Covered Clips

A Weekly Summary of News and Activities for the Cover Arizona Coalition[](http://stylegirlfriend.com/wp-content/uploads/2012/04/paper-clips-style-girlfriend.jpg)

Week of February 17th

**Latest Marketplace Numbers**

43,495 Arizonans have selected Marketplace plans from October 1 to February 1.

Nationally, January was the first month that Marketplace enrollment exceeded monthly enrollment projections.

<http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Feb2014/ib_2014feb_enrollment.pdf>

**Marketplace Enrollment among States with**

**Federally Facilitated Marketplaces 10/1 -1/30**

|  |  |  |
| --- | --- | --- |
| Rank/State | Individuals Who Selected a Plan | Individuals Who Selected a Plan as Percent of Uninsured |
| 1/FL | 296,892 | 8% |
| 2/TX | 207,546 | 3% |
| 3/NC | 160,161 | 12% |
| 4/PA | 123,681 | 9% |
| 5/MI | 112,013 | 10% |
| 6/GA | 101,276 | 5% |
| 7/IL\* | 88,602 | 5% |
| 8/VA | 74,199 | 7% |
| 9/OH | 60,122 | 5% |
| 10/TN | 59,705 | 7% |
| 11/WI | 56,436 | 10% |
| 12/NJ | 54,805 | 4% |
| 13/MO | 54,157 | 6% |
| 14/IN | 47,735 | 6% |
| 15/AZ\* | 43,496 | 4% |

\*States that are also conducting outreach for expanded Medicaid

* There are thirty-six federally facilitated states in total.
* Arizona’s enrollment appears far more impressive when enrollment for Medicaid restoration/expansion is taken into account. (Arizona is only one of two states among the top performing federally facilitated exchanges that is also working to enroll people under Medicaid expansion.) As of January 10, 2014, 98,203 adults have been approved for AHCCCS coverage under the expansion/restoration categories.

**Tucson among Top Ten Cities Nationally for Low Marketplace Premiums**

Kaiser Health News listed the ten cities with the lowest Marketplace premiums across the country. Tucson was listed the fourth lowest.

See <http://www.kaiserhealthnews.org/Stories/2014/February/13/10-Least-Expensive-Health-Insurance-Markets-In-US.aspx?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+khn%2Fheadlinesonly+(All+Kaiser+Health+News+(Headlines))>

**One-Fifth of New Enrollees under Health Care Law Fail to Pay First Premium**

One-in-five people who signed up for health insurance under the new health care law failed to pay their premiums on time and therefore did not receive coverage in January, insurance companies and industry experts say.

<http://www.nytimes.com/2014/02/14/us/politics/one-in-5-buyers-of-insurance-under-new-law-did-not-pay-premiums-on-time.html?_r=0>

**Need for Enrollment Assistance**

According to Enroll America, of those Arizona uninsured/underinsured consumers who have not yet enrolled in affordable health coverage but have pledged to:

* 41 percent said they would use an application assistor
* 9 percent would use the healthcare.gov hotline
* 32 percent would try it themselves online at healthcare.gov
* 12 percent unsure

**Enrollment Assistance Spreading across Arizona**

New maps from Enroll America show both the locations of enrollment assisters and the areas where the uninsured is likely to reside. The maps suggest that our state – for the most part – is doing well in matching the two. See <http://www.enrollamerica.org/state-maps-and-info/uninsured-population-enrollment-assisters/arizona/>

**Challenges Continue with Transfers of Applications between State and Federal Systems**

From AHCCCS:

There are 60,000 consumers who applied for healthcare coverage through the federal Marketplace at [www.healthcare.gov](http://www.healthcare.gov) and were told their income qualified them for AHCCCS coverage instead. AHCCCS has been working with the federal government to transfer these 60,000 applicants from the federal Marketplace into the AHCCCS system. This step is necessary in order to complete the individual’s AHCCCS eligibility.

The federal government has indicated that Arizona and a number of other states are “in production” with regards to the transfer of these applications. However, there are a number of technical problems with the accounts that are being transferred from the federal Marketplace making eligibility determinations impossible to complete in some cases. AHCCCS is attempting to develop a way to work around these challenges manually. While AHCCCS is working diligently with the federal government to address this issue, this account transfer process will be slow and cumbersome for the foreseeable future. In the meantime, AHCCCS continues to urge individuals who are assessed Medicaid/AHCCCS eligible by healthcare.gov to go to [www.healthearizonaplus.gov](http://www.healthearizonaplus.gov) directly to apply.

