Covered California Webinar

Eligibility and Enrollment Key Policy Issues and Single Streamline Application Update

Date: Thursday, March 14, 2013

Time: 9 – 10:30AM PST

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Agenda

1. Covered California's Vision, Mission and Values
2. Covered California's Target Populations
3. Key Components to Success
4. Eligibility and Enrollment Guiding Principles
5. Key Eligibility Milestones
6. Policy Update
7. Staff Recommendations
8. Next Steps
9. California-Based Single Streamline Application Update

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Covered California
Vision, Mission and Values

The vision of the Covered California is to improve the health of all Californians by assuring their access to affordable, high quality care.

The mission of the Covered California is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

The Covered California is **guided by the following values:**

- **Consumer-focused:** At the center of Covered California's efforts are the people it serves, including patients and their families, and small business owners and their employees. Covered California will offer a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of those we serve.
- **Affordability:** Covered California will provide affordable health insurance while assuring quality and access.
- **Catalyst:** Covered California will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities.
- **Integrity:** Covered California will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability, and cooperation.
- **Partnership:** Covered California welcomes partnerships, and its efforts will be guided by working with consumers, providers, health plans, employers and other purchasers, government partners, and other stakeholders.
- **Results:** The impact of Covered California will be measured by its contributions to expanding coverage and access, improving health care quality, promoting better health and health equity, and lowering costs for all Californians.

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Covered California Target Populations

- Covered California's primary target population reflects 5.3 million California residents projected to be uninsured or eligible for tax credit subsidies in 2014:
  - 2.6 million who qualify for subsidies and are eligible for Covered California qualified health plans; and
  - 2.7 million who do not qualify for subsidies, but now benefit from guaranteed coverage and can enroll inside or outside of Covered California.

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Key Components to Success

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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;
- Present coverage options in a manner that is accurate, accessible, understandable and that empowers consumers to make informed health care decisions;
- Continue to learn and adjust strategies and tactics based on input from our national partners, California stakeholders, on-going research, evaluation and measurement of the programs’ impact on awareness and enrollment.

*Note: These guiding principles stem from the Statewide Marketing, Outreach And Education Program.

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Key Eligibility Milestones

March 23, 2010

- The Patient Protection Patient Protection and Affordable Care Act (PPACA) is passed and signed into law.

July 15, 2011

- Center for Medicaid and Medicare Services (CMS) issues proposed rules Establishment of Exchanges and Qualified Health Plans

March 27, 2012

- Center for Medicaid and Medicare Services (CMS) issues guidance in the form of Interim Final Regulations that establishes the State Exchanges

January 22, 2012

- The Centers for Medicare & Medicaid Services (CMS) issues proposed rule that address the coordination of the application, enrollment and appeal process.

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Policy Update

- **Key Policy Issues:**

  - **Staff are identifying and recommending key policy issues to the Board and Stakeholders for consideration and discussion.**

  - **Staff recommendations guided by the:**

    - ✓ Affordable Care Act
    - ✓ Covered California's Vision, Mission, and Values
    - ✓ Eligibility and Enrollment Guiding Principles
    - ✓ Final Interim Federal Regulations (dated March 27, 2012)
    - ✓ Recently proposed Federal Regulations (dated January 22, 2013)
    - ✓ Ensuring transparency to consumers by informing and educating them

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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
Authorized Representative process
Periodic data matching process
Requirements for consumers to self-report changes
Appeals Process

Covered California's Key Policy Issue
Processing Time Frames to Conduct Eligibility Determinations

Federal Requirements:	Staff Recommendation:
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 that do not require the resolution of any inconsistency 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. (This is the maximum timeframe that is being recommended for proposed State Regulations.)***** • Paper (e.g. self-service or in-person assistance), or faxed application which require additional information because there are missing data elements will be processed within 10 calendar days of receipt. (This is the maximum timeframe being recommended for proposed State Regulations.)***** • On-line, telephone, paper (e.g. self-service or in-person assistance) or faxed applications that require the resolution of inconsistency will result in the consumer being conditionally eligible for Covered California, if their self-reported information qualifies them for coverage. Consumer has 90 days to resolve the inconsistency.

