Marketplace Update for Assisters

November 7, 2017

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PY2018 Open Enrollment Reminders: System Maintenance / Waiting Rooms / Window Shopping

CMS has released a fact sheet that discusses key updates to the Federal Health Insurance Exchange 2018 Open Enrollment Period. To read it, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-10-25.html.

HealthCare.gov Maintenance

Every major website needs routine maintenance and updates to keep things running smoothly and efficiently. This year, CMS is keeping the potential hours for planned website and partner maintenance similar to previous years, and limiting potential system downtime to the lowest-traffic time periods on HealthCare.gov. CMS also made sure to share those potential plans in advance of Open Enrollment with Navigators and certified application counselors, in response to your requests, to help you plan your interactions with consumers.

HealthCare.gov Waiting Rooms

Similar to previous years, CMS may deploy a “waiting room” when website traffic is high for some consumers logging in or creating an account on HealthCare.gov. The waiting room is one tool we utilize to optimize a consumers’ experience because it allows us to control the volume of users resulting in

better performance of the website. Consumers see a message asking them to stay on the page. The waiting room will refresh when a consumer can continue to apply and enroll with a smooth experience.

Window Shopping

On October 25, 2017, CMS launched updates to window shopping ("See plans & prices") which allow consumers to preview 2018 plans and prices before Open Enrollment begins. As in previous years, window shopping lets consumers browse plans without logging in, creating an account, or filling out the official application. Starting November 1, consumers can log in to HealthCare.gov and CuidadodeSalud.gov or call 1-800-318-2596 to fill out an application and enroll in a 2018 Exchange health plan.

Refer to this fact sheet released on October 25th for more open enrollment updates including important information about re-reenrollment.

Marketplace Assister Call Lines

Similar to the previous open enrollments, there will once again be a designated call center line for Assisters. This year the line features several enhancements designed to help better streamline the call process. Utilizing the Assister line will only allow Assisters to bypass the regular call center line if they need help with password resets or accessing certain call center-initiated SEPs. This enhancement is designed to help minimize the time they have to spend on the phone trying to resolve certain consumer issues. For all other issues, the wait time will be the same as the regular call center line.

The Call Center will be tracking the topics assisters request assistance with through the designated assister lines. We encourage assisters to use the assister line when working with consumers not only to receive enhanced service, but also in order to enable the Call Center to better monitor and meet assisters' needs. Please note there are two different Assister lines, one for Navigators and one for CACs:

Assister Line for Navigators: **1-855-868-4678**

Assister Line for CACs: 1-**855-879-2683**

If Assisters are having difficulty accessing the Assister line, please reach out to your project officer if a Navigator, or email CACInbox@cms.hhs.gov if you are a CAC. CCIIO will verify that the code you are utilizing matches our records.

Failure to Reconcile (FTR) Updates

Summary: A consumer may not be determined eligible for advance payments of premium tax credit (APTC) if the tax filer for the household did not comply with the requirement to file an income tax return for a year in which APTC was paid on his/her behalf and reconcile the associated APTC for that year. This situation is called "failure to file and reconcile" or "FTR."

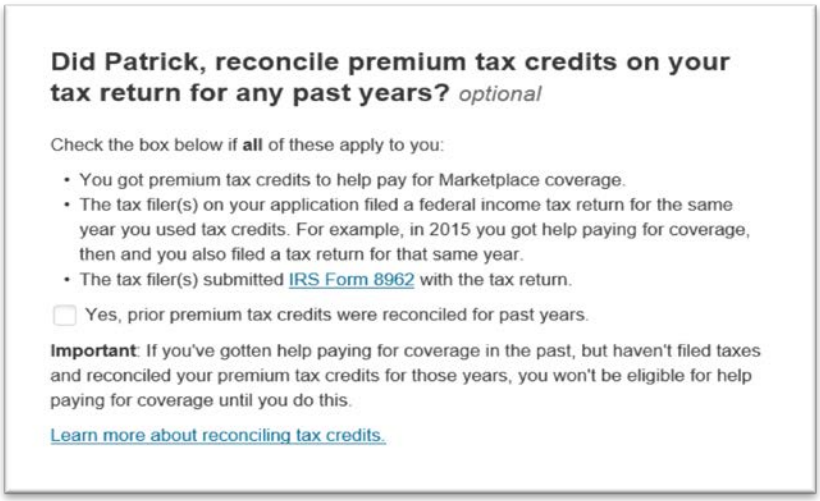
Policy

Starting January 1, 2016, a consumer was determined ineligible for APTC if APTC was paid on his or her behalf in a prior year, but the tax filer for the household did not file a tax return for that year. In 2018, if a consumer's tax filer filed a tax return but did not reconcile the associated APTC using IRS Form 8962 (known as a "non-reconciler"), the Marketplace will determine him or her ineligible for APTC, in addition

to the non-filers.