AHCCCS recognizes that many Arizonans are stuck in this difficult consumer experience. AHCCCS is doing everything possible to accurately resolve these applications. AHCCCS will keep its website updated as this process moves forward.

<http://www.azahcccs.gov/shared/news.aspx#ApplyHEAPlus>

**FAQ: Proving AHCCCS Denial to Apply for Marketplace Coverage**

**Question:** When applying for AHCCCS (Medicaid) through Health-e-Arizona Plus, there's a preliminary eligibility screen that says whether or not they're eligible for AHCCCS. Is that enough proof for the Marketplace to answer the Medicaid question (if they've been denied) or do they need to wait 45 days for the official determination?

**Answer:** The Arizona Alliance of Community Health Centers received confirmation from Mandy Cohen from CMS/CCIIO that the preliminary assessment that the HEA+ application does is enough to answer the question on the Marketplace which asks: “Were any of these people found not eligible to get Medicaid and Children’s Health Insurance Program (CHIP) since October 1, 2013?”

As a safety precaution, advise the consumer to take a screenshot of the preliminary determination as proof, should they need to upload it on the Marketplace.

To take a screenshot, just google “screenshot windows x” (“x” is whatever Windows version you have. If you have Windows 8, you’d google “screenshot windows 8”). If you have Windows 8, I found this link useful- <http://windows.microsoft.com/en-us/windows/take-screen-capture-print-screen#take-screen-capture-print-screen=windows-8>

**More on Proving AHCCCS Denial for Marketplace Coverage**

From Families USA:

A new question has been added to the marketplace application to identify individuals who have been denied eligibility for Medicaid or the Children’s Health Insurance Program (CHIP) since October 1, 2013. This question will help ensure that people who are not eligible for Medicaid or CHIP will not be incorrectly assessed as eligible and, as a result, experience a delay in receiving financial assistance for a marketplace plan.   
  
Alternatively, if you are helping a consumer who has not yet heard back from his or her state Medicaid or CHIP agency, you can call the federal call center hotline and ask a representative to set up a three-way call with the state agency to find out the status of the consumer’s application.

**Overview of the New Change in Circumstances Functionality on HealthCare.gov**

Last week, the federal government implemented new Marketplace functionality on Healthcare.gov and through the Call Center that now allows consumers to report changes in their lives and households throughout the year, and also allows consumers to make changes to their application through Healthcare.gov.

The new functionality is sometimes referred to as consumer-initiated changes or change in circumstances (CiC) functionality.  Now consumers can report changes directly to the Marketplace through MyAccount in Healthcare.gov. Note that changes which do not impact eligibility, such as an address change within the same zip code, should be reported to both the Marketplace and the insurance company. The new functionality and corresponding process replaces the interim process detailed to assisters in January as the federal government worked to improve Healthcare.gov, where consumers in the short term were to contact their insurance company directly to add dependents as a result of birth, adoption, or placement for adoption or foster care and make the change with the insurance company.  Now consumers should report these changes directly to the Marketplace.

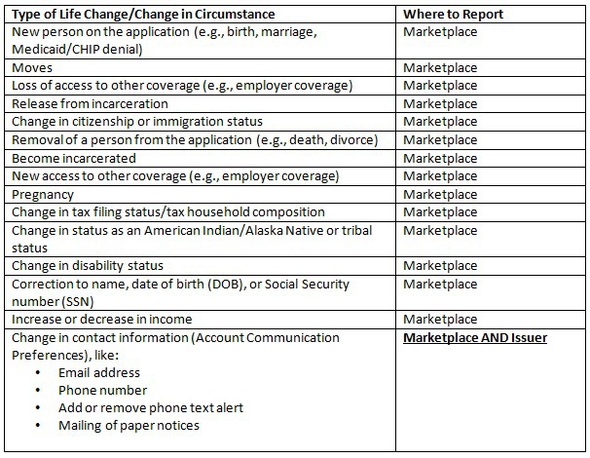
Now that this new functionality exists allowing a consumer to be able to report all changes directly to the Marketplace, the federal government encourages all assisters to inform consumers that they should now use this new functionality.

It is no longer necessary for consumers to “remove” their applications and start over in order to edit submitted information.  The federal government now strongly encourages all consumers to report a change in their existing application through their MyAccount using the “Report Life Changes” functionality.  If consumers believe their resulting eligibility determination is incorrect due to system errors, and they have not yet selected a plan, they can consider “removing” and restarting their application.  Again, it is important to note that in some cases, some changes a consumer makes may result in (1) changing a consumer’s eligibility determination, (2) the consumer’s receiving a Special Enrollment Period eligibility determination, or (3) different premiums AND/OR coverage dates as a result of these changes.

