Eligibility & Enrollment

Thien Lam
Deputy Director, Eligibility & Enrollment

California Health Benefit Exchange Board Meeting
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Eligibility and Enrollment
Guiding Principles

Through a “No Wrong Door” approach promote maximum enrollment into coverage.

Facilitate a smooth enrollment process beginning with the use of a single streamline application and seamless renewal process.

Present information in a manner that is accurate, accessible, understandable and transparent to consumers to inform and educate them.

Continue to learn and adjust strategies and tactics based on input from our national partners, California stakeholders, ongoing research, evaluation and measurement of the programs’ impact on awareness and enrollment.

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Policy Update

Key Policy Issues:

- Staff are identifying and making initial recommendations on key policy issues to the Board and Stakeholders for consideration and discussion.

- Stakeholder webinar was scheduled on March 14, 2013 to solicit public feedback. (Over 300 individuals registered. Comments due on March 28, 2013.)

- **Staff recommendations guided by the:**
  - ✓ Affordable Care Act
  - ✓ Covered California's Eligibility and Enrollment Guiding Principles
  - ✓ Interim final Federal Regulations (published on March 27, 2012)
  - ✓ Recently proposed Federal Regulations (published on January 22, 2013)

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Policy Update

Key Policy Issues
Processing time frames to conduct eligibility determinations
Special exceptions to maintain enrollment after 90-day reasonable opportunity period
Periodic data matching process
Requirements for consumers to self-report changes
Authorized Representative process
Appeals process

Covered California's Key Policy Issue

Time Frames to Conduct Eligibility Determinations

Special Exceptions to Maintain Enrollment After 90-Day Reasonable Opportunity Period

Key Policy Issue:	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."	• **Complete on-line applications** (e.g., self-service or in-person assistance) and **telephone applications** will occur "real time" and within minutes. • **Complete paper** (e.g., self-service or in-person assistance) or **faxed applications** that do not require resolution of any inconsistency will be processed within 10 calendar days of receipt*. • **Incomplete paper** (e.g., self-service or in-person assistance) **or faxed applications** that require follow-up as a result of missing information will be processed within 10 calendar days of receipt*. ✓ It is recommended that the administrative service level standards to process applications and eligibility determinations occur within 5 business days. • All applications resulting in conditionally eligibility for Covered California will allow the consumer at least 90 days to resolve the inconsistency.
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.	• Consumers may submit a request to extend the 90-day reasonable opportunity period: ✓ Must provide the reason why the consumer is unable to furnish documents or why documents do not exist to resolve the inconsistency. Examples below model policies adopted by Department of Health Care Services for the Medi-Cal Programs: ➢ Applicant provides a copy of a request to obtain documentation such as a photocopy of letter or e-mail to the agency who will issue documentation. ➢ Provide a copy of a check, receipt, order form, or other documentation notating that the documentation has been ordered. ➢ Provide a written or verbal statement describing the applicant's efforts to obtain documentation needed. ✓ Consumer's justification will be reviewed and must be approved by Covered California in order for the 90-day reasonable opportunity period be extended. Recommend a 15 business processing timeframe. • If approved, Covered California will follow-up with the consumer, reminding them that they need to resolve the inconsistency during this exception period. • Written notification will be sent to the consumer with the outcome of the decision.

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Covered California's Key Policy Issue

Periodic Data Matching Process

Requirements for Consumers to Self-Report Changes

Key Policy Issue:	Staff Recommendation:
Periodic Data Matching Process: Federal Regulations require that, once a consumer is determined eligible and enrolled in Covered California, periodic data matching must occur. During the periodic data matching process, Federal Regulations require Covered California to at a minimum verify: 1) Whether or not the consumer is deceased; and 2) 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 while maintaining accuracy and minimizing delays.	• Periodic data matching process occurs semi-annually.* ✓ Staff will later review and re-assess its effectiveness to determine whether more frequent matching needs to be considered. • Periodic data matching also occurs for household income. This approach has the following benefits to the consumer: ✓ Help inform and educate consumers about any potential impact to their eligibility for tax credit or cost sharing reductions due to changes in income. ✓ Enable consumers to adjust their 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 information, as well as, the enrollee's projected eligibility. ✓ 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. ➢ 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.
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: 1) Change in U.S. Citizenship, National or lawfully present status, 2) Change in state residency status, or 3) Incarceration status. Federal Regulations allow Covered California to establish a reasonable threshold which an individual is not required to report a change of income.	• Consumers be required to report any change of income that may impact the amount of their tax credit or cost sharing reduction. • This approach has the following benefits to the consumer: ✓ Help inform and educate consumers about any potential impact to their eligibility for tax credit or cost sharing reductions due to changes in income. ✓ Enable consumers to adjust their 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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Covered California's Key Policy Issue
Authorized Representative Process
Appeal Process

