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 March 17th

**Marketplace Enrollment Hits 5 Million Mark Nationally**

Monday, the federal government announced that enrollment nationally hit the 5 million mark.

**Consumer Assistance in Other Federally Facilitate Marketplace States**

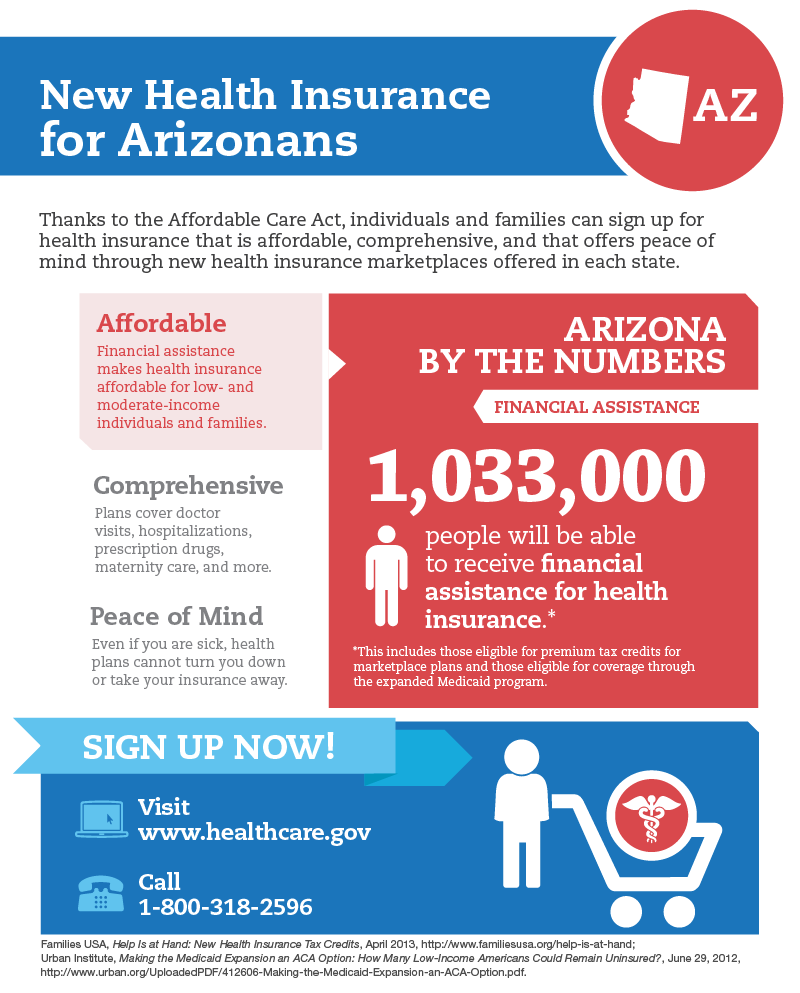
Many states that are utilizing a Federally Facilitated Marketplace (FFM) or that established a marketplace in partnership with the federal government are working to minimize the potential for consumer confusion by coordinating with federal systems and building on their historical experience to regulate and deliver health insurance to their residents. This brief explores ways in which states other than Arizona are sharing the responsibility of consumer assistance with the federal marketplace in three key areas: marketing and advertising initiatives, the work of navigators and other in-person assisters, and the development of a system for eligibility decision appeals.

This brief released in January from the National Academy of State Health Policy (NASHP) provides specific examples of states’ experiences providing consumer assistance, and illustrates some of the ways that FFM and state partnership states can work with their existing consumer assistance structures and with the federal government to help consumers find their way in a new coverage landscape.

http://www.nashp.org/sites/default/files/Shared\_Responsibility\_in\_Consumer\_Assistance.pdf

**Infographic for Arizona**

Here is great new infographic from Families USA.



You can download it at: http://familiesusa.org/sites/default/files/product\_documents/\_ACA\_Enrollment\_Financial-Assistance\_final\_Arizona.png

**Attitudes on Health Reform**

Recent polling from the Urban Institute explore consumer opinions of the Affordable Care Act, including the opinions of the uninsured. Among the findings:

* Americans most likely to have an unfavorable view of the ACA are in the middle- and higher-income groups, have private insurance, are in very good/excellent health, are white, and live in rural areas. Those most likely to have no opinion are the groups most likely to benefit from the law—those in fair/poor health, those with lower incomes, the uninsured, nonwhites and Hispanics, high school graduates (or less), and the young.
* Those living in states that have adopted the Medicaid expansion or that have a state-based Marketplace were less likely to have an unfavorable opinion of the law than those living in other states.
* Large proportions of uninsured adults, particularly whites and middle-income adults, were more likely to have an unfavorable than a favorable opinion of the law. In addition, the uninsured most likely to benefit from the ACA (e.g., lower- and middle-income adults, including nonwhites and Hispanics) expressed only weak support for it and were more likely to have no opinion than to have a favorable view.