It is important to note that some changes a consumer will report to the Marketplace may make them eligible for a special enrollment period (SEP). (See more on SEPs, below.) A SEP will allow them to either change their Marketplace plan enrollment or enroll in coverage for the first time. Also, it is important to note that some changes a consumer may report may also affect their eligibility for Medicaid, CHIP, and the advanced premium tax credit (APTC), including the amount of the APTC the consumer receives.

**Reportable Changes**

The table below shows examples of the changes in circumstance and where to report the changes. Again, remember that all of the changes that a consumer must report to the Marketplace (except the Account Communication Preferences, e.g. change in contact information) may result in changes to a consumer’s eligibility, premium and coverage effective dates.



**Process**

The consumer should follow the below process to report changes in circumstance through Healthcare.gov.

1. To make a change, a consumer should go to Healthcare.gov and log into his or her MyAccount.  The consumer should click the “Report a Life Change” button (NOTE: this button is only enabled for consumers who have already submitted an application).
2. Next, the consumer will see a page with information about the types of changes that must be reported to the Marketplace or both the Marketplace and the issuer. Please note that changes to Account Communication Preferences only (e.g. phone number, email, and notification preferences) are not transmitted to the issuer. Consumers **must** update these communication preferences with their issuer, in addition to updating their Marketplace preferences.
3. Next, the consumer will be shown a pre-populated version of their application, based on information and attestations from their previously submitted application.  The consumer will go through the application and, for every page, either make a change (e.g. add or remove members) or click “confirm” if no changes need to be made.  While completing the application, the consumer may also find a few new questions have been added.
4. If the consumer is eligible for a SEP, the consumer’s eligibility determination notice will contain information regarding their eligibility for a SEP.  The consumer can then enroll in a new plan if they want to.  The notice will also contain the consumer’s SEP end date, which is the last day consumers have to select a plan.  Consumers not granted a SEP will not be able to change to a different plan.
5. QHP-eligible consumers then proceed to the enrollment to-do list page, even for those who have already enrolled.
6. The consumer may set the amount of APTC the tax household will use, if eligible for APTC, and must select a plan (or re-select and confirm his or her current plan, depending on the situation).
7. The consumer can set and adjust the amount of APTC, regardless of SEP eligibility. Any eligible consumer can slide the bar to get their maximum or less than their maximum APTC amount.  Please note that the only way to get to the APTC page is to go all the way through a consumer’s application, verifying the pre-populated information by clicking “confirm” as described in Step 3.
8. Consumers eligible for SEPs can select any plan they want from all QHPs available in their service area, as if they were enrolling for the first time.  If consumers still qualify for their existing plan, and they want to keep it, they can select it again here. If a consumer doesn’t remember his or her current plan, he or she can see it in My Plans and Programs. Consumers not eligible for a SEP will be limited to confirming only their existing plan.
9. Once the consumer selects or confirms a plan, the Marketplace will automatically notify the insurance company of the confirmed plan.   A consumer MUST confirm a plan to make sure their new eligibility changes actually go to the issuer. There is no other way for the issuer to know of the changes to eligibility and enrollment.
10. The final screen allows consumers to pay. However, the green “pay now” box only appears in cases where the issuer accepts online payment.

Consumers can see their current and past enrollment under My Plans & Programs by clicking “My Plans & Programs” in upper right corner of screen).

