Marketplace Open Enrollment Wrap Up and Tips to Assist Clients to Stay Enrolled

As presented on
January 18, 2018

Centers for Medicare & Medicaid Services (CMS)
Center for Consumer Information & Insurance Oversight (CCIIO)

Disclaimer

The information provided in this presentation is intended only as a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, and formal policy guidance that it is based upon. This presentation summarizes current policy and operations as of the date it was presented. Links to certain source documents have been provided for your reference. We encourage audience members to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information about the requirements that apply to them.

This document generally is not intended for use in the State-based Marketplaces (SBMs) that do not use HealthCare.gov for eligibility and enrollment. Please review the guidance on our Agents and Brokers Resources webpage (http://go.cms.gov/CCIIOAB) and Marketplace.CMS.gov to learn more.

Unless indicated otherwise, the general references to "Marketplace" in the presentation only includes Federally-facilitated Marketplaces (FFMs) and State-based Marketplaces on the Federal Platform (SBM-FPs).

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Webinar Agenda

- Key Areas for Ongoing Agent/Broker Assistance to Clients
  - Pay Premiums to Effectuate Coverage
  - Resolve Data Matching Issues (DMIs)
  - Regain Eligibility for Advance Payments of the Premium Tax Credit (APTC) Lost for Plan Year 2018
  - Special Enrollment Period (SEP) Enrollments and Change in Circumstance Reporting
- Other Marketplace Updates
- Questions and Answers

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Premium Payments to Effectuate Coverage

Make Sure Your Clients Have Completed All Steps to Effectuate Plan Year 2018 Coverage

- Consumers must pay their first month's premium ("binder payment") for enrollment to be effectuated.
- The deadline for making the binder payment for enrollment to be effectuated must be:
  - No earlier than the coverage effective date.
  - No later than 30 calendar days from the coverage effective date.
- Grace periods generally do not apply to the deadline an issuer sets for the payment of a binder to effectuate coverage.

NOTE: CMS has granted issuers flexibility to extend binder payment deadlines and grace periods for individuals affected by 2017 hurricane disasters. See details at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2017-Hurricane-Disasters-Guidance.pdf.

Scenario 1

On December 15, 2017, Stephanie selects a plan.

She pays the binder payment fully or within the tolerance of an applicable premium payment threshold* by the deadline of January 1, 2018.

On January 1, 2018 Stephanie's coverage starts.

*Qualified health plan (QHP) issuers may, at their option, effectuate an enrollment if the consumer makes a payment within a reasonable threshold of the total member responsible portion of the premium amount due (the suggested threshold percentage is equal to or greater than 95%).

Scenario 2

On November 4, 2017, Nicholas selects a plan with a January 1, 2018 effective date.

He does not pay binder payment fully or within the tolerance of an applicable premium payment threshold by the deadline of January 30, 2018.

His coverage is cancelled retroactively to January 1, 2018.

NEW
Effective June 19, 2017

Consumers Who Owe Past-Due Plan Premiums

- Subject to state law, an issuer meeting certain requirements may
  - Apply an individual's binder payment made for new coverage to past-due premiums owed to that issuer (or to an issuer in the same controlled group*) for coverage within the prior 12 months, and
  - Refuse to effectuate the new coverage based on failure to pay the initial premium payment.
- Notice of premium payment policy: Issuers adopting this policy must describe in any enrollment application materials, and in any notice regarding non-payment of premiums, the consequences of non-payment on future enrollment.
- Effective for individuals to whom notice was provided prior to their failure to pay premiums that become past-due.
- An issuer may only condition the effectuation of new coverage on payment of past-due premiums for the individual contractually responsible for the past-due premium.

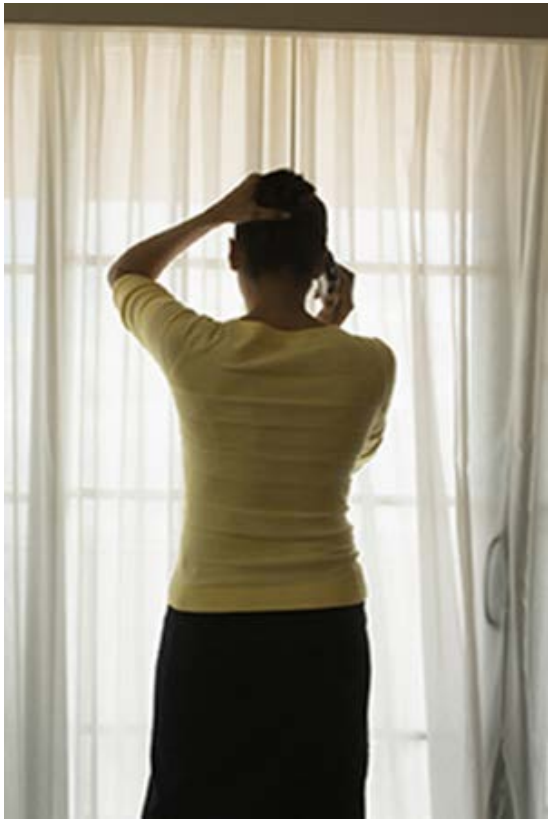
*A controlled group is a group of two or more related entities that is treated as a single employer under the Internal Revenue Code. For example, a parent company and its subsidiaries may be considered to be within the same controlled group.