Key Policy Issue:	Staff Recommendation*:
Authorized Representative Process: Current Proposed Regulations indicate that consumers may designate an Authorized Representative to act on their behalf in **all** matters: • 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.	Allow consumers the flexibility 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 **limit** 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 • 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 not 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.*	
Appeals Process: 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 with any of the following: 1) Eligibility determination; 2) Determination of the amount of advance payments of the premium tax credit and level of cost sharing reductions; 3) Annual redetermination of eligibility; and 4) Eligibility determination for an exemption from the individual mandate.	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.

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California-Based
Single Streamline Application Update

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California-Based Single Streamline Application Update

- **Application data elements currently being developed and identified. And, were guided by:**
  - Center for Medicare & Medicaid Services (CMS) federal single streamline application data elements and draft paper application prototype.
  - Questions currently identified on the Medi-Cal and Healthy Families applications (MC 210 and MC 321).
  - Consumer focused specific questions needed to make eligibility determinations for full array of insurance affordability programs
  - Not asking questions that make it more burdensome for the consumer to apply for coverage.

- **Data elements identified currently being used as the basis to design the on-line website portal (e.g., California Healthcare Eligibility, Enrollment, & Retention System [CalHEERS]).**

- **Paper application will be developed modeling the data elements that are currently identified and the prototype of the federal paper application.**

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California-Based Single Streamline Application Update

Summary of Application Sections
Getting Started • Terms and conditions • Authorized Representative or Assister Information • How did the consumer hear about Covered California • Open Enrollment or Special Enrollment Period
Primary Contact Information (including written/spoken language and preferred method of communication)
Additional Household Members • Contact Information • Demographic Data • Personal Tax information • Blind/disabled for non-Modified Adjusted Gross Income (non-MAGI) Medi-Cal Program eligibility determination • Retro-Active Medi-Cal Coverage
Applying Members: • Long term care needs (for non-MAGI Medi-Cal Program) • Other Healthcare Information (e.g., employer sponsored insurance) • Referral to Non-Health Services (e.g., CalWORKS and/or CalFRESH)
Income: • Household Information • Summary
• **Signatures**

* Please refer to Board handout material for list of proposed California-based application data elements.

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Next Steps

Activity:	Proposed Timeline:
Readability & Usability Evaluation Begins for CalHEERS	January 2013
AB 1296 Stakeholder Process	March 8, 2013
Stakeholder webinar to solicit public feedback and input	March 14, 2013
Stakeholder webinar to solicit public feedback and input	Mid-April 2013
Readability & Usability Evaluation Begins for Paper Application	April 2013
Focus Group Testing/Field Testing Begins (English, Spanish and Asian languages in northern central and southern California	Summer 2013
Draft Prototype for Paper Single Streamline Application	Summer 2013
Written Translations Begins (to produce application in culturally and linguistically appropriate manners)	Summer 2013
Federal Review and Approval of Paper Application Prototype	TBD

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Eligibility & Enrollment

Draft Proposed State Regulations

(Covered California Individual Subsidized and Non-Subsidized Programs)

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Eligibility and Enrollment Regulations

(Covered California Individual Subsidized and Non-Subsidized Programs)

Articles and Sections of the draft Eligibility and Enrollment proposed State Regulations related to subsidized and non-subsidized programs are as follows:

Articles	Sections (Table of Contents)
Article 2: Abbreviations and Definition	• Abbreviations and definition of terms throughout the proposed State Regulations
Article 4: General Provisions	• Accessibility and Readability Standards • Exemption from Individual Responsibility
Article 5: Application, Eligibility and Enrollment Process for the Individual Exchange:	• Application • Eligibility Determination Processes • Verification Processes • Special Eligibility Standards for Federally Recognized Native American Indians • Annual Eligibility and Redetermination • Initial and Annual Open Enrollment • Special Enrollment Period • Termination of Coverage

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Next Steps

Activity:	Proposed Timeline:
First draft of proposed Eligibility & Enrollment State Regulations presented at Board Meeting (discussion item)	March 21, 2013
Stakeholder webinar to solicit public feedback and input	Early/Mid-April 2013
Final proposed Eligibility & Enrollment State Regulations presented at Board Meeting (for Board action)	April 25, 2013
Submission of Final Eligibility & Enrollment Regulations to the Office of Administrative Law	Early-May 2013

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Send Comments to:

Eligibility@Covered.ca.gov

Comments Due

March 28, 2013

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