**Special Enrollment Periods (SEPs)**

* A SEP allows a consumer to enroll in health coverage and have it be effective, outside of a normal enrollment period.
* Certain limited situations will allow consumers to receive a special enrollment period.
* Consumers have 60 days from qualifying life event or other circumstance that initiates a SEP to select and enroll a plan.
  + - <https://www.healthcare.gov/what-if-my-current-individual-plan-is-changing-or-not-being-offered-in-2014/>
    - <https://www.healthcare.gov/how-can-i-get-coverage-outside-of-open-enrollment/>
    - <https://www.healthcare.gov/help/losing-health-coverage/>
    - <https://www.healthcare.gov/help/what-to-do-if-you-move-out-of-state/>
* Types of SEPs: Other Circumstances
  + Other limited circumstances, beyond qualifying life events, that consumers may be experiencing during the initial Open Enrollment which makes them eligible to receive a SEP include:
    - Enrollment errors
    - Exceptional circumstances
    - Misrepresentation
    - Benefit Display errors
    - These SEP types are handled through a special process and are not initiated through the qualifying life change reporting process.
  + Enrollment Errors
    - Enrollment errors occur when the consumer chose a plan by the appropriate deadline but the enrollment either wasn’t processed timely or the insurance company says it doesn’t have the enrollment.
    - Examples of enrollment errors:
      * Missing enrollment records: This is when the Marketplace’s data shows that a consumer has chosen a plan, but the consumer isn’t in the insurance company’s enrollment system.
      * Defective enrollments: These are other general errors where an enrollment is received by the insurance company and may be processed by the plan, but the enrollment file contains defective or missing data which makes the insurance company unable to enroll the consumer.
  + Exceptional Circumstances
    - Exceptional circumstances include serious situations that prevent a consumer from enrolling in a plan by the appropriate deadline, such as:
      * A serious medical emergency: This includes situations like an unexpected hospitalization or a temporary cognitive disability that caused a consumer to be incapacitated.
      * Natural disasters: This includes situations like an earthquake, massive flooding, or hurricanes that occurred in a timeframe that prevented the consumer from enrolling in a timely manner.
  + Misrepresentation
    - This is a determination that misconduct of misinformation by individuals or entities providing formal enrollment assistance (like an insurance company, navigator, certified application counselor, call center representative, or agent or broker) resulted in a failure to enroll the consumer in a plan, or an enrollment error for the consumer, including situations where the consumer:
      * Is enrolled in the wrong plan
      * Does not receive the premium tax credit or cost-sharing reduction (CSR) when he or she is eligible.
    - Consumers impacted by alleged misrepresentation or misleading on the part of a plan, their representative, or insurance agent, should also report the alleged misconduct to their State Department of Insurance
      * <http://www.azinsurance.gov/aca/index.html>
  + Benefit Display Errors
    - Benefit display errors will be identified after CMS investigates potential display discrepancies raised by issuers or consumers, or noticed by CMS
      * Display errors could include premiums, benefits, or copay/deductibles.
  + General Process for Other Circumstances SEPs
    - The first step to initiate the process to receive an SEP in these circumstance is for the consumer to call the federal Call Center and indicate the need for a special enrollment period.
    - If a consumer chooses to switch plans from a SEP, any out-of-pocket costs that the consumer paid for coverage under the first plan would not count towards the new plan’s deductible or out-of-pocket maximum.

**Network Adequacy and Advocacy**

From Community Catalyst:

As millions of people begin to use their new health insurance plans, there will be an increased focus on the benefits provided to consumers, access to those benefits, and how consumers feel about their available providers. These are all components of network adequacy and an area where advocates are positioned to weigh in.

Network adequacy is the ability of a health plan to give enrollees timely access to enough in-network providers, including primary care and specialty physicians, as well as other important health care services. We are now seeing many states struggle with [networks](http://www.newrepublic.com/article/115991/obamacare-insurance-plans-cedars-sinai-hospital-limits-many) that may not meet the needs of consumers.

The ACA outlines network adequacy criteria, but these standards are not specific. Consumer advocates have an opportunity to push for more robust network adequacy standards.  To support this work, Community Catalyst has developed a number of materials to guide consumer advocates:

* [**Network Adequacy: What Advocates Need to Know**](http://www.communitycatalyst.org/resources/publications/document/Network-Adequacy_what-advocates-need-to-know_FINAL-01-28-14.pdf). This brief provides an overview of network adequacy requirements outlined in the ACA for qualified health plans (QHPs) and other standards in private insurance markets, Medicaid, and Medicare.
* [**Finding Common Ground: Network Adequacy Principles**](http://www.communitycatalyst.org/resources/publications/document/Principles-for-Network-Adequacy-FINAL-01.28.14.pdf)**.** This document provides a set of network adequacy principles to unite consumer groups in their advocacy for network adequacy standards that ensure affordable access to the highest quality providers.
* [**Educating Policymakers about Network Adequacy – Talking Points for Advocates**](http://www.communitycatalyst.org/resources/publications/document/Network-Adequacy-TPs-Educating-Policymakers.docx). These talking points help explain the issue to policymakers and can be tailored to your state.
* [**Improving Network Adequacy: Ideas for Advocacy Strategies.**](http://www.communitycatalyst.org/resources/publications/document/Improving-Network-Adequacy-Ideas-for-Advocacy-Strategies-FINAL-02-18-14.pdf) This brief highlights important steps during the planning phase and ideas for advocacy strategies to help advocates in this work.