The full report can be found at: <http://hrms.urban.org/briefs/aca-opinions.html>

**More Social Media Aimed at Encouraging Young Adults to Get Covered**

A new video features the moms of Jonah Hill, Adam Levine, Jennifer Lopez and Alicia Keys, encouraging young adults to get covered.

<http://www.usmagazine.com/celebrity-moms/news/michelle-obama-teams-up-with-moms-of-jennifer-lopez-adam-levine-others-for-yourmomcares-video-2014143>

**Facilitating Access to Health Coverage for Juvenile Justice-Involved Youth**

The National Academy of State Health Policy (NASHP) has released a new report on improving access to coverage for juvenile justice-involved youth.

As states and juvenile justice stakeholders work to facilitate health coverage and access for system-involved youth, they can draw upon the experiences of their counterparts across the country to improve eligibility, enrollment, and outreach processes. Medicaid eligibility strategies in several states have already facilitated seamless coverage for juvenile justice-involved youth, and consumer assistance programs created by the Affordable Care Act (ACA) will provide additional resources to support continuity of care. Key to the success of these strategies will be ongoing collaboration between the multiple state and federal agencies that interact with the juvenile justice population.

See more at: <http://www.nashp.org/publication/facilitating-access-health-coverage-juvenile-justice-involved-youth#sthash.XNCm6NWb.dpuf>

**New Insurance Rights for Same-Sex Couples**

Addressing gay and lesbian concerns, the Obama administration Friday moved to expand health insurance access for same-sex couples and close a loophole that threatened to leave some HIV/AIDS patients without coverage.

In separate announcements, the Health and Human Services Department said:

— Insurers offering spousal coverage for heterosexual couples must also provide it to legally married couples of the same gender.

— Insurers cannot turn down HIV/AIDS patients whose premiums are being paid through the federal Ryan White program.

The administration acted after gays and lesbians complained about confusing rules on spousal coverage in the new health insurance exchanges, particularly in states that do not recognize same-sex marriage.

HHS also countered a move by insurers in Louisiana to stop accepting premium payments made by the federal Ryan White program on behalf of HIV/AIDS patients.

The insurers, who said they were relying on another federal policy that discourages third parties from paying premiums for individuals, wound up in federal court after advocates filed suit. The issue is seen as a national test of whether insurance companies will be able to continue avoiding costly patients. President Barack Obama's health care law requires insurers to take all applicants, regardless of their medical history.

The new rule says insurers must accept third-party premium payments from the Ryan White and other federal and state programs.

The policy on coverage for same-sex spouses takes effect next year and applies to plans offered in the health care law's new insurance markets. It also covers many — but not all — individual and employer plans offered outside that marketplace.

The administration said it intends to make coverage "more accessible and equitable for married same-sex couples." It's part of a government-wide effort to codify the rights of same-sex spouses. That follows the Supreme Court decision last year striking down the federal Defense of Marriage Act, which opened the way for same-sex spouses to receive government benefits.

The new HHS policy says that if an insurance company offers spousal coverage to heterosexual couples, it must also provide that benefit to same-sex couples who were legally married in a jurisdiction that recognizes marriage between people of the same sex.

The administration is urging insurers to voluntarily comply with the same-sex rule right away. It will be a requirement for coverage starting Jan. 1, 2015, or later.

Many large employer plans are already operating under similar rules issued last fall by the Labor Department. These are so-called self-insured plans in which an employer sets aside its own money to cover most of the expected medical costs of workers. Self-insured employers generally hire an insurance company to administer their benefit plan.

The new rules apply instead to plans that are sold directly by insurance companies to individuals and employers, usually small to mid-sized companies.

There are exceptions:

—"Grandfathered" plans that were in existence when the health law passed four years ago and have changed very little since then do not have to offer coverage to same-sex spouses. Those plans, however, represent a dwindling share of the market.

—The new policy does not apply to Medicaid coverage for low-income people. The administration encourages states to offer Medicaid benefits to same-sex spouses, but state authorities have the final say.