Tax filers use IRS Form 8962 to reconcile the APTC paid on their behalf (based on *projected* household income) with the final premium tax credit the enrollee is eligible for (based on *actual* household income for the year during which APTC was paid on his or her behalf.

Generally, it takes IRS 3 to 10 weeks to process a tax return, depending on how it is filed (electronic vs. paper) and IRS updates the Marketplace on tax filing and reconciliation status for enrollees on a weekly basis. To account for these delays in IRS data available to the Marketplace, a question displays on the application to allow consumers to attest, under penalty of perjury, that their tax filer did file a tax return and reconcile all past APTC. This attestation allows the consumer to obtain or maintain eligibility for APTC (if otherwise eligible) even if IRS' data has not yet been updated.



Avoid losing APTC in 2018

Enrollees can avoid losing APTC in 2018 by filing their 2016 tax returns and reconciling their 2016 APTC IMMEDIATELY. For more information on how to file and reconcile visit: https://www.irs.gov/affordable-care-act/individuals-and-families/premium-tax-credit-claiming-the-credit-and-reconciling-advance-credit-payments.

- After, filing/reconciling for 2016, enrollees should return to the Marketplace, create a 2018 application and attest on the application that their tax filer has filed a tax return and reconciled all past APTC.

- In mid-December 2017, the Marketplace will do a final check of IRS data for FTR enrollees who did not return to the Marketplace, in order to retain APTC for those who filed and reconciled since the original IRS data check in September 2017.

Enrollees whose APTC is discontinued beginning January 1, 2018, due to failure to file and reconcile can still take additional steps to restore their APTC. As long as the enrollee remains enrolled in their Marketplace plan, he or she 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, following the 15th of the month coverage effective date rules.

What Assisters Can Do

- Encourage enrollees who haven't yet filed their 2016 federal income taxes and who had APTC paid on their behalf in 2016 to file and reconcile **as soon as possible**.
- https://www.irs.gov/affordable-care-act/individuals-and-families/premium-tax-credit-claiming-the-credit-and-reconciling-advance-credit-payments.
- Remind enrollees that even if they usually don't have to file an income tax return based on their income, if APTC was paid on their behalf, they must file a return for that year.
- Help enrollees who haven't yet filed their taxes understand what steps to take, including helping them access their Forms 1095-A

For more information, including how you as an assister can help consumers, check out the slides from the Wednesday, November 8 Assister Webinar here (insert hyperlink to the deck).

Extension of Equitable Relief for Beneficiaries Dually Enrolled in Medicare and Marketplace

CMS is extending the deadline through Sept 30, 2018, for equitable relief assistance to Medicare beneficiaries currently enrolled in Medicare Part A and the Marketplace. This assistance provides eligible individuals with an opportunity to enroll in Medicare Part B without penalty. Further, CMS is offering assistance to eligible individuals who were dually enrolled in Medicare Part A and the Marketplace and subsequently enrolled in Medicare Part B with a penalty. This assistance provides these individuals an opportunity to request a reduction in their Medicare Part B late enrollment penalty.

- Refer to the limited equitable relief fact sheet.

Marketplace Application Refreshers: Identity Proofing / Family & Household / APTCs & CSRs / Plan Compare

Identity Proofing

Identity proofing is an essential part of completing a Marketplace application. If this step is not completed, the consumer cannot move forward with creating an application. This step is used to verify a consumers identity by asking questions based on the consumers personal and financial history. This process helps prevent an unauthorized person from going to the Marketplace to create an application in a consumer's name, without their knowledge.

If a consumer's identity cannot be verified they will be referred to the Experian helpdesk for assistance. If the Experian helpdesk is unable to verify, the consumer will need to upload or mail in documents to verify his or her identity. If the consumer uploads documents for verification, processing time will be sooner than if they have to mail them. If mailed, it typically takes 7-10 business days to process. After identity is

verified, a written notice will be sent letting the consumer know whether his or her identity has been verified or if he or she needs to submit more information to verify.

Some helpful tips/reminders:

- Prepare consumers to complete ID proofing. They might need to answer questions on topics such as: addresses of current and past places they have lived; names of current and past employers; and information about mortgages, credit cards, and/or loans they may have.

