) of this section, for a QHP selection received by the Exchange from a qualified individual—

(i) Between the first and the fifteenth day of any month, the Exchange must ensure a coverage effective date of the first day of the following month; and

(ii) Between the sixteenth and the last day of any month, the Exchange must ensure a coverage effective date of the first day of the second following month.

(2) *Special effective dates.* (i) In the case of birth, adoption or placement for adoption, the Exchange must ensure that coverage is effective on the date of birth, adoption, or placement for adoption, but advance payments of the premium tax credit and cost-sharing reductions, if

applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and

(ii) In the case of marriage, or in the case where a qualified individual loses minimum essential coverage, as described in paragraph (d)(1) of this section, the Exchange must ensure coverage is effective on the first day of the following month.

(3) *Option for earlier effective dates.* Subject to the Exchange demonstrating to HHS that all of its participating QHP issuers agree to effectuate coverage in a timeframe shorter than discussed in paragraph (b)(1) or (b)(2)(ii) of this section, the Exchange may do one or both of the following for all applicable individuals:

(i) For a QHP selection received by the Exchange from a qualified individual in accordance with the dates specified in paragraph (b)(1) or (b)(2)(ii) of this section, the Exchange may provide a coverage effective date for a qualified individual earlier than specified in such paragraphs, provided that either—

(A) The qualified individual has not been determined eligible for advance payments of the premium tax credit or cost-sharing reductions; or

(B) The qualified individual pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of advance payments of the premium tax credit and cost-sharing reduction payments until the first of the next month.

(ii) For a QHP selection received by the Exchange from a qualified individual on a date set by the Exchange after the fifteenth of the month, the Exchange may provide a coverage effective date of the first of the following month.

(c) *Length of special enrollment periods.* Unless specifically stated otherwise herein, a qualified individual or enrollee has 60 days from the date of a triggering event to select a QHP.

(d) *Special enrollment periods.* The Exchange must allow qualified individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

(1) A qualified individual or dependent loses minimum essential coverage;

(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;
- (8) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; and
- (9) A qualified individual or enrollee demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide.
- (e) *Loss of minimum essential coverage.* Loss of minimum essential coverage includes those circumstances described in 26 CFR 54.9801-6(a)(3)(i) through (iii). Loss of coverage does not include termination or loss due to—
- (1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
 - (2) Situations allowing for a rescission as specified in 45 CFR 147.128.

Attachment D: 45 CFR § 155.715 Eligibility determination process for SHOP.

- (g) *Notification of employer withdrawal from SHOP.* If a qualified employer ceases to purchase coverage through the SHOP, the SHOP must ensure that—



- (1) Each QHP terminates the coverage of the employer's qualified employees enrolled in the QHP through the SHOP; and
- (2) Each of the employer's qualified employees enrolled in a QHP through the SHOP is notified of the termination of coverage prior to such termination. Such notification must also provide information about other potential sources of coverage, including access to individual market coverage through the Exchange.