Separately, HHS issued another one-month extension for the Pre-Existing Condition Insurance Plan, known as PCIP. Patients in the temporary program will now have until April 30 to find a new policy. PCIP was created as a transitional program for people turned down for coverage because of health problems.

Source: <http://abcnews.go.com/Health/wireStory/health-insurance-rights-sex-couples-22914765>

# Payment Is Required to Complete Plan Enrollment

From HHS:

We want assisters to remind consumers that the final step of enrollment is for the consumer to make their first premium payment.  Consumers must pay their premiums in order to have health insurance coverage.  Consumers who select a plan should be reminded to:

1. Pay their contribution to the first month's premium (and every premium when it is due) to their plan directly – not to the Marketplace. After the consumer selects a plan they will either see a link to the insurance company’s website or instructions on how to pay their premium payments to their insurance company. Consumers should check with their insurance company to find out when their first premium is due. Note: The plan’s payment deadline cannot be any earlier than the day before coverage begins. For example, for coverage beginning April 1st, the earliest permissible payment deadline is March 31st.
2. Carefully review their member card or other materials the plan sends to them.  This should include confirming which members of the household will be covered by the plan.
3. Review their plan’s provider directory for 2014 and decide who will provide them care. Please note that this should also be done immediately before selecting a plan.
4. Contact their plan with any questions or if they don’t receive a member card.

Consumers who enroll between now and March 15th will have coverage that begins April 1st.  Consumers who enroll between March 16th and March 31st will have coverage that begins May 1st.

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# Check Provider Networks Before Enrollment

From HHS:

With just a few weeks left in the open enrollment period, assisters can help consumers avoid a common problem related to health insurance benefits. Some consumers wait until they are enrolled in a plan before they check to see if their doctors are in network. However, it is very important that consumers do this before enrolling in a plan because it is not uncommon for doctors to go in and out of provider networks for a variety of reasons. Assisters should remind consumers to make sure their doctor is in the plan’s network before they enroll to make sure that the doctor is not just part of any network offered by the insurance company but is part of the network of the specific plan they are considering. The best way to do this is for consumers to call their doctor as well as the insurance company to make sure the doctor is in the network.

This will help consumers avoid “plan remorse” when they realize after enrollment that the network coverage doesn’t meet their needs. By then, in most cases it will be too late to change plans. Dissatisfaction with network coverage does not make a consumer eligible to switch plans. There are a narrow set of circumstances under which this may be permissible, and we are exploring options to handle those situations.

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# Enrolling Twins

# From HHS:

We’ve heard recently that some consumers with twins (or other dependents on an application with the same name and date of birth) are having difficulty enrolling those twins.  The Marketplace system was having difficulty sending multiple individuals with the same birth date to the insurance company so both twins weren’t always enrolled.  We recently updated the Marketplace system to be able to enroll consumers with the same birth date so this should no longer be an issue.  For those consumers who could not get both twins enrolled, but had both twins on the application, they should go to their insurance company to add the second dependent to the plan.

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# FAQs of the Week

# PLEASE NOTE THAT THE FAQ (Q1) PROVIDED BELOW IS A CORRECTION TO A PREVIOUS FAQ contained in Covered Clips.

**Q1: I’m separated (or otherwise estranged from my spouse), and have filed for divorce. If I don’t plan to file taxes jointly with my current spouse, how can I apply and potentially be determined eligible for tax credits and cost-sharing reductions?**

A1: According to IRS rules, if you’re married, you must file jointly in order to receive advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSR). When submitting your application or making a change to your application, you must attest to whether you are currently married and planning to file jointly. HHS rules specify that you must tell the Marketplace if you are currently married, even if you plan to be legally divorced later in the year. In accordance with IRS rules, if you attest to being married and filing separately, you will not qualify for APTC or CSRs. Please note that if you are considered unmarried under IRS rules (26 CFR 1.7703-1(b)) at the time of submitting your application or changes to your application, you should attest to your unmarried status, and may qualify for APTC and CSRs.

If your circumstances change during the year and you are no longer married in accordance with IRS rules (e.g. your divorce decree is finalized), then you need to report that change to the Marketplace so that your eligibility can be re-determined with the new information. At that time you may update your application to attest to being unmarried and are planning to file as an individual.  To update your application, select “Report a Life Change” in My Account on HealthCare.gov, and review your application, revising answers as necessary.  At tax time, the IRS will reconcile the information and determine whether you are eligible for more or less tax credit for the year based on your filing status and income.

