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ACA DUAL ENROLLMENT AND VOLUNTARY TERMINATIONS

Consumer Direct Broker Training

DECEMBER 2018

Summary

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- Members in Under 65 individual plans can voluntarily terminate coverage.
  - Often, they do so to change to new plans.

- In most cases, CareFirst Blue Cross BlueShield (CareFirst) must receive a termination instruction in writing from the subscriber.

- This happens often during Open Enrollment when subscribers decide to change plans:
  - In many cases, subscribers do not act when required to terminate coverage when another type of coverage is being implemented.
    - Failure to act can result in a “dual enrollment” situation.
    - The subscriber is billed for enrollment in two plans – the plan they want and an unintended plan they don’t want.

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VOLUNTARY TERMINATIONS

Why Voluntary Termination Is Important

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THE PROBLEM: CareFirst cannot assume that a subscriber's application for a new plan will automatically cancel his/her old plan.

- In the Under 65 market, it's the subscriber's right to keep more than one health plan.
- In many cases, a subscriber **must** take the action to terminate any plan no longer needed or wanted.

THE RULES: Specific laws govern how CareFirst can address the problem:

- CareFirst does not have the ability to unilaterally cancel a plan. This action would violate HIPAA.
- Federal law requires that the termination be in a signed writing – not over the phone and not by email.

THE COMPLICATION: If the subscriber does not submit a written termination request, he/she will remain enrolled in the old plan **and** is enrolled in the new plan simultaneously.

- There are important and adverse consequences to being enrolled in two (2) plans simultaneously that will be outlined in this presentation.

THE EXCEPTION: There are specific exceptions to the voluntary termination rule that are outlined on slides 5 + 6.

When Does the Subscriber NEED to Act?

