Covered California: Initial Eligibility & Enrollment Policy Recommendation

Key Policy Issues:	Federal Requirements:	Staff Recommendation:
Processing time frames to conduct eligibility determinations	Affordable Care Act (ACA) and Federal Regulations do not explicitly identify the processing timeframe (e.g., how many days) to conduct an eligibility determination once an application is received. Federal statutes and Regulations state that the eligibility determination must be conducted in "real time" and without "undue delay."	Staff recommends the following timeframes to conduct eligibility determinations, based on the following scenarios: • **Complete on-line applications** received via the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) that do not require the resolution of any inconsistency will occur "real time" and immediately. • **Complete telephone applications** received that do not require the resolution of any inconsistency will occur "real time" and immediately. • **Complete paper or fax applications** that are received and do not require resolution of any inconsistency will be processed within 10 calendar days of receipt (this maximum timeframe is being recommended for proposed State Regulations*****). • **On-line, paper, or faxed application** which are received, but require additional information because the application data elements are missing, will be processed within 10 calendar days of receipt (this maximum timeframe is being recommended for proposed State Regulations*****). • **On-line, telephone, paper or faxed applications that require the resolution of inconsistency** will result in the consumer being conditionally eligible for Covered California subsidies, if their self-reported information qualifies them for coverage. Their conditional eligibility will be for the 90-day reasonable opportunity period which provides consumers adequate time to resolve the inconsistency. The consumer will be required to demonstrate their eligibility by resolving the inconsistency in order to maintain coverage beyond the 90-day timeframe. ***Note:** *While staff recommends that the 10 calendar day maximum timeframe be identified in our proposed State Regulations, Covered California's internal administrative process will have stricter service level standards. It is recommended that the administrative service level standards to process applications and eligibility determinations occur within five (5) business days from the date of receipt of the application.*

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Special exceptions to maintain enrollment after 90-day reasonable opportunity period	Federal Regulations require Covered California to extend the 90-day reasonable opportunity period on a "case by case" basis for circumstances in which the consumer is unable to provide documentation to resolve the inconsistency. This extension shall not occur in situations where the consumer is resolving an inconsistency pertaining to U.S. Citizenship, National or lawfully present status.	Staff recommends the following process: Consumers may submit a request to extend the 90-day reasonable opportunity period. The individual will be required to provide Covered California the reason why the consumer is unable to furnish documents or why documents do not exist to resolve the inconsistency. The consumer's justification shall be reviewed and must be approved by Covered California in order for the 90-day reasonable opportunity period be extended. Covered California will follow-up with the consumer, reminding them that they need to resolve the inconsistency during this exception period. Within 30 days from the date in which the consumer was approved for the special exception, Covered California will contact the consumer by telephone and a written reminder notice will be sent to the consumer in their preferred method of communication. The consumer will be reminded that they must provide additional information to confirm their ongoing eligibility for the program. The consumer will have 30 days to respond from the date of the reminder notice. In the event the consumer responds within the 30-day timeframe and provides additional information as to why they are still unable to furnish their documents, Covered California will review the consumer's explanation to determine whether or not the consumer continues to qualify for the special exception. In the event the consumer does not respond to the reminder notice, then, the individual will be disenrolled from the program and will receive a termination letter that identifies their appeal rights.

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Authorized Representative process	Recent proposed Federal Regulations were published on January 22, 2013. Proposed Regulations indicate that consumers may designate an Authorized Representative to act on their behalf by signing an application on the individual's behalf, submit an update or respond to a redetermination, receive copies of the individual's notices and other communications from Covered California, and act on behalf of the individual in <u>all</u> other matters with Covered California. • Authorized Representative is valid until the consumer modifies the authorization; • Consumer must notify the Authorized Representative and Covered California that the representative in no longer authorized to act on the consumer's behalf; or • Authorized Representative notifies the consumer and Covered California that they no longer are acting in such capacity.	In staff's comments on the proposed Federal Regulations, staff recommends that Covered California have the flexibility to allow consumers to designate a more limited role for an Authorized Representative. Rather than giving full authority to the representative to act on behalf of the consumer in all matters, the consumer would have the choice to **<u>limit</u>** the role of the Authorized Representative. For example, the consumer may decide to only allow the Authorized Representative to act on their behalf during any of the following circumstances (or combination thereof): • Initial application process • Initial enrollment or effective date of coverage • Disenrollment process • Appeals process • Annual eligibility re-determination process • Change of circumstances (including self-reporting changes) • Periodic eligibility determinations ***Note:*** *The initial implementation of the Authorized Representative process will be consistent with the requirements identified in the proposed Federal Regulations. The recommended approach to permit consumers to limit the role of the Authorized Representative will <u>not</u> be available at the initial implementation launch; however, will be made available at a later date. In addition, the recommended approach will be incorporated into our proposed State Regulations.*