Scenario 3

During plan year 2017, Carla qualified for an SEP and enrolled in a Marketplace QHP, but she became ineligible for APTC due to her inability to resolve an income DMI. She stopped paying premiums once her issuer billed her for the full monthly premium amount, which she felt she could not afford.

She completed a plan year 2018 enrollment selection with the same issuer, but then received a letter from that issuer demanding payment for past-due premiums for her plan year 2017 coverage before it will effectuate her plan year 2018 coverage.

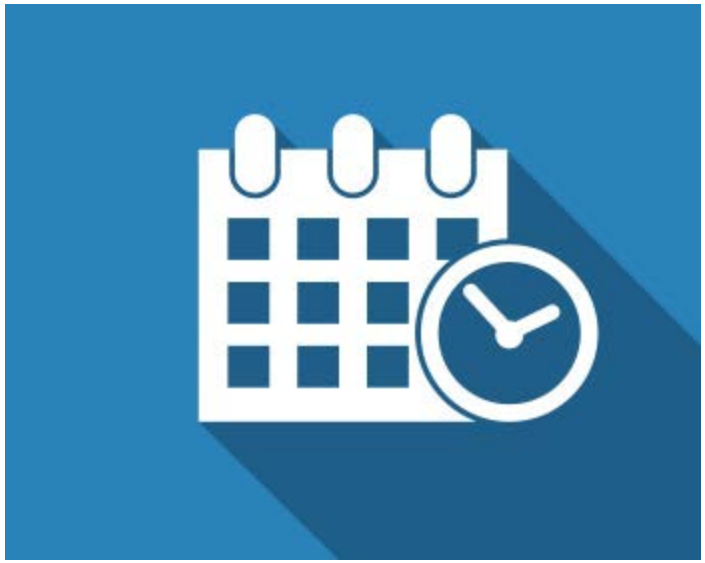
Carla must pay all past-due premiums owed to the issuer **AND** the initial plan premium binder to resolve this and effectuate her plan year 2018 coverage.*



* Carla may also be able to appeal her plan year 2017 APTC eligibility determination, if the appeal is requested within 90 days of the date of the Marketplace's final eligibility determination.

Reminder of Marketplace Grace Period Policy

- A grace period gives consumers additional time to pay their monthly health insurance premiums before their coverage is terminated for non-payment of premium.
- The length of a grace period depends on the consumer's eligibility according to the following guidelines:
  - Consumers receiving APTC when they became delinquent have a grace period of three consecutive months.
  - All other consumers not receiving APTC have a grace period determined by state rules.



- Contact your state Department of Insurance for information on grace periods in your state.
- Grace periods generally do not apply to the deadline an issuer sets for the payment of a binder to effectuate coverage.

TIP: Remind your clients that it is important to pay all outstanding insurance premiums during a grace period so their issuer does not end their coverage.

Termination for Non-payment of Premiums

- Consumers must pay all outstanding premium amounts or an amount sufficient to satisfy any premium payment threshold established by applicable issuers before the end of the grace period to avoid termination for non-payment of premiums.
- The Marketplace grace period does not "reset" when an enrollee makes a partial payment.
- When a consumer's coverage is terminated for non-payment of premiums, the consumer does not qualify for an SEP for the resulting loss of minimum essential coverage.
- A consumer who is eligible for APTC but elects not to receive APTC is not eligible for a three-month grace period, but is eligible for the grace period required by the consumer's state for consumers who are delinquent in paying their premiums.

Claims for Consumers that are Behind in Premium Payment

- During the first month of a three-month grace period for consumers receiving APTC, the issuer must pay all appropriate claims for services rendered to the consumer.
- The issuer may pend claims for services rendered during the second and third months of the grace period for consumers receiving APTC.
- If a consumer fails to pay all outstanding premiums, or an amount that satisfies any applicable premium threshold, before the end of the grace period:
  - The consumer's coverage will be terminated, effective on the last day of the first month of the grace period, for non-payment of their premium.
  - The issuer will deny any claims that were pended during the second and third months of the three-month grace period.

Scenario 4

John is eligible for APTC and selected his plan during Open Enrollment. He makes his binder payment on time to effectuate his coverage on January 1, 2018.

