

The Role of the Exchange in Addressing Churn Between Public and Private Coverage

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The Affordable Care Act expands insurance coverage by extending Medicaid eligibility and subsidizing commercial insurance for individuals and families at varying levels up to 400% FPL. Changes in income, employment status, and household composition can change eligibility between Medicaid and private insurance throughout the year, potentially disrupting continuity of care with providers and creating the possibility for gaps in coverage.

The purpose of this paper is to explore whether there are strategies that may ease transitions between public and private coverage that are appropriate to include as components of QHP certification in 2015 and beyond. There are no federal QHP certification requirements related to addressing issues associated with churn between public and private coverage. The issue of easing transition between public and private coverage is being raised out of recognition that significant movements between public and private coverage are likely to occur and that these transitions are likely to be disruptive and/or confusing for some consumers.

For purposes of discussion in the Plan Certification Subgroup, we are focusing on policy options and operational strategies to address churn between public and private coverage at whatever income level it occurs (regardless of whether the State establishes a Basic Health Plan or pursues other options for addressing coverage of populations above Medicaid eligibility levels.) Discussions related to coverage options for different populations are outside the scope of the Plan Certification Subgroup and are being addressed as part of the Access Workgroup associated with the Governor's Health Care Reform Task Force.

Access to Providers Under Certain Circumstances

Minnesota Statutes 62Q.53 provides enrollees access to a provider from whom they are currently receiving treatment for certain types of care if an employer changes plans and the treating provider is not included in the new health plan network. (See excerpted language beginning on page 3.)

Understanding that differences exist between providers available through Medicaid and those included in commercial products, it may be appropriate to consider whether access to a treating provider should be incorporated into QHP certification criteria when a consumer transitions from Medicaid to private coverage under certain circumstances. The statute referenced here is one standard that could be considered.

Consideration of Auto Enrollment

A potential strategy for promoting continuity of coverage when consumers are no longer eligible for Medicaid is to auto enroll them in a QHP. This would essentially take a first step on behalf of enrollees toward ensuring they obtain coverage in the private market. Under Exchange rules, coverage under a QHP is not effective until a premium is paid. Auto enrollment, therefore, does not trigger coverage by

itself, but would be an initial step toward coverage in a QHP. The concept of auto enrollment would still allow a consumer to affirmatively make a choice of a different QHP within 60 days of losing Medicaid eligibility if desired.

It is unclear whether federal Exchange rules permit auto enrollment of a consumer who previously was enrolled in Medicaid in a QHP. There are numerous operational and policy considerations for auto enrollment, including encouraging an enrollee to have eligibility determined for the advanced premium tax credit and cost sharing reductions and how auto enrollment rules would be structured. The purpose of raising the prospect of auto enrollment as part of proposed QHP certification rules is to solicit stakeholder input on whether this is a desirable policy option to pursue. Given the tight timelines for developing Exchange policies and the information technology infrastructure to facilitate required core Exchange functionality, it is likely more viable to explore potential options around auto enrollment as part of 2015 QHP certification criteria and Exchange operations.

Discussion Questions:

- Should the Exchange attempt to ease transitions from public to private coverage by allowing access to providers who were in Medicaid networks but are not in a QHP network under limited circumstances? What are the advantages and disadvantages of this idea?
- Is auto enrollment into a QHP a desirable policy option? What are the advantages and disadvantages of auto enrollment? What issues would need to be considered as part of exploring whether/how to structure auto enrollment?
- Are there other strategies for easing transitions between public and private coverage that merit consideration as part of QHP certification rules?

Excerpt from Minnesota Statutes 62Q.56

Subd. 2. **Change in health plans.** (a) If an enrollee is subject to a change in health plans, the enrollee's new health plan company must provide, upon request, authorization to receive services that are otherwise covered under the terms of the new health plan through the enrollee's current provider:

(1) for up to 120 days if the enrollee is engaged in a current course of treatment for one or more of the following conditions:

(i) an acute condition; (ii) a life-threatening mental or physical illness; (iii) pregnancy beyond the first trimester of pregnancy; (iv) a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or (v) a disabling or chronic condition that is in an acute phase; or

(2) for the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or less.

For all requests for authorization under this paragraph, the health plan company must grant the request for authorization unless the enrollee does not meet the criteria provided in this paragraph.

(b) The health plan company shall prepare a written plan that provides a process for coverage determinations regarding continuity of care of up to 120 days for new enrollees who request continuity of care with their former provider, if the new enrollee:

(1) is receiving culturally appropriate services and the health plan company does not have a provider in its preferred provider network with special expertise in the delivery of those culturally appropriate services within the time and distance requirements of section 62D.124, subdivision 1; or

(2) does not speak English and the health plan company does not have a provider in its preferred provider network who can communicate with the enrollee, either directly or through an interpreter, within the time and distance requirements of section 62D.124, subdivision 1.

The written plan must explain the criteria that will be used to determine whether a need for continuity of care exists and how it will be provided.

(c) This subdivision applies only to group coverage and continuation and conversion coverage, and applies only to changes in health plans made by the employer.

Subd. 2a. **Limitations.** (a) Subdivisions 1, 1a, 1b, and 2 apply only if the enrollee's health care provider agrees to:

(1) accept as payment in full the lesser of the health plan company's reimbursement rate for in-network providers for the same or similar service or the enrollee's health care provider's regular fee for that service; (2) adhere to the health plan company's preauthorization requirements; and (3) provide the health plan company with all necessary medical information related to the care provided to the enrollee.

(b) Nothing in this section requires a health plan company to provide coverage for a health care service or treatment that is not covered under the enrollee's health plan.