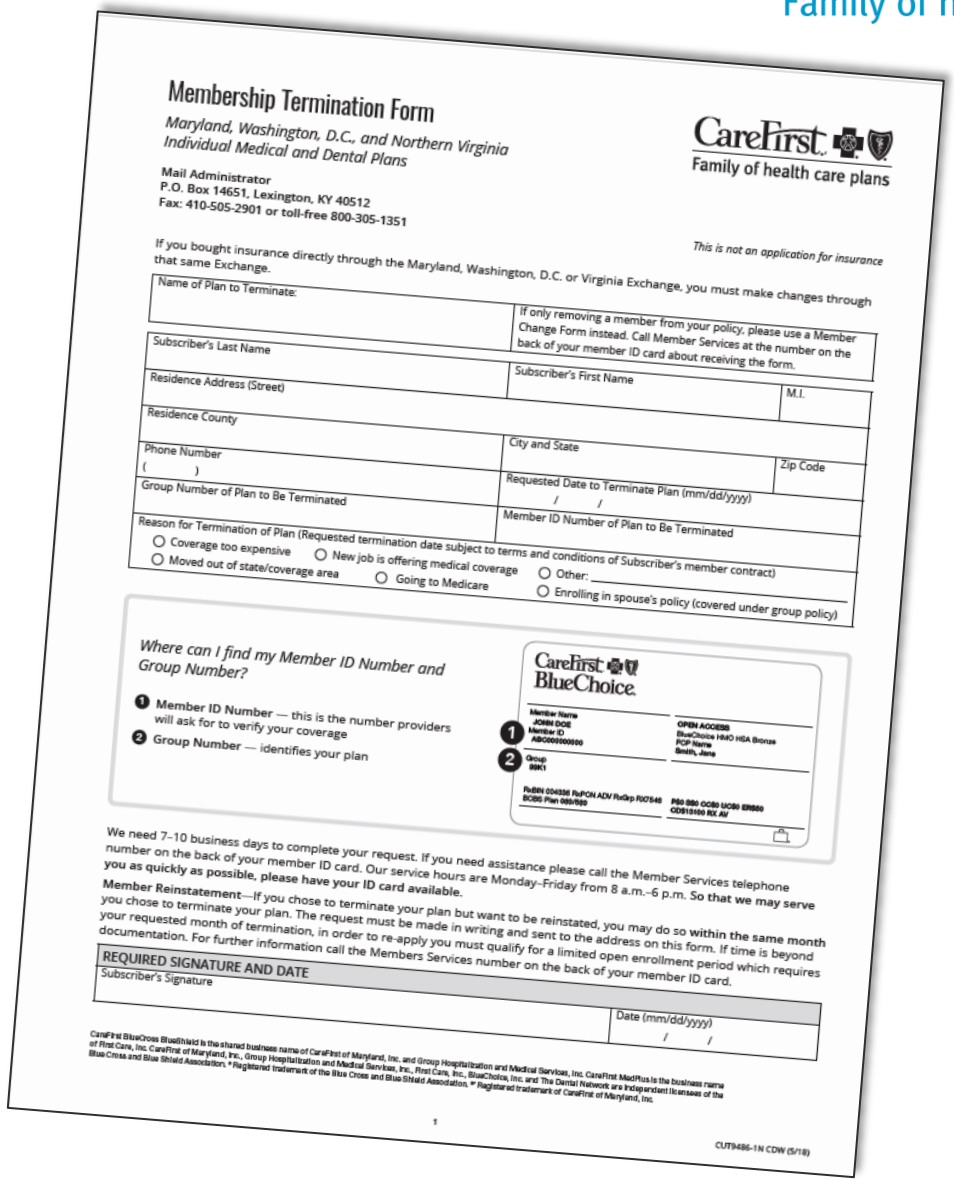
Scenario	Subscriber Action	Example
Active Product/Plan Change To Future Year Plan During Open Enrollment Period (OEP) (Same Manner of Enrollment)	**NO ACTION NEEDED:** Scenario **does not require** a termination of the current plan. **No action needed ONLY if the Subscriber previously enrolled On Exchange and selects a new On Exchange plan OR the Subscriber previously enrolled in a CareFirst Off Exchange plan and selects a new CareFirst Off Exchange plan.**	• A subscriber changes On Exchange plans for 2019 (active renewal). • The 2018 (current) On Exchange plan does not require a voluntary termination to ensure it ends 12/31/18. • ***THIS IS THE ONLY EXCEPTION TO THE VOLUNTARY TERMINATION RULE.***
Changing From a Plan that is On Exchange to an Off Exchange (or vice versa)	**ACTION NEEDED:** Scenario **does require** a voluntary termination to be provided by the subscriber.	• A Maryland On Exchange 2018 subscriber enrolled with CareFirst directly for a 2019 Off Exchange plan. • The subscriber should terminate the 2018 plan by contacting the Exchange and requesting that the coverage end on 12/31/18. • If the terminated plan is Off Exchange, they can use the CareFirst Member Termination form found on carefirst.com.

When Does the Subscriber NEED to Act? *continued*

Scenario	Subscriber Action	Example
Switching Jurisdictions: Changing from a Plan in MD to DC or VA	**ACTION NEEDED**: The subscriber ***is required*** to contact the Exchange or CareFirst to request the previous plan is terminated.	• A MD subscriber moves to northern Virginia which is within the CareFirst service area. • The subscriber should terminate the 2018 plan by contacting the Exchange or CareFirst requesting the coverage end 12/31/18. • If the terminated plan is Off Exchange, the subscriber can use the CareFirst Member Termination form found on carefirst.com.
Switching from Group to Individual Coverage (or vice versa)	**ACTION NEEDED**: The subscriber ***is required*** to contact their employer, the Exchange or CareFirst to request the previous plan is terminated.	• A subscriber would need to terminate the 2018 plan by contacting the Exchange or carrier and requesting that the coverage end 12/31/18. • If the coverage requested to be terminated is group coverage, they would need to ensure their employer group has terminated the coverage.
Being a Subscriber in One Plan and a Dependent in Another	**NO ACTION NEEDED:** Subscriber/member ***is not*** required to terminate one of the plans.	• Subscriber of an individual plan is also covered under their spouse's plan as a dependent on a group or individual policy.