John does not make a premium payment for May. By the end of the three-month grace period, John has not paid all outstanding premium owed.

His grace period expires on July 31 (the final day of the third month after his grace period started on May 1). His coverage is terminated retroactively to May 31.

John's QHP issuer may deny all pended claims from June and July, although it may keep the APTC paid on John's behalf for May and any premium John paid for May coverage. Any premium that John paid to the QHP issuer for coverage in June or July must be refunded to John.

Scenario 5

Patrick is eligible for APTC and selected his plan during Open Enrollment. He makes his binder payment on time to effectuate his coverage on January 1, 2018.

Patrick fails to make his August and September premium payments on time, but then pays both months' premiums in full at the end of September and before the October premium is due. This ends his grace period.

Patrick fails to make his October premium payment. If he does not pay his October premium by the deadline, he will enter a new grace period that will end on December 31.

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Resolution of DMIs

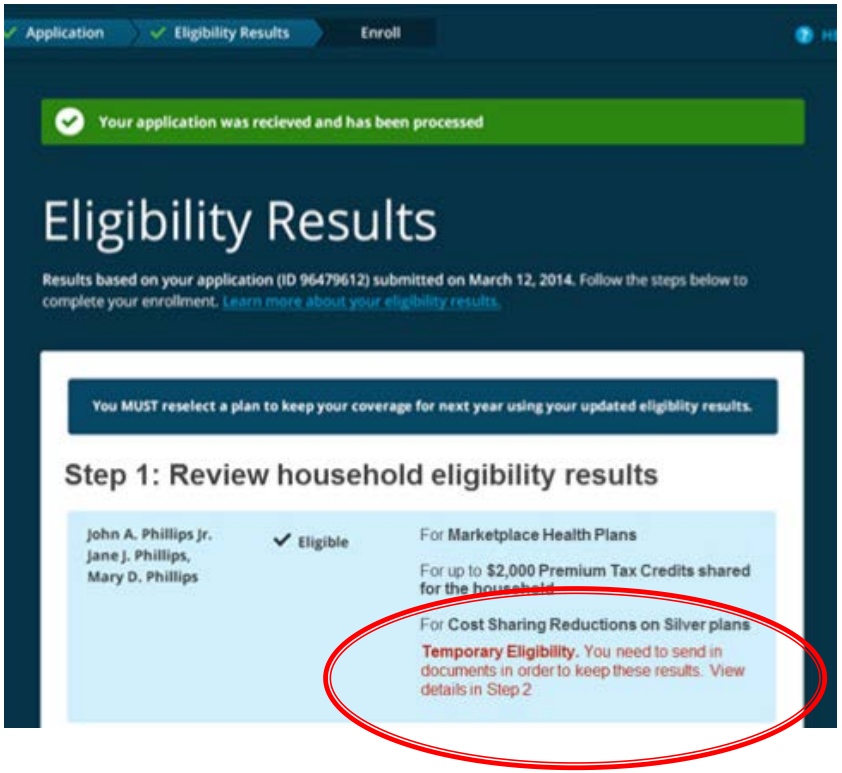
Your Clients May Need Help to Resolve a DMI.

- Although the Open Enrollment period has ended, your clients may still need to respond to a request to submit information needed for the Marketplace to resolve a DMI.*
- Consumers will receive 90-, 60-, and 30-day notices advising them to submit requested information to resolve their DMIs.
- Consumers who do not resolve their DMIs by the close of the 90-day period will lose their Marketplace coverage or risk having their financial assistance adjusted or terminated.

*DMIs are generated when there are inconsistencies between the consumer's application and the information contained in the approved electronic sources the Marketplace uses to verify eligibility.

You Can Help Consumers Follow the Correct Process to Resolve DMIs.

- Read the consumer's full Marketplace eligibility notice. If a consumer has a DMI, it will:
  - Instruct the consumer to send the Marketplace more information.
  - List what documents the consumer can submit to resolve the DMI.
  - Identify which members of the household have DMIs.
- Consumers can also check the **Application Details** section of their Marketplace accounts for a list of all DMIs.



- Consumers with DMIs will also receive reminder notices requesting documentation.