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Periodic data matching process	Federal Regulations require that, once a consumer is determined eligible and enrolled in Covered California, periodic data matching must occur. The periodic data matching will help the program determine whether or not the consumer continues to qualify for coverage during the benefit year. The periodic data matching is not considered to be the annual eligibility redetermination process, but rather occurs mid-year (e.g., within the same benefit year). During the periodic data matching process, Federal Regulations require Covered California to at a minimum verify the following: • Whether or not the consumer is deceased • Whether or not the consumer had a recent eligibility determination which resulted in enrollment into Medicare or no-cost Medi-Cal. Federal Regulations permit Covered California to consider periodically verifying other eligibility requirements (e.g., income), so long as it would reduce the administrative costs and burdens on individuals meanwhile maintaining accuracy and minimizing delay.	Staff recommends that a periodic data matching process occurs semi-annually. A semi-annual frequency is being recommended because all individuals will be required to go through an annual eligibility redetermination process during each Open Enrollment period. Individuals who are enrolled during the Special Enrollment period will have an annual redetermination in the fourth quarter of the calendar year, regardless of their initial enrollment date. Staff will later review the periodic data match frequency and re-assess its effectiveness to determine whether or not more frequent matching needs to be considered. In addition to conducting periodic data matching on a consumer's deceased status and whether or not they are recently enrolled in Medicare or no-cost Medi-Cal, staff also recommends that periodic data matching occurs for household income. This approach has the following benefits to the consumer: • Help inform and educate consumers about any potential changes to their eligibility for tax credit or cost sharing reductions as a result of a change of income. • Enable consumers to adjust their advance premium tax credit accordingly based on their needs, which will help minimize repayment of excess advance tax credit taken during the benefit year. • Increase the ability to obtain more affordable coverage when income decreases. In the event the periodic data matching indicates that the consumer's income is different compared to what was originally used to determine their initial eligibility, a notice will be sent to the consumer which identifies the new income that was indicated using electronic data sources. The consumer will have 30 calendar days to respond to the notice. If the consumer does not respond to the notice, the consumer will be able to maintain their Covered California eligibility and tax credit, based on their original eligibility information. However, the consumer will have to confirm their eligibility during the annual eligibility redetermination process and will be required to reconcile the tax credit at the end of the year through their annual tax filing.

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Requirements for consumers to self-report changes	Federal Regulations require that consumers self report changes to Covered California within 30 calendar days from the date of a change. Specifically for: • Change in U.S. Citizenship, National or lawfully present status • Change in state residency status • Incarceration status However, Federal Regulations allow Covered California to establish a reasonable threshold Which an individual is not required to report a change of income.	Staff recommends that consumers be required to report any change of income that may result in a change in the amount of their tax credit or cost sharing reduction. As noted earlier in the periodic data matching process, this approach has the following benefits to the consumer: • Help inform and educate consumers about any potential changes to their eligibility for tax credit or cost sharing reductions as a result of a change of income. • Enable consumers to adjust their advance premium tax credit accordingly based on their needs, which will help minimize repayment of excess advance tax credit taken during the benefit year. • Increase the ability to obtain more affordable coverage when income decreases.

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Appeals process	Recent proposed Federal Regulations were published on January 22, 2013. Proposed Regulations identify the appeals process for Covered California and require the coordination of appeals between Covered California and Department of Health Care Services. Consumers may submit their Covered California appeals on-line, by telephone or by mail if they disagree with any of the following: • Eligibility determination • Determination of the amount of advance payments of the premium tax credit and level of cost sharing reductions • Annual redetermination of eligibility • Eligibility determination for an exemption from the individual mandate Consumers will have 90 calendar days from the notice date of the determination to submit an appeal. When an appeal is submitted, Covered California will have 90 calendar days to adjudicate the appeal. During this 90-day timeframe, Covered California must establish an informal resolution process, prior to the appeal being adjudicated via hearing process. In the event the consumer is dissatisfied with the outcome of the informal resolution, the consumer's appeal will be adjudicated through the formal hearing process. In addition, should the consumer be dissatisfied with the appeal hearing decision, the consumer may appeal directly to HHS.	In staff's comments on the proposed Federal Regulations, staff recommends that the Federal Regulations consider extending the 90-day timeframe to adjudicate appeals to be 120 calendar days. This allows adequate time for Covered California to work closely with the consumer to conduct a thorough and comprehensive informal resolution process. An effective informal process will provide consumers with a quicker resolution of their problem.