How to Voluntarily Terminate a CareFirst Plan (Off Exchange)

- **Membership Termination Form:**
  - CareFirst has a formal published termination form on its Members' website.
  - Access the link to view a copy of the form: CareFirst Membership Termination Form
  - This form can be used for any CareFirst policy bought directly through CareFirst.
  - For On Exchange policies, subscribers need to contact the Exchange.



Membership Termination Form

Maryland, Washington, D.C., and Northern Virginia Individual Medical and Dental Plans

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Mail Administrator
P.O. Box 14651, Lexington, KY 40512
Fax: 410-505-2901 or toll-free 800-305-1351

This is not an application for insurance

If you bought insurance directly through the Maryland, Washington, D.C. or Virginia Exchange, you must make changes through that same Exchange.

Name of Plan to Terminate:

If only removing a member from your policy, please use a Member Change Form instead. Call Member Services at the number on the back of your member ID card about receiving the form.

Subscriber's Last Name | Subscriber's First Name | M.I.

Residence Address (Street)

Residence County | City and State | Zip Code

Phone Number ( ) | Requested Date to Terminate Plan (mm/dd/yyyy) / /

Group Number of Plan to Be Terminated | Member ID Number of Plan to Be Terminated

Reason for Termination of Plan (Requested termination date subject to terms and conditions of Subscriber's member contract)

- ○ Coverage too expensive
- ○ New job is offering medical coverage
- ○ Other:
- ○ Moved out of state/coverage area
- ○ Going to Medicare
- ○ Enrolling in spouse's policy (covered under group policy)

Where can I find my Member ID Number and Group Number?

1. **Member ID Number** — this is the number providers will ask for to verify your coverage
2. **Group Number** — identifies your plan

We need 7–10 business days to complete your request. If you need assistance please call the Member Services telephone number on the back of your member ID card. Our service hours are Monday–Friday from 8 a.m.–6 p.m. **So that we may serve you as quickly as possible, please have your ID card available.**

Member Reinstatement—If you chose to terminate your plan but want to be reinstated, you may do so **within the same month** you chose to terminate your plan. The request must be made in writing and sent to the address on this form. If time is beyond your requested month of termination, in order to re-apply you must qualify for a limited open enrollment period which requires documentation. For further information call the Members Services number on the back of your member ID card.

REQUIRED SIGNATURE AND DATE

Subscriber's Signature | Date (mm/dd/yyyy) / /

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CareFirst Voluntary Termination General Guidelines

- **On Exchange Terminations:** All Subscribers are to be referred to the Exchange. Subscribers cannot submit a Membership Termination Form to CareFirst.

- **Future Voluntary Terminations:** If the subscriber falls into arrears with a non-payment termination, they will be termed for non-payment.

CareFirst Voluntary Termination General Guidelines

- **Retroactive Terminations:**
  - There are no State or Federal mandates or contract provisions that require Consumer Direct business to retroactively terminate a policy.
  - CareFirst will not retroactively terminate for other coverage beyond the current month in which we receive the termination request.
    - The only exception is:
      - A termination due to death which are completed on date of death.
        - The CareFirst enrollment area must obtain a copy of the subscriber/member's death certificate.

NOTE: Some On Exchange policies may be retroactively terminated but they MUST be approved by both an Exchange and CareFirst management representative and can be for up to 6 months prior to notification.

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DUAL ENROLLMENT

What Is Dual Enrollment?

- Dual Enrollment is when a Subscriber selects a new plan (and the *exception* does not apply) AND does not submit a timely Membership Termination Form. In this case, the Subscriber will remain enrolled in the old plan and is enrolled in the new plan simultaneously.

CAREFIRST MUST, BY LAW, ASSUME THAT THIS SUBSCRIBER INTENDED TO BE ENROLLED IN TWO PLANS.

- The Subscriber will be billed for BOTH the old plan and the new plan.

THIS CREATES UNINTENDED AND ADVERSE CONSEQUENCES.

What Are the Consequences to Dual Enrollment?