*****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 5 business days from the date of receipt of the application.*

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Covered California's Key Policy Issue

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

Federal Requirements:	Staff Recommendation:
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.	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. • Consumer's justification will be reviewed and must be approved by Covered California in order for the 90-day reasonable opportunity period be extended. Written notification will be sent to the consumer with the outcome of the decision. • If approved, 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 of the approval, Covered California will contact consumer by telephone and send a written reminder notice (in preferred method of communication). ✓ Consumer has 30 days from the date of the reminder notice to respond. ✓ In the event consumer responds to reminder notice and provides additional information as to why they are still unable to furnish documents, Covered California will review the explanation to determine if the consumer continues to qualify for the exception period. Written notification will be sent to the consumer with the outcome of the decision.

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Special Exceptions to Maintain Enrollment after 90-day Reasonable Opportunity Period*

Key Policy Issue:

Some examples in which a special exception may be granted in cases where the consumer demonstrates due diligence in trying to obtain documentation to resolve an inconsistency are (but not limited to):

- Applicant provides a copy of a request to obtain documentation such as a photocopy of letter or email 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 order.
- Provide a written or verbal statement describing the applicant's efforts to obtain documentation needed.

**NOTE:* Individuals will have to attest that they are aware that any advanced payment of the premium tax credit paid on their behalf will be reconciled at the end of the year through their annual tax filing.

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Covered California's Key Policy Issue
Authorized Representative Process

Federal Requirements:	Staff Recommendation*:
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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Covered California's Key Policy Issue
Periodic Data Matching Process

Federal Requirements:	Staff Recommendation:
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 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 meanwhile maintaining accuracy and minimizing delays.	• 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. ✓ 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. • 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 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 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. • 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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Covered California's Key Policy Issue
Requirements for Consumers to Self-Report Changes

Federal Requirements:	Staff Recommendation:
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.	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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Covered California's Key Policy Issue
Appeals Process

Federal Requirements:	Staff Recommendation:
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: 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. 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.

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Next Steps

Activity:	Proposed Timeline:
Stakeholder webinar to solicit public feedback and input	Early/Mid-March 2013
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	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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California-Based
Single Streamline Application Update

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
  - 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

Application Section:	Application Questions (High Level Summary):
Getting Started	• Whether or not consumer is applying for subsidized coverage • Assistance in filling out application (e.g., Authorized Representative or Assister) • Whether or not the consumer is applying during the Special Enrollment period • General questions regarding household size • How consumer learned about Covered California • Consent to verification process
Primary Contact Information	• Contact information (e.g., name, telephone numbers, home, mailing, and e-mail addresses) • Preferred method of communication • Preferred written and spoken language
Additional Household Members	• Information about individuals living in the home and if they are applying for coverage • Name, date of birth, gender, U.S. Citizen/National or lawfully present status, Social Security Number, etc. • Relationship to the primary contact person

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California-Based Single Streamline Application Update

Application Section:	Application Questions (High Level Summary):
Additional Household Member Contact Information	• Contact information (e.g., address, telephone numbers, home and mailing address if different from the primary contact's information, and e-mail address)
Additional Household Member Demographic Data	• Martial status • Pregnant with due date and number of babies expected • Member of a federally recognized Indian tribe • Full-time student • Blind and/or disabled (for non-MAGI Medi-Cal eligibility determination) • Medical expenses in the last 3 months (e.g., request for retro-active Medi-Cal) • In foster care at the age of 18
Additional Household Members – Personal Tax Information	• Tax filing status

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California-Based Single Streamline Application Update

Application Section:	Application Questions (High Level Summary):
Applying Members – Other Health care Information	• Employer-sponsored insurance (e.g., meets minimum standard value and cost for monthly premiums) • Long Term Care Needs (for non-MAGI Medi-Cal eligibility determination) • Medicare coverage
Applying Members – Referral to non-health services programs	• CalWORKS and/or CalFRESH
Optional Information	• Ethnicity • Member of federally recognized Indian tribe • Preferred written and spoken language of communication
Income Information	• Income type/income source, amount and frequency
Income Summary	• Projected annual household income if different from “Income Information”
Signature Page	• Rights and Responsibilities • Signature

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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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For a list of California-Based Single Streamline Application data elements click here

*Note: The data elements identified on the document are not worded the way they will be shown on the final application. The data elements are presented for context.

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Send Comments on
Key Policy Issues
and
California-Based
Single Streamline Application to:

Eligibility@Covered.ca.gov

Comments due March 28, 2013

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