- Tell consumers the Center for Medicare and Medicaid Services (CMS) uses credit reporting agencies like Experian and Equifax to verify their identity and application information, so they may see an inquiry from CMS when checking their credit reports. This CMS inquiry does not affect consumers' credit scores.

- Tell consumers whose identities couldn't be verified through HealthCare.gov to resolve their ID proofing issues:

- Call the Experian Help Desk at 1-866-587-5409 and provide the reference code as shown on the Marketplace application screen.

- If the Experian Help Desk cannot verify a consumer's identity, the consumer can upload documents showing his/her identity to his/her Marketplace account on HealthCare.gov or mail documents to the Marketplaces.

If consumers are still having trouble with ID proofing, consumers should contact the Marketplace Call Center and complete the online application with a Marketplace Call Center representative.

- For more information on identity proofing visit marketplace.cms.gov, identity proofing and information inconsistencies, including why it is important and what to do if consumers have issues (also available in Spanish).

- Consumers who want to learn more about why they need to submit personally identifiable information (PII) and how the Marketplaces use this information should review should visit HealthCare.gov: How We Use Your Data (also available in Spanish) and the Privacy Act Statement (also available in Spanish) on HealthCare.gov.

The Family & Household Section of the Marketplace Application

Consumers who apply for health coverage through the Marketplace must fill out the Family & Household section of the Marketplace application to help determine their eligibility for coverage.

It is important to remember that eligibility for the Advance Payments of the Premium Tax Credit (APTC) and Cost-Sharing Reductions (CSR's) are calculated based on a family's size and their total household income. This is why the Marketplace asks questions about the applicant's family members, even those who are not applying for coverage for themselves.

Assisters should remind consumers that a tax household includes the tax filer, his or her spouse, if applicable, and anyone they claim as a dependent, even if they aren't applying for coverage for

themselves and file their own taxes. Only members of the same tax household can enroll in a Marketplace plan together if they apply for financial assistance to purchase coverage. Family members in a different tax household must apply for coverage separately. Other members of the household who are part of a separate tax household should still be listed on the application as non-applicants, so they are counted in the applicant' family size and their income can be included in household income. Married couples are required to file a joint return to be eligible for APTC.

Assisters should also advise consumers to enter the Social Security Numbers (SSN's) for everyone in the household who has one. Including a SSN helps confirm an individual's income and will aid in speeding up the application process.

For more on the Family & Household section of the Marketplace application, assisters can review the following resources:

- For information about, Who To Include In Your Household, visit https://www.healthcare.gov/income-and-household-information/household-size/
- For information about Health Coverage for Immigrants, visit: https://www.healthcare.gov/immigrants/
- For more information about how to help applicants denied Medicaid and CHIP eligibility because of their immigration status, visit https://marketplace.cms.gov/technical-assistance-resources/immigrants-with-income-under-100-percent-fpl.pdf.

APTC/CSRs

Consumers applying for coverage through the Marketplaces may be eligible for financial assistance in the form of APTC to help save on their monthly premiums and CSRs to help save on their out-of-pocket health care costs. Eligibility for these savings depends on a consumer's household income, family size, and whether they already have access to or are enrolled in certain other forms of minimum essential coverage. Some consumers seeking financial assistance may also be assessed or determined to be presumptively eligible for Medicaid or the Children's Health Insurance Program (CHIP) by the Marketplaces.

Assisters should explain to consumers who receive APTC through the Marketplaces that they must file a federal income tax return, even if their income level would not otherwise require them to do so. As outlined in the above FTR article, assisters should advise consumers if they don't file a tax return to reconcile the APTC they received, their financial assistance may be discontinued in future years. For consumers who receive APTC, the Marketplaces will send consumers a Form 1095-A with information that they will need. Once consumers receive their 1095-A, they are required to complete Form 8962, to reconcile the APTC they received with their actual income for the year.

Consumers who make between 100% and 400% of the Federal Poverty level (FPL) may be eligible to receive APTC. In many cases, consumers who make 250% or below of the FPL may be eligible for CRSs to help reduce their out-of-pocket costs. Assisters should remind consumers that to benefit from CSRs, consumers must select a silver plan.

- Check out this list of IRS Premium Tax Credit resources for more information or visit the IRS page on premium tax credits:

- For income resources, visit: https://marketplace.cms.gov/technical-assistance-resources/income-resource-chart.pdf

- Find information that you can share with consumers about how they may be able to save on monthly premiums by receiving APTC (also available in Spanish**).** At this link, you will find a tool that you can share with consumers that can help them determine if they may qualify for APTC based on their household size and the state in which they live.