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The subscriber may…

- **…NOT BE ABLE TO RETROACTIVELY TERMINATE HIS/HER OLD PLAN**: Neither CareFirst nor the Exchange are required by law to retroactively terminate an old plan that the Subscriber forgot to voluntarily terminate. The Exchanges have some guidelines they can follow but your clients cannot assume they will qualify.
- **…LOSE HIS/HER NEW PLAN**: The subscriber is billed for both plans and the new plan may be terminated in January for failure to pay the IPP (Initial Premium Payment) or for failure to pay premiums.
  - As Open Enrollment ends the previous December, the subscriber may not be able to re-enroll in the new plan they chose.
- **…LOSE APTC SUBSIDY**: More importantly, there are tax impacts to those with Advanced Premium Tax Credits (APTC) through an ACA plan.
  - If a subscriber is enrolled in more than one plan and one of those plans has APTC, he/she may have to pay penalties when filing annual taxes with the federal government.
- **…LOSE AMOUNTS THAT WOULD BE CREDITED TO THEIR DEDUCTIBLE AND OOP MAX**: Under, Coordination of Benefits (COB) rules, claims and subscriber payments may be credited to the older (unwanted) plan.

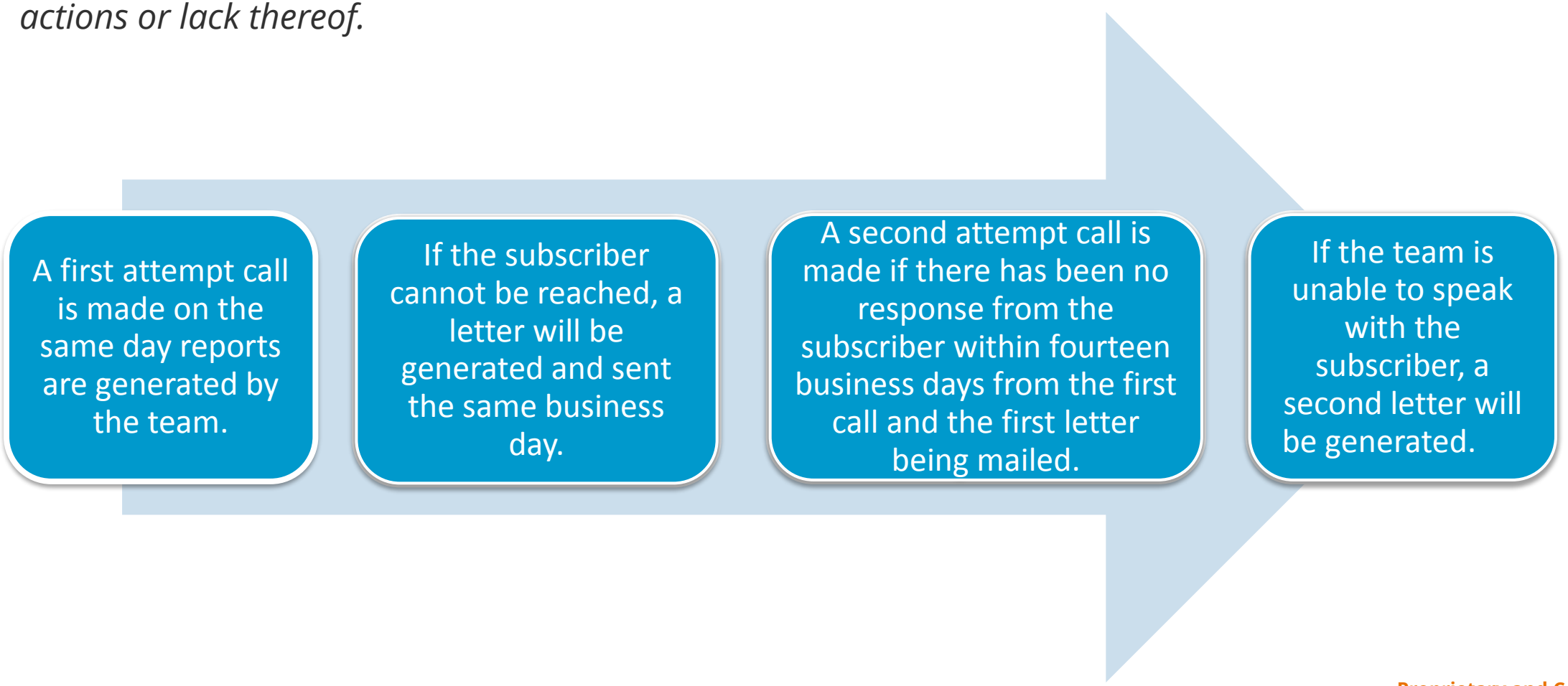
CareFirst Dual Enrollment Scenarios

Most Common Dual Enrollment Scenarios

- On and Off Exchange
- Group and Individual Coverage
- Two+ Dental Plans
- Subscriber and Dependent