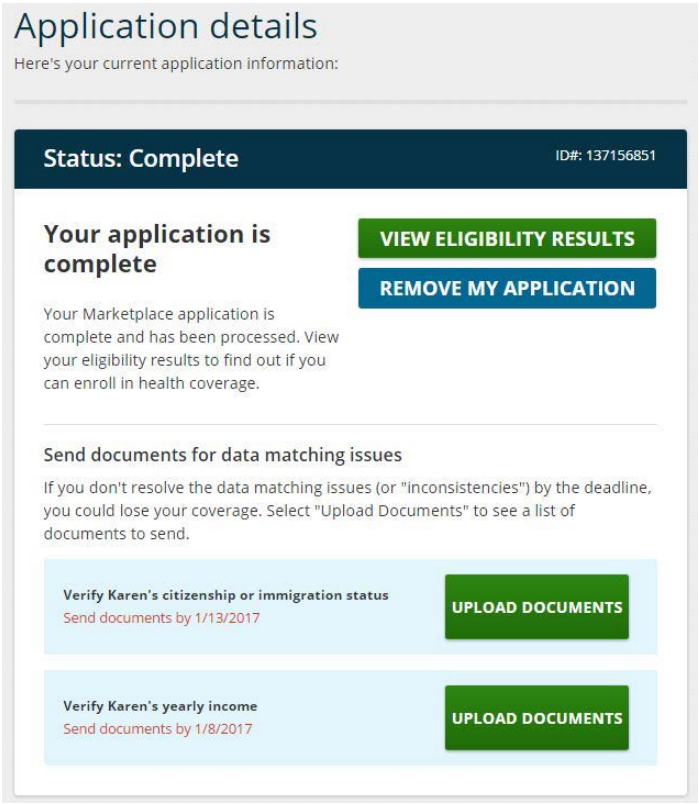
Tips for Helping Consumers Resolve DMIs

- Encourage consumers to submit the requested information as soon as possible.
- Encourage consumers to make digital copies and upload the requested documents through his or her HealthCare.gov account.
- Emphasize that if the consumer does not send the requested documentation by the deadline, he or she may lose eligibility for coverage through the Marketplace or experience a modification of APTC or cost-sharing reductions, if applicable.

Remember: You may not log in to HealthCare.gov on a consumer's behalf (i.e., using the consumer's HealthCare.gov account).

Digital Upload: Steps the Consumer Must Take

- Log in to his or her HealthCare.gov account and select “Start a new application or update an existing one“.
- Click on his or her name in the top right corner of the screen and select “My applications & coverage” from the drop-down list.
- Select his or her current application under "Your existing applications," and click on "Application Details.”
- Click the green button next to each item that requires verification, choose a document type from the drop-down list, click "Select file to upload," select the document from its location on the consumer’s computer, and click "Upload.”



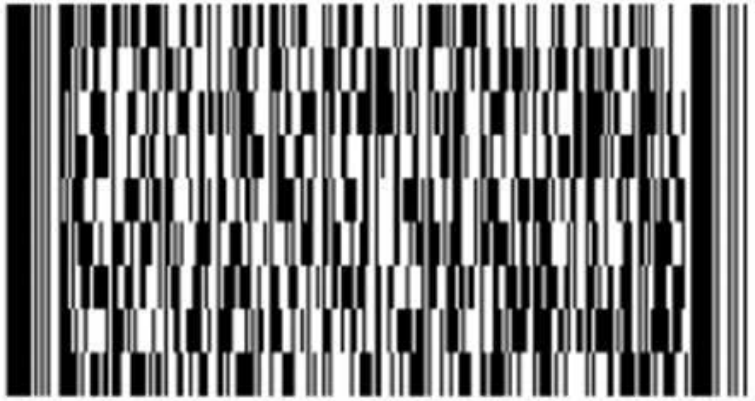
- Confirm a checkmark appears next to the file name, which indicates the upload was successful.

Tips for Successful Digital Upload

- Make sure the file:
  - Is in one of these formats: .pdf, .jpeg, .jpg, .gif, .xml, .png, .tiff, or .bmp.
  - Is under 10 MB.
  - Has a file name without a colon, semicolon, asterisk, or any other special character (e.g., /\:*?<>|).
- Clear and legible cell phone photos are permitted if a copy cannot be scanned.
- Consumers may upload a document that is not listed in the drop-down list of **Document Types** viewable after clicking **Upload Documents** by choosing **Other** from the drop-down menu.

If a Consumer Chooses to Mail Documents to Resolve a DMI

- Remind consumers that they should never mail original documents.
- Remind the consumer to include the page from the eligibility notice that includes a barcode unique to that consumer's application.
- If the consumer does not have the page with the barcode, the consumer should include his or her state, full legal name, and application ID with the mailed documents.



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- Mail all household documents together at one time.
- Mail to: Health Insurance Marketplace, Attn: Supporting Documentation, 465 Industrial Blvd., London, KY 40750.

Other Tips for Resolving DMIs

- If a consumer's documentation is successful in resolving the DMI, the Marketplace will send a notice that indicates nothing further is needed.
- If a consumer's documentation is not sufficient, the Marketplace will send a notice that indicates additional information is needed.
- Consumers who have made a good faith effort to obtain the required documentation, but need more time beyond the normal 90 days may request more time to submit documentation.
- Consumers who cannot provide the necessary documentation because of special circumstances, like a fire, hurricane, or a flood, may request that their DMI be resolved without submitting documentation. This flexibility is granted on a case-by-case basis, and is not available with respect to citizenship or immigration status DMIs.