- Find information you can share with consumers about how they may be able to save on out-of-pocket costs through CSR's (also available in Spanish).

Plan Comparison and Selection

The plan comparison and selection process is a very important step in determining the coverage consumers will have for an entire year. Once the open enrollment period is over, they cannot change their plan until the next open enrollment period, unless they qualify for a special enrollment period. It is vital that consumers complete the application "To-Do-List" appropriately, in order to view the plans that are available to them and their families.

After receiving eligibility results, the application will take the applicant to the "Enroll to-do list" which helps the applicant navigate through the plan comparison process. The "Enroll to-do-list" will take the applicant through seven steps, if they are eligible for Advance Premium Tax Credits (APTCs), and six steps if they are not eligible for APTCs. Below you will see an example of the "Enroll to-do-list when a member has APTCs available.

Find the enrollment to-do-list at https://marketplace.cms.gov/technical-assistance-resources/plan-compare-job-aid.pdf.

Consumers have the option to browse plans before walking through the entire application by visiting HealthCare.gov. To browse plan options click here: See Plans.

- Find information about how to choose Marketplace coverage for consumers (also available in Spanish).

- Find information about using Marketplace coverage for consumers (also available in Spanish).

- Find 5 questions consumers should ask when choosing a plan.

COBRA Coverage Overview

COBRA allows temporary continuation of group health coverage that otherwise might be terminated to eligible covered employees, their spouses, their former spouses, and their dependent children.

COBRA is only available when coverage is lost due to certain specific qualifying events:

- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct;
- Reduction in the hours worked by the covered employee;
- Divorce or legal separation of the covered employee;
- Death of the covered employee; or,
- A dependent child reaching the age at which he or she is no longer eligible for active coverage under the group plan (usually age 26).

When one of the above qualifying event occurs, consumers have 60 days to decide whether to enroll in COBRA coverage. Once they choose COBRA coverage, they have 45 days after making the election to pay the first month’s premium. Consumers may also elect to have their COBRA coverage start retroactively to the date the job-based insurance ended, as long as the election is made within the 60 day eligibility period.

In most cases COBRA coverage lasts for 18 months. However, if a COBRA participant is determined to

be disabled by the Social Security Administration, then coverage may continue for up to an additional 11 months; for a total maximum period of 29 months. Additionally, COBRA participants who experience a divorce or death qualifying event are eligible for an 18-month extension; giving a total maximum period of 36 months of continuation coverage.

If consumers decide not to elect COBRA coverage, they may enroll in a Marketplace plan instead within 60 days if they qualify for a Special Enrollment Period (SEP). Consumers may also be eligible for advance premium tax credits (APTC) or cost-sharing reductions (CSRs) through the Marketplace. Consumers should carefully consider things such as total cost, access to care, and whether or not they may keep their current providers before making a decision. If they decide to terminate their COBRA coverage early, they may have to wait until the next Open Enrollment Period to enroll in a Marketplace plan.

Frequently Asked Questions received during the September 22, 2017 webinar:

Q1. Are organizations with fewer than 20 employees allowed to participate in COBRA coverage?

A1. The law generally applies to all group health plans maintained by private-sector employers with 20 or more employees, or by state or local governments. The law does not apply to plans sponsored by the Federal Government or by churches and certain church-related organizations. In addition, many states have laws similar to COBRA, including those that apply to health insurers of employers with less than 20 employees (sometimes called mini-COBRA). Consumers should check with their state insurance commissioner's office to see if such coverage is available.

Q2. If the consumer has already paid toward their deductible before choosing COBRA, does the deductible start all over again with a COBRA plan or will the deductible rollover into the COBRA plan?

A2. Since COBRA is a continuation of the same health plan previously held through an employer, if the deductible has already been met, it does not start again with COBRA. Any payment towards the deductible with the employed based plan would be applied towards the COBRA plan. Consumers are subject to the same rules and limits that would apply to a similarly situated participant or beneficiary, such as co-payment requirements, deductibles, and coverage limits. The plan's rules for filing benefit claims and appealing any claims denials also apply.

Q3. If a consumer has been on COBRA for a few months with no employer subsidy and then decides to cancel COBRA, is he or she eligible for a SEP?