How CareFirst Tries to Help: Dual Enrollment Process

Dual enrollment is identified by CareFirst using various reporting tactics.
Subscriber outreach is needed because claims payments can be impacted by subscriber actions or lack thereof.



How CareFirst Tries to Help: Dual Enrollment Process

- **New for 2019:**
  CareFirst will be including group and individual dual enrolled subscribers to outreach efforts.

- Cases that require action from an Exchange due to an error additionally get handled in conjunction with the Exchange.

- **Important Voluntary Termination Rules:**
  - CareFirst can only accept a termination request in writing from an Off Exchange subscriber.
    - A “wet” signature is required to terminate a plan from any Off Exchange subscriber.
  - For On Exchange, CareFirst can only terminate coverage from notification from the Exchange.

Final Note: CareFirst Guidelines: Dual Enrollment and Medicare

- Regulations issued in 2017 indicated carriers cannot renew members known to be eligible for or enrolled in Medicare.
- CareFirst and the three jurisdictions (MD, DC and Northern VA) where CareFirst conducts business apply this regulation differently.
- **Off Exchange:**
  - CareFirst will not renew any Off Exchange subscriber known through Coordination of Benefits (COB) to have both an ACA plan and Medicare.
- **On Exchange:**
  - MD and VA On Exchange terminations will be conducted by CareFirst during the 2019 OEP.
    - CareFirst will initiate the termination and provide an update to the Exchange.
  - The DC Exchange will allow renewals of Medicare eligible subscribers.
    - CareFirst will send the DC Exchange the list of members it believes should be terminated based on COB.

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APPENDIX

Coordination of Benefits (COB) Review

- Coordination Of Benefit Rules:
  - Member Evidence of Coverage (EOC) language applies first. If EOC language does not address, NAIC COB guidelines should be followed where applicable- http://www.naic.org/store/free/MDL-120.pdf
  - If everything is the same for both On Exchange policies, one policy has subsidy, the other one doesn't, the On Exchange policy with subsidy is primary.
  - If everything is the same for both On Exchange policies, both policies have subsidy, the On Exchange policy which enrollment application was received first is primary.
  - If everything is the same for both On Exchange policies, neither policy has subsidy, the On Exchange policy which enrollment application was received first is primary.
  - If everything is the same for the one On Exchange policy and the one Off Exchange policy, On Exchange policy will be primary.
  - If the Exchange requested CareFirst to term one policy and keep the other policy without overlapping period, a claims analyst will send the claim to be processed under the correct policy with detailed notes. A claims processer will put the same detailed notes in Facets for the claim.
  - If the Exchange terminates one policy, but there is an overlapping period for both On Exchange policies and claims date of service is in the overlapping period, same COB rules will apply as stated above.

Wet Signatures and Terminations

- Law: Electronic Signatures in Global and National Commerce Act (15 USC §§ 7001-7006) was enacted under President Clinton in 2000. Although this federal statute generally allows electronic signatures in lieu of handwritten signatures, there is a specific exception at § 7003(b)(2)(c) that prohibits the statute from applying to "the cancellation or termination of health insurance or benefits" which would include voluntary member cancellations.
  - Code section with the exception listed here: https://www.law.cornell.edu/uscode/text/15/7003. This is meant to be a consumer protection.
- A provision exists in § 7003(c) that allows a federal agency to eliminate an exception if it is no longer necessary to protect consumers. The elimination of an exception would require the federal agency to publish a proposed rule and solicit public feedback. The "exception" for health insurance cancellation still stands so CareFirst can't accept an electronic signature to cancel a health insurance policy.
- At the state level, Maryland has enacted its own electronic transactions statute, called the Uniform Electronic Transactions Act, which mirrors the current federal language.
  - Section 21-102(b)(4)(iii) of the Maryland Commercial Code specifically states that the Maryland Uniform Electronic Transactions Act does not apply to notice of health insurance termination or cancellation.
  - Even *if* the federal exception was eliminated, CareFirst still could not accept on-line terminations in Maryland unless the state also changed its law.