**Encouraging Consumers to Report Changes in Income, Other Changes**

From Families USA:

Consumers who have submitted their application can now report changes in their information by signing in to their account and clicking on the “Report a Life Change” button. Changes that consumers can report include adding or removing a family member, gaining or losing coverage through a job, and changes in income. If consumers need to change their contact information, such as an email address, phone number, or preferences for electronic or paper notices, they will need to report these changes to their health plan directly in addition to reporting them to the Marketplace.   
  
Assisters and other helpers are encouraged to talk with consumers about the importance of reporting changes to the marketplace as soon as they happen, including explaining how life changes can affect the [amount of financial assistance](http://fusa.convio.net/site/R?i=s83JtLmPmuY-JhrS5MtoFg) consumers can receive. Now, you can also show consumers exactly how to report changes online.

**Naturalized Citizenship Verification**

Naturalized or derived citizens who do not have a Naturalization Certificate or a Certificate of Citizenship can upload their U.S. Passport as supplemental documentation for citizenship verification.

<https://www.healthcare.gov/help/citizenship-and-immigration-status-questions/>

**Latinos and the Marketplace**

In our state, there are 367,000 Latinos who are uninsured but eligible for the Marketplace or Medicaid. We rank fifth among states in the number of eligible but uninsured Latinos. The Phoenix area ranked 9th among metropolitan areas nationally in the number of uninsured, eligible Latinos. Eight-in-ten eligible but uninsured Latinos nationally qualify for Medicaid, CHIP or Marketplace tax credits.

Find the full report here: <http://aspe.hhs.gov/health/reports/2013/UninsuredLatinos/rb_uninsuredLatinos.pdf>

**AHCCCS Applications and Dependents Living in Mexico**

In most situations, children living in Mexico are not part of an applicant’s household (they do not live together), nor are they temporarily absent from the customer’s U.S. home (they live permanently in Mexico), so they should not be included on HEAplus screens.

However, you do need to enter the children living in Mexico on the Tax Filing screens in HEAplus if your customer is expecting to claim the children on his/her federal tax return.  This is very important now that the Affordable Care Act requires a new eligibility determination rules based in part on tax filing status which impact the customer’s family size and income standard.  HEAplus does not treat children who live in Mexico any differently than any other dependents that the customer plans to claim on their tax return who do not live with the customer.

You do not need to enter a SSN for the children who live in Mexico if they do not have one. HEAplus does not require entry of a SSN.   For tax filing purposes only, a TIN can be requested and used for children living in Mexico.  Do NOT enter the TIN in the SSN field.

It is not necessary to provide SSNs or birth certificates for persons who do not live with the customer and are not applying for benefits. Children who live in Mexico cannot qualify for AHCCCS, Nutrition Assistance or TANF because they do not live with the customer and they do not live in Arizona.  If the customer is claiming the child as a qualifying relative for tax purposes, the customer must be aware of any income the child has directly or from someone else so that the customer knows that he/she meets the support test for the child. So, questions about the child’s income are not unreasonable.

The medical portion of the HEAplus Marketplace was designed to align with the Federal Marketplace, and questions are very similar, so if you can explain the “rift” it would be helpful.

Here is information from IRS:

**Child in Canada or Mexico.** You may be able to claim your child as a dependent even if the child lives in Canada or Mexico. If the child does not live with you, the child does not meet the residency test to be your qualifying child. However, the child may still be your qualifying relative. If the persons the child does live with are not U.S. citizens and have no U.S. gross income, those persons are not “taxpayers,” so the child is not the qualifying child of any other taxpayer. If the child is not the qualifying child of any other taxpayer, the child is your qualifying relative as long as the gross income test and the support test are met.

You cannot claim as a dependent a child who lives in a foreign country other than Canada or Mexico, unless the child is a U.S. citizen, U.S. resident alien, or U.S. national. There is an exception for certain adopted children who lived with you all year. See [*Citizen or Resident Test*](http://www.irs.gov/publications/p501/ar02.html#en_US_2013_publink1000220881), earlier.

**Example:** You provide all the support of your children, ages 6, 8, and 12, who live in Mexico with your mother and have no income. You are single and live in the United States. Your mother is not a U.S. citizen and has no U.S. income, so she is not a “taxpayer.” Your children are not your qualifying children because they do not meet the residency test. But since they are not the qualifying children of any other taxpayer, they are your qualifying relatives and you can claim them as dependents. You may also be able to claim your mother as a dependent if the gross income and support tests are met.