A3. No, consumers do not qualify for a Special Enrollment Period if:

- They decide to end COBRA early (and are paying the full cost)
- They lose COBRA coverage because they didn’t pay the premiums

Note: Consumers don’t need a Special Enrollment Period if they voluntarily end COBRA early during a Marketplace Open Enrollment Period. Consumers can drop their COBRA plan and enroll in a Marketplace plan at that time.

Q4. If a consumer first elects to apply for COBRA at the end of the 60 day time frame, is there an option for the consumer to make to make their coverage effective for the current or next month or

is backdating the only possibility?

A4. The election period is measured from the date of the qualifying event or the date the COBRA election notice is provided. COBRA coverage is retroactive if elected and paid for by the qualified beneficiary.

Q5. Will the consumer receive documentation of the COBRA coverage and notification of any premium changes?

A5. Yes. Group health plans must give each employee and each spouse who becomes covered under the plan a general notice describing COBRA rights. This Notice of COBRA Rights must be provided within the first 90 days of coverage. The COBRA rights provided under the plan must be described in the plan's Summary Plan Description (SPD). The SPD is a written document that gives important information about the plan, including what benefits are available under the plan, the rights of participants and beneficiaries under the plan, and how the plan works.

A notice of COBRA rights generally includes the following information:

- A written explanation of the procedures for electing COBRA,
- The date by which the election must be made,
- How to notify the plan administrator of the election,
- The date COBRA coverage will begin,
- The maximum period of continuation coverage,
- The monthly premium amount,
- The due date for the monthly payments,
- Any applicable premium amount due for a retroactive period of coverage,
- The address to which to send premium payments,
- A qualified beneficiary's rights and obligations with respect to extensions of COBRA coverage, and
- The bases for early termination of the period of COBRA coverage.

Resources

- EMPLOYEE'S GUIDE TO HEALTH BENEFITS UNDER COBRA
- https://www.healthcare.gov/unemployed/cobra-coverage
- https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_qna.html

- https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/cobra-continuation-health-coverage-consumer.pdf

Standing Assister Resources: Helpful Links / Call Center Hours / Contact Us

Links to Helpful Resources

- Marketplace Assister Training Resources and Webinar
- Technical Assistance Resources
- CMS Marketplace Applications & Forms
- CMS Outreach and Education Resources
- Marketplace.CMS.gov Page
- CMSzONE Community Online Resource Library Pilot for Marketplace Assisters
- Find Local Help

Marketplace Call Center and Shop Center Hours

Health Insurance Marketplace Call Center: 1-800-318-2596 (TTY: 1-855-889-4325). For customer service support, to start or finish an application, compare plans, enroll or ask a question. Available 24 hours a day, 7 days a week. Closed Memorial Day, July 4th, Labor Day, Thanksgiving Day and Christmas Day. CACs and Navigators should call their dedicated phone lines so the Call Center can better track the needs of assisters. The dedicated Assister Line can also help with password resets and can help with access to non-application SEPs. Contact your Navigator Project Officer (for Navigators) or your designated organization leadership (for CACs) for more information on the Assister Line.

Navigator Marketplace Call Center line: 1-855-868-4678

CAC Marketplace Call Center line: 1-855-879-2683

General consumer Call Center line: 1-800-318-2596 (TTY: 1-855-889-4325).

SHOP Call Center: For customer service support, including assisting employers and employees apply for

and enroll in SHOP. 1-800-706-7893 (TTY: 711). Available M-F 9:00 am-7:00 pm EST. Closed New Year's Day, Martin Luther King Day, Memorial Day, July 3rd, Labor Day, Veterans Day, Thanksgiving and the day after, and Christmas.

Stay in Touch

To sign up for the CMS Weekly Assister Newsletter, please send a request to the Assister Listserv inbox (ASSISTERLISTSERV@cms.hhs.gov) write "Add to listserv" in the subject line, please include the email address that you would like to add in the body of your email. For requests to be removed from the listserv, please forward a copy of a webinar invite or newsletter received and write "Remove" in the subject line.

If you have specific questions or issues that you would like to see us highlight in our weekly webinar series or here in this newsletter please contact us.

- For **HHS Navigator grantees** - please get in touch with your Navigator Project Officer.
- For **CAC Designated Organizations in FFM or SPM states** - please send an email to CACQuestions@cms.hhs.gov.

Follow @HealthCaregov Twitter with the hashtag #ACAassisters for updates, reminders, and new publications for assisters.

We welcome questions, suggestions and comments, so please feel free to contact us!

Please note that the information presented in this Assister Newsletter is informal, technical assistance for assisters and is not intended as official CMS guidance.