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Regaining APTC Eligibility Lost for Plan Year 2018

Did Your Client Lose APTC Due to Failure to Reconcile?

- Consumers whose APTC was discontinued beginning January 1, 2018, due to failure to file and reconcile the premium tax credit when filing 2016 taxes, can still take action to restore their APTC.
- Since Open Enrollment has ended, consumers **cannot change plans** unless they qualify for an SEP.
- After the tax filer files and reconciles APTC paid on the consumer's behalf for 2016, as long as the consumer remains enrolled in his or her Marketplace plan, the consumer may return to the Marketplace application, report a life change, attest to filing and reconciling, receive a new eligibility determination, select a plan, and receive APTC prospectively.
- They can regain APTC eligibility with the following coverage effective dates:
  - The first day of the following month if the update took place between the 1st and 15th day of any month; or
  - The first day of the second month following if the update took place between the 16th and the last day of any month.

What if Your Client Wants to Appeal Lost APTC?

- A consumer may also appeal his or her eligibility determination notice stating that he or she is not eligible for financial assistance.
- The consumer can elect to continue receiving the financial assistance he or she was receiving before the revised eligibility determination notice.
- If the appeals entity determines the Marketplace incorrectly terminated financial assistance for failure to file and reconcile (that is, if the tax filer did file and reconcile), then the appeals entity will reverse the Marketplace's revised eligibility determination notice and the enrollee will continue to be eligible for financial assistance (if otherwise eligible).

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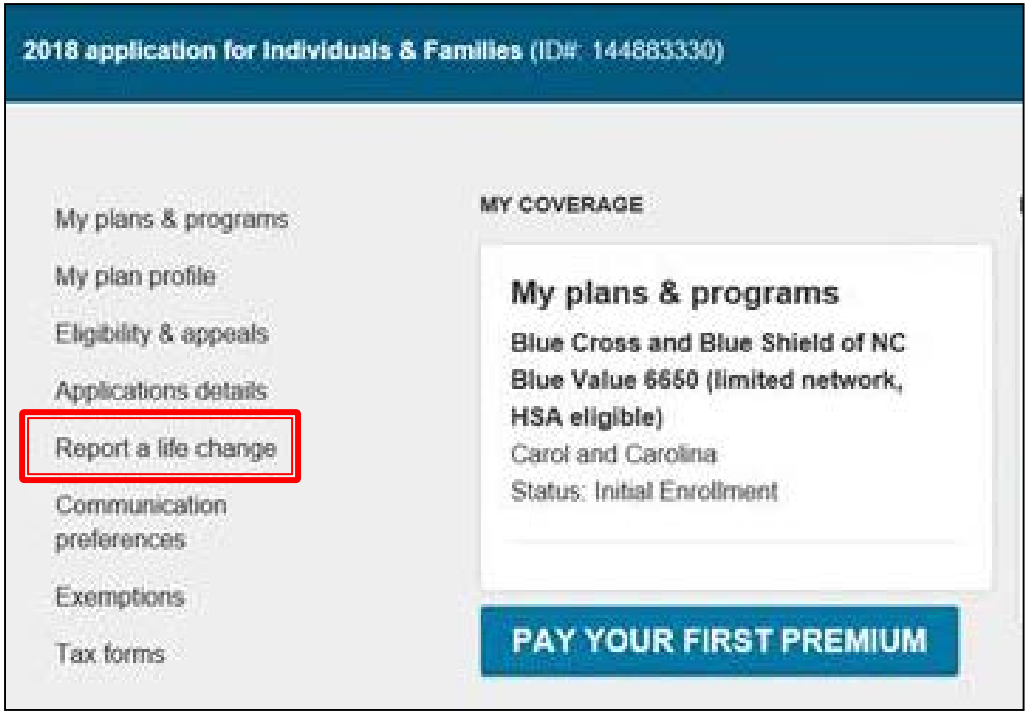

SEP Enrollments and Reporting Changes in Circumstance

Ongoing Help to Clients who May Qualify for an SEP

- SEPs provide a way for people who lose health insurance or experience other qualifying events during the year to enroll in or change coverage outside of the annual Open Enrollment period.
- You should help your clients understand what may make them eligible for an SEP and what they need to submit in terms of documentation to prove eligibility for an SEP.

SEP Qualifying Events

- Loss of qualifying health coverage
- Change in household size
- Change in primary place of living
- Change in eligibility for Marketplace coverage or help paying for coverage
- Enrollment or plan error
- Other situations

- Watch your email for invitations to upcoming webinars that you can attend to learn more about assisting clients with SEPs.

Encourage Clients to Report Changes in Circumstances.

