Insurance Reform Work Group – Open Stakeholder Meeting 5/11/2012
Summaries of Topics and Discussion Questions

Open Enrollment/Special Enrollment

State provision: Chapter 288 of the Acts of 2010 defines the following open enrollment periods for the individual and small group market (which doesn't include Young Adult Plans or CommCare):

For 2011: (two open enrollment periods)
1. Jan 1, 2011 - Feb 15, 2011 (6 weeks) and
2. July 1, 2011 - Aug 15, 2011 (6 weeks)

For 2012 and after: (one yearly open enrollment period)
July 1 - August 15 * (6 weeks)

* The July 1 - August 15 open enrollment period allows people to enroll into plans for coverage effective in August or September

ACA provision: The Exchange final rule defines the following open enrollment periods:

For benefit years from Jan 1, 2014 - Dec 31, 2014:
October 1, 2013 - March 31, 2014 (6 months)***

For benefit years on or after Jan 1, 2015:
October 15th - December 7th (8 weeks) of the preceding calendar year

**** According to §155.410 of the final rule:*

- *Between the 1st and 15th day of the initial open enrollment period: coverage is for the 1st day of the following month;*
- *Between the 16th and last month (for any month between December 2013 and March 31, 2014): coverage is for the 1st day of the 2nd following month.*
- *An exchange has the option of having earlier effective coverage dates (if the exchange can demonstrate to HHS that all of its participating QHP issuers agree to a shorter timeframe)*

Special enrollment periods: people are allowed to enroll outside of the defined open enrollment periods for a list of different reasons. The list of reasons is different in state law vs. the ACA.

Questions for Stakeholder Feedback:

- What is the impact of the different open enrollment dates in state law vs. the ACA?
- Should non-Exchange plans should have the same open enrollment period as the Exchange plans?
- How should consumers be informed of open enrollment changes? Learning from the state's transition to one open enrollment period, what might be dome differently for the transition in 2013-2014?

Termination of Coverage in a Qualified Health Plan

According to §155.430(d) of the Exchange final rule, an individual must be allowed to voluntarily terminate coverage in a Qualified Health Plan (QHP). In the case of voluntary termination of coverage by the individual, the effective date for the termination of coverage is either: (1) the date requested by the enrollee if "appropriate notice"is provided to the Exchange, where appropriate notice is defined as 14 days; (2) fourteen days after the termination request without reasonable notice; (3) in fewer than fourteen days if the individual requests an earlier termination date and the QHP issuer can accommodate it; or, (4) the last day of coverage before enrollment in Medicaid, CHIP, or the Basic Health Plan begins.

The final rule allows the Exchange to initiate termination of coverage if:

- The enrollee is no longer eligible for coverage in a QHP through the Exchange.
- The enrollee does not pay premiums and, if applicable, the 3-month grace period required for individuals receiving APTCs has been exhausted as described below. The last day of coverage for non-payment of premiums for enrollees not receiving APTCs is in accordance with State law.
- The enrollee's coverage is rescinded.
- The QHP terminates or is decertified.
- The enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period.

§156.270 of the final rule requires a 90 grace period for individuals who receive APTCs before they can be terminated for non-payment of premium. The three month grace period applies whenever the issuer has received less than the full amount of the enrollee's share of the premium for a given month.

QHP issuers must pay all claims during the initial month of the grace period. The final rule permits issuers to either pay or pend claims in the second and third months. If the enrollee settles all outstanding payments by the end of the grace period, pended claims must be paid. If the enrollee does not settle all outstanding payments by the end of the grace period, claims for the second and third months could be denied. Issuers must notify providers who submit claims for services rendered during the second and third months of the grace period that claims will be pended and potentially not reimbursed.

Questions for Stakeholder Feedback:

- Are there any concerns with allowing mid-month terminations?
- Are there any concerns with the list of reasons an Exchange or QHP issuer is allowed to initiate termination of coverage provided in the final rule?
- Are there any administrative concerns with pending claims during the second and third months of the 90 grace period?

Coverage for Individuals Participating in Approved Clinical Trials

ACA Provision

Section 2709 of the Affordable Care Act, as added by Section 10103, prohibits insurers from dropping coverage of an individual because an individual chooses to participate in a clinical trial or from denying that individual coverage for routine care that the insurer would otherwise provide just because an individual is enrolled in a clinical trial. This provision applies to all clinical trials that treat cancer or other life-threatening diseases. Section 2709 provides specific guidance on coverage, definition of a qualified individual, limitations on coverage, definition of an approved clinical trial, and definition of life-threatening condition.

Current Massachusetts Law/Regulations

An insurer may not deny an insured coverage for covered services that the plan would otherwise provide just because an individual is enrolled in a clinical trial. This provision applies to all clinical trials that treat cancer. M.G.L. cc. 175 §110L. 176A §8X, 176B §4X, and 176G §4P along with DOI Bulletin 2002-13 provide specific guidance on coverage, definition of patient care service and definition of qualified clinical trial.

Questions for Stakeholder Feedback:

- What, if any, concerns in administering both the state and the ACA guidelines?
- Do you see that legislative changes may be necessary in order for health plans to administer both requirements??
- If you feel that legislation is not necessary, would you require any further guidance from the DOI?
- Any other questions/comments with respect to the various options?