**Marital Status Changes and the Marketplace**

From Community Catalyst (*In the Loop*):

There are a lot of questions from the enrollment assistance community about individuals who are [separated](http://enrollmentloop.us7.list-manage1.com/track/click?u=aedff476eafc201cb10f0a05b&id=dff53bce29&e=9e4ceaa378) or [estranged](http://enrollmentloop.us7.list-manage.com/track/click?u=aedff476eafc201cb10f0a05b&id=c65e6ba433&e=9e4ceaa378) from their spouses. To get Advanced Premium Tax Credits (APTCs), the ACA requires an individual who is married to file taxes jointly with one’s spouse, except in limited circumstances. One important note to keep in mind – it’s a consumer’s marital status on **December 31st** of the relevant tax year (e.g. for this open enrollment, its 12/31/14). So what are the options for individuals estranged from their spouses?

**Obtain a divorce or legal separation by the end of 2014.** If an individual expects to be legally separated or divorced by the end of 2014, the individual could indicate filing taxes singly on the application. But a court must grant formal legal separation, it cannot merely be a physical separation.

**File as a “Head of Household.”** A person who is married but does not wish to or cannot file taxes with a spouse may qualify to file as a “[Head of Household](http://enrollmentloop.us7.list-manage.com/track/click?u=aedff476eafc201cb10f0a05b&id=e0957ea6b5&e=9e4ceaa378)” (HOH), which allows receipt of APTCs. To file as HOH, a consumer must have a qualifying person living with the HOH for more than half the year (usually a dependent child but some other dependents qualify as well), pay more than half the cost of keeping up the home, **and** have been living apart from the spouse for the last six months of the tax year. The FFM application, however, does not allow a consumer to designate HOH status so a consumer seeking to claim this status likely will have to file an appeal.

Those who cannot meet option 1 or 2 will not receive ATPCs. Many have already raised the need for alternative solutions for consumers who cannot meet either option, such as [victims of domestic violence](http://enrollmentloop.us7.list-manage1.com/track/click?u=aedff476eafc201cb10f0a05b&id=4f5d37d3ac&e=9e4ceaa378). Federal policymakers are aware that this is a problem. Further guidance may be forthcoming from the IRS but as of yet, no decisions have been made. So at this point, the only way to get ATPCs if married remains to file jointly, obtain a divorce or legal separation, or file as a head of household.

**Webinars**

**“Health Care for Immigrant Families in the Affordable Care Act Era”**

**Thursday, February 20, 2014, 1-2:30PM EST (11AM-12:30PM AZ time)**

The webinar will reexamine the health care reform law and ACA-related regulations that affect immigrants’ eligibility, as well as the **barriers immigrants face** when trying to access ACA programs, particularly if they are part of mixed–immigration status families. Webinar participants will also learn which **immigrant eligibility rules** have *not* changed. They should come away from the webinar with a basic picture of the **range of coverage options** that are available to immigrant families as the ACA open enrollment period approaches its end on March 31, 2014.

[https://attendee.gotowebinar.com/register/6502576993951802113](http://org.salsalabs.com/dia/track.jsp?v=2&c=t85zVV11R%2B%2BiEzOPJ1y42A31a0zqehSA)

**“Helping Consumers Pick a Plan that Will Meet their Health Needs”**

**Wednesday, February 26, 2014; 1:00PM ET (11AM AZ time)**

This webinar is designed to help you think through what types of questions to ask consumers as they go through the plan selection process. Listen as one of your peers’ talks about her process for helping consumers choose a plan that’s right for them. In addition, two national experts will highlight important questions to ask consumers pertaining to dental coverage, as well as questions to think through when assisting people with disabilities.

<https://cc.readytalk.com/cc/s/registrations/new?cid=ynljimmxfd7c>

**“Beyond the Basics of Health Reform: Diving Deep on Commonly Encountered Eligibility and Enrollment Issues”**

**Wednesday, February 26, 2014; 2PM-3:30PM ET (12PM-1:30PM AZ time)**

This webinar will focus on three topics that have frequently arisen during open enrollment:

* Coverage options for people who have the option of COBRA coverage
* Applying for health coverage for young adults and students
* New Healthcare.gov functionality to report changes in circumstances and how the recalculation of premium tax credits and cost-sharing reductions will work.

<https://www4.gotomeeting.com/register/661862495>

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Have something you want us to possibly add to next week’s newsletter? Email Kim VanPelt at [kim.vanpelt@slhi.org](mailto:kim.vanpelt@slhi.org).