What to Report to the Marketplace

- Change to expected annual income
- Change in health coverage (e.g., gaining or losing eligibility for employer-sponsored coverage, eligibility for Medicaid, Medicare, or Children's Health Insurance Program)
- Change in household members (e.g., birth, marriage, divorce, death, child turning age 26)
- Change in address
- Corrections to name, date or birth, or Social Security number
- Change in status (e.g., disability, citizenship/immigration, incarceration)

- Changes in circumstances may affect the coverage or savings your clients are eligible for.
- Clients who experience these changes should report them to the Marketplace throughout the year as they happen so that the Marketplace can adjust their eligibility, if needed. Marketplace enrollees are required to report changes to their eligibility information **within 30 days of the change**.
- Learn more about reporting changes in circumstances by attending the Assister webinar on **Friday, January 26** 2-3:30 PM ET.

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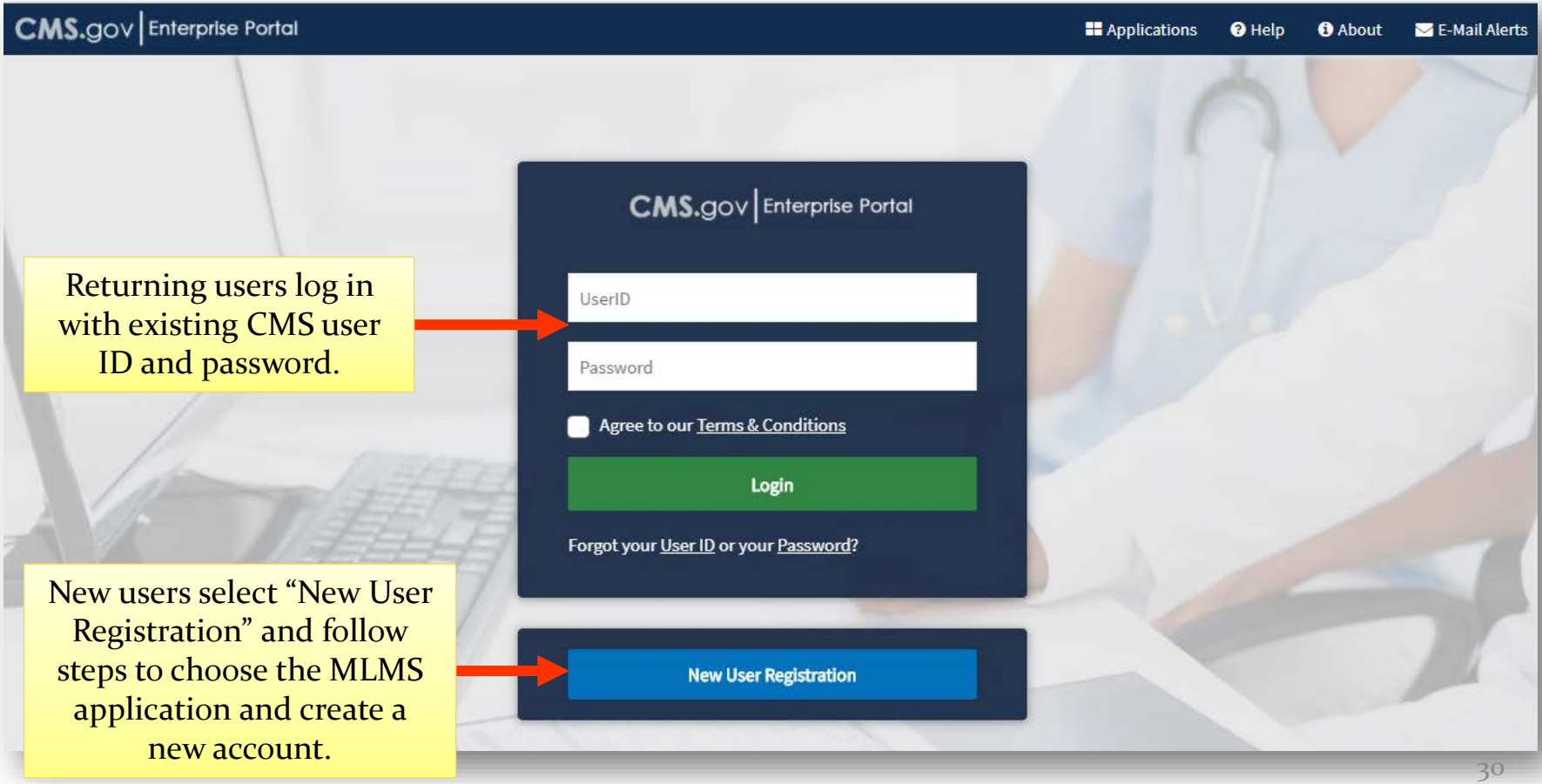
Other Marketplace Updates

New User Interface for CMS Enterprise Portal

- The CMS Enterprise Portal (https://portal.cms.gov) is used to
  - Access the Marketplace Learning Management System (MLMS)
  - Make updates to your public facing profile on Find Local Help, and
  - Check your profile is public to be eligible to participate in Help on Demand.
- CMS has redesigned the user interface to simplify the log in process and improve the user experience.
- The look is different, but navigation is largely the same.
- This change went live on December 20, 2017.