Source: CareFirst Legal 1/12/18

CareFirst Voluntary Termination Retroactivity Guidelines

- In all other cases, when a subscriber/member's voluntary termination request is received, there will be no retroactive activity unless approved by management due to an escalated case from one of the Insurance Administrators; or due to a CareFirst error.
  - In the event of a retroactive terminated policy, CareFirst will refund any unearned premium for the balance of the month(s).
  - All supporting documentation and approval from a CareFirst supervisor or manager is required.

- CMS has offered guidance as it pertains to the timing of retroactive termination requests when the subscriber is Medicaid/CHIP/Medicare/MEC or due to an error at the Exchange or by the carrier.

CMS Retroactive Termination Guidelines

- Retroactive effective dates can result from unforeseen life events, such as death; from FFM or issuer error, such as incorrect data being manually entered from a paper application; or from an administrative process, such as an eligibility appeal decision.
- There are exceptional circumstances that are not specifically addressed in the regulations.
  - For example, if a consumer fulfilled all enrollment requirements, but, for some reason, the FFM or issuer was unable to process the enrollment for the required effective date, the FFM (or designee) will process a retroactive enrollment effective date.
- If an enrollment was never processed, or if a valid termination request was properly made, but not processed or acted on by the FFM or the QHP/QDP, the FFM (or designee) will grant retroactive terminations.
- Those circumstances will be addressed on an individual basis, and determinations of outcomes will be decided by the FFM in collaboration with issuers, when needed.

Source FFM Enrollment Manual 08/09/16

CMS Guidelines on Retroactive Terminations

- In most cases, issuers will receive an 834 transaction which communicates the correct retroactive termination effective dates.
  - However, in some cases (e.g., an eligible enrollee opts for retroactive effect of the appeal decision), CMS notifies the issuer which specifies the effective date for the retroactive enrollment or termination and/or application of APTCs or CSR amounts.

- Unlike a reinstatement, which is a correction of records to “erase” an action, a retroactive enrollment is an action to enroll a for a new time period.

- In some limited cases, CMS may determine that a consumer is eligible for an SEP due to an extraordinary circumstance beyond the consumer’s control and may also permit retroactive enrollment and termination, as necessary.

Source FFM Enrollment Manual 08/09/16

CMS Terminations Reasons

CMS Termination Reason	Effective Date
Adoption, Placement for Adoption, or Placement in Foster Care	Date of Event
FFM or QHP/QDP Issuer Error	Original Effective Date
FFM or QHP/QDP Issuer Error	Original Effective Date
Exceptional Circumstances	Date To Be Determined (TBD) by the FFM
Eligibility Appeals Outcome	Date TBD by Appeal Outcome
Death	Date of Event
Rescission	Projected Effectuation Date
Exhausted Three Consecutive Month Grace Period	Last Day of First Month of Grace Period
Retroactive Medicaid/CHIP/Medicare/MEC	No sooner than 14 days from the date the enrollee's request is made at the FFM [**Note:** Issuers have the discretion, at the consumer's request, to provide a termination date as early as the date that the request is made at the FFM.] If the enrollee is newly eligible for Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Marketplace, the last day of QHP coverage is the day before the consumer is determined eligible for Medicaid, CHIP, or the BHP.
FFM or QHP/QDP Issuer Error	No sooner than 14 days from the date the request is made at the FFM [**Note:** Issuers have the discretion, at the consumer's request, to provide a termination date as early as the date that the request is made at the FFM.]30
Exceptional Circumstances	Date TBD by the FFM
Eligibility Appeals Outcome	Prospective or the Date the Incorrect eligibility decision was made

Source FFM Enrollment Manual 08/09/16

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For more information, contact

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