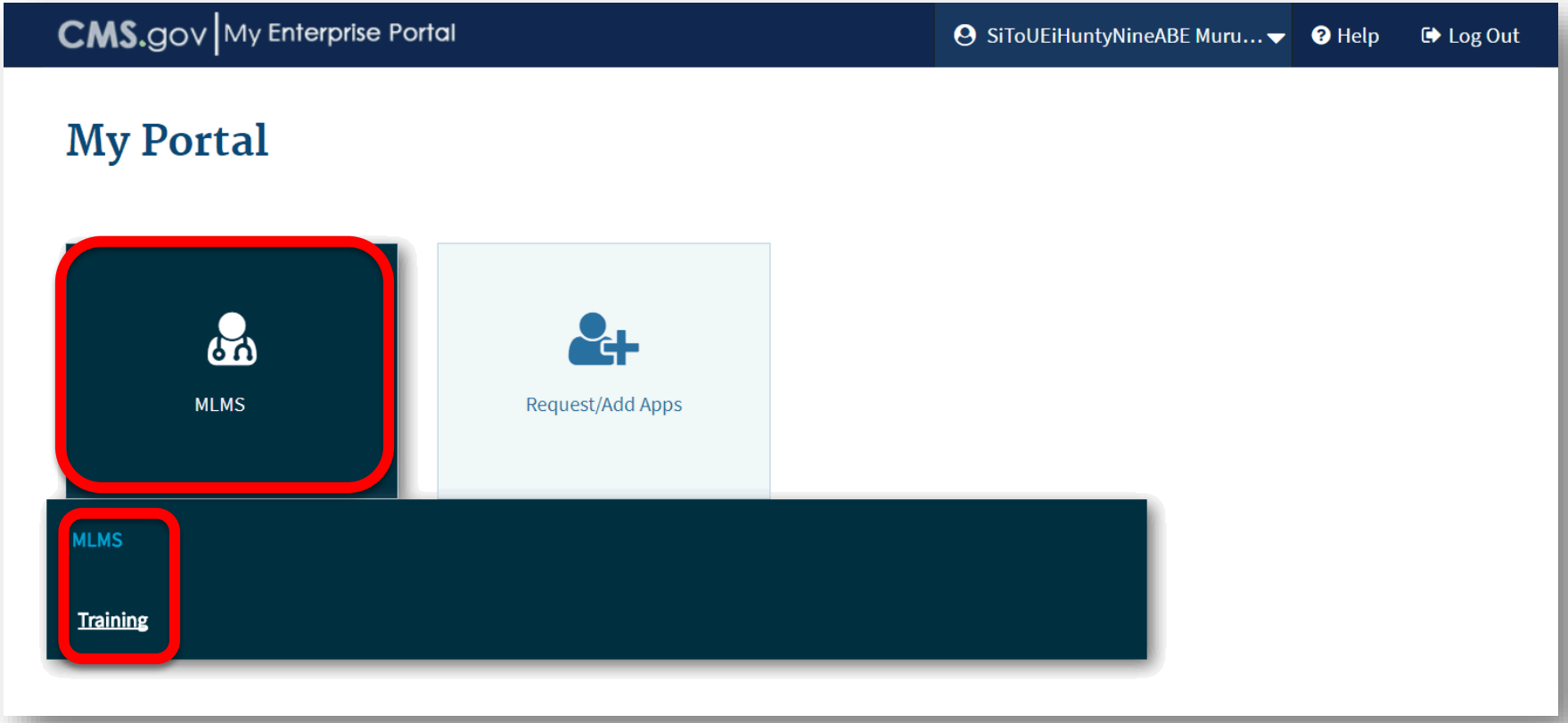
Redesigned CMS Enterprise Portal: Public Landing Page

The public landing page provides registration functionality for new users and login functionality for returning users.



Redesigned CMS Enterprise Portal: Access to the MLMS

- Successful log in takes you to the "My Portal" page.
- Select the "MLMS→ Training" link to access Marketplace agent and broker training.



COMING SOON

Agent/Broker Feedback Request

- To identify future improvements to the Marketplace agent and broker program, we plan to conduct a feedback questionnaire on a variety of topics, including the annual training/registration requirement, ongoing webinars and technical assistance, email messaging, and Call Center support.
- Watch your email for an invitation and a link to complete the questionnaire.

Upcoming Activities

- The slides from this webinar are available on REGTAP at www.REGTAP.info and will be available on the Resources for Agents and Brokers webpage in the coming days.
- Watch your email for invitations to upcoming webinars.

Upcoming Agent/Broker Webinar*

February 1, 2:00-3:00 PM ET

Overview of COBRA and how it interacts with Marketplace coverage

*Webinar dates and topics are subject to change. CMS will share current webinar information via email.

Questions and Answers

- Dial **1-866-549-8866** to enter the phone queue
- Enter your webinar access PIN* provided to you in the confirmation email from REGTAP
- Dial star (*) pound (#) to enter the question queue
- You may also enter your feedback in the webinar Q&A panel.

*If you do not have your webinar access PIN, contact the registrar by calling **(800) 257-9520**.

Agent and Broker Resources

Resource	Description	Link
Agents and Brokers Resources webpage	Primary outlet for information about participating in the Health Insurance Marketplace	http://go.cms.gov/CCIIOAB
HealthCare.gov	Official site of the Health Insurance Marketplace used for researching health coverage choices, eligibility, and enrollment	https://www.healthcare.gov/
Marketplace information source for Agents and Brokers	Provides additional technical assistance resources about Marketplace eligibility, financial assistance, enrollment, and more	https://marketplace.cms.gov
Plan Year 2018 Marketplace Registration and Training for Agents and Brokers	Describes the process and requirements for completing annual Marketplace registration and training for agents and brokers	https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Plan-Year-2018-Registration-and-Training.html

Agent and Broker Resources (Continued)

Resource	Description	Link
Registration Completion List	Public list of agents and brokers who have completed Marketplace registration; used by issuers to verify your eligibility for compensation for assisting with consumer enrollments	https://data.healthcare.gov/ffm_ab_registration_lists
Find Local Help	Tool available on HealthCare.gov that enables consumers to search for a local, Marketplace-registered agent or broker with a valid health line of authority to assist with FFM enrollment	https://localhelp.healthcare.gov/
Help On Demand	A service that connects consumers seeking assistance with Marketplace-registered, state-licensed agents and brokers in their area who can assist with Marketplace enrollment when the consumer is available	https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Help-On-Demand.pdf
Agent and Broker NPNs	Provides a search function to determine the correct NPN to enter in your MLMS profile and on Marketplace applications	www.nipr.com/PacNpnSearch.htm

Most Frequently Used Agent/Broker Marketplace Help Desks and Call Centers

Name	Phone # and/or Email Address	Types of Inquiries Handled	Hours (Closed Holidays)
Direct Agent/ Broker Partner Line	855-788-6275 Note: Enter your NPN to access this line.	• Assist consumers with HealthCare.gov account password resets • SEPs not available on the consumer application • Individual Marketplace eligibility and enrollment issues	Mon–Sun 24 hours/day
Agent/Broker Email Help Desk	FFMProducer-AssisterHelpDesk@cms.hhs.gov	• General enrollment and compensation questions • Manual identity proofing/Experian issues • Escalated general registration and training questions (not related to a specific training platform) • Agent/Broker Registration Completion List issues • Find Local Help and Help On Demand issues	Mon–Fri 8:00 AM–6:00 PM ET
Agent/Broker Training and Registration Email Help Desk	MLMSHelpDesk@cms.hhs.gov	• Technical or system-specific issues related to the agent/broker training and registration system (i.e., the MLMS) • User-specific questions about maneuvering in the MLMS site, or accessing training and exams	Mon–Fri 8:00 AM–5:30 PM ET
Marketplace Service Desk	855-CMS-1515 855-267-1515 CMS_FEPS@cms.hhs.gov	• CMS Enterprise Portal password resets and account lockouts • Login issues on the Direct Enrollment agent/broker landing page • Other CMS Enterprise Portal account issues or error messages • 501 Downstream Error message on HealthCare.gov website issues • General registration and training questions (not related to a specific training platform)	Mon-Fri 8:00 AM–8:00 PM ET

For a full list of Agent/Broker Help Desks and Call Centers, see https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Agent-Broker-Help-Desks.pdf.

Acronym Definitions

Acronym	Definition
APTC	Advance Payments of the Premium Tax Credit
CCIIO	Center for Consumer Information and Insurance Oversight
CMS	Centers for Medicare & Medicaid Services
DMI	Data Matching Issue
FFM	Federally-facilitated Marketplace
FLH	Find Local Help
MLMS	Marketplace Learning Management System
NPN	National Producer Number
QHP	Qualified Health Plan
REGTAP	Registration for Technical Assistance Portal
SBM	State-based Marketplace
SBM-FP	State-based Marketplace on the Federal Platform
SEP	Special Enrollment Period

Closing Remarks