**Q2: I am enrolled in a QHP but just had a baby. How do I get insurance coverage for my baby and when does coverage start?**

A2: You are now able to report life changes, such as adding a new family member through birth, adoption, placement for adoption or foster care, directly through the Marketplace. You should log into your account and click the “Report a Life Change” button. This particular life change also triggers a Special Enrollment Period (SEP) that allows you to select a new QHP. The SEP applies to your whole family not just to your new baby. The same SEP option applies to consumers reporting an adoption or placement for adoption or foster care. In all these cases, the consumer may select a plan on any day of the month. The effective date of the newly-selected QHP is the day the child was born, adopted, or placed for adoption or foster care. Consumers have 60 days from the qualifying life event to select and enroll in a plan.

**Q3: What does it mean to be “incarcerated?” For example, are individuals serving a sentence but allowed work release or individuals being held pending bond or sentencing considered incarcerated and therefore not eligible for Marketplace coverage?**

A3: According to section 1312(f)(1)(B) of the ACA, for purposes of eligibility for enrollment in a QHP, “An individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges.”  For purposes of Marketplace coverage, “incarcerated” means individuals convicted of a crime (felony or misdemeanor) and confined to a correctional institution. Individuals serving a sentence but allowed work release are still considered confined until release and therefore considered incarcerated. Individuals being held pending bond have not been convicted and can be released as soon as they can pay their money for bail.  These individuals are not considered incarcerated based on Marketplace rules or electronic verification. Those individuals being held pending sentencing have been convicted and would be considered incarcerated based on Marketplace rules.

**Q4: Some consumers have reported that the Marketplace is incorrectly flagging them as being incarcerated based on information received from electronic data sources, which would make them ineligible for enrollment in a QHP. How can a consumer resolve an inconsistency related to incarceration status?**

A4: Marketplaces verify incarceration status using data from the Social Security Administration (SSA) Prisoner Update Processing System, the only national-level database that includes incarceration information reported from federal, state and local correctional facilities and agencies that CMS has access to for the purposes of this verification. Consumer information is verified against these data using a combination of name, date of birth and social security number, all of which are mandatory matching elements. SSA is not the source of record of this information and cannot resolve erroneous records of incarceration.

The Marketplace is aware that the release dates in these incarceration records are not always up to date, but generally are not more than two years out of date. The Marketplace is also aware that in rare cases consumers assert to never having been incarcerated. To address this, the Marketplace has modified the list of Marketplace documentation to include those documents that demonstrate that the consumer is living or active in the community, and therefore not incarcerated, so that consumers without release documents are able to resolve the inconsistency as quickly as possible.

When an inconsistency does occur between an applicant attestation of non-incarceration and the results of the electronic verification, consumers will be able to provide the Marketplace documentation that they are not incarcerated. A consumer’s ability to enroll in a plan and receive APTC/CSRs is not impacted during this period. If the consumer does not provide additional satisfactory documentation, they will lose their eligibility to enroll in a QHP. The consumer should not attempt to contact SSA directly to resolve the inconsistency, as SSA is unable to resolve the discrepancy and is simply maintaining the data reported by federal, state and local correctional facilities and agencies.

To resolve the situation, a consumer should upload documents to “My Account” on [HealthCare.gov](http://healthcare.gov/) or mail the information to: Health Insurance Marketplace; Dept. of Health and Human Services; 465 Industrial Blvd.; London, KY 40750-0001. The types of documents accepted include:

1) Release papers showing the date of incarceration and release in cases where the individual was incarcerated; or 2) Documents that show that the consumer is living in the community and is not incarcerated such as:

* Unexpired State ID
* Driver’s License
* Work ID
* Passport
* Paystubs
* Cell Phone Bill
* A lease that covers the benefit year or a rent receipt
* Federal, State, or Local benefit letter
* Bank or Credit card statement showing transaction history
* Clinic, doctor, or hospital records or bills for services provided
* Medical claim explanation of benefits provided
* School record/schedule showing enrollment
* Military Record
* Signed notarized statement from individual with alleged false incarceration inconsistency indicating they are living in the community; the statement must include the individual’s name, date of birth, address and phone number
* Written statement from someone within the community which states the name, date of birth, address, phone number, and their relationship with the individual with alleged false incarceration inconsistency and that the individual is present and participating within the community
* A written explanation of circumstances as to why the applicant does not have any of this documentation

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# Enrollment for Immigrant Families

# From HHS:

In response to direct feedback from national partners, community advocates, and the in-person assister network, we have worked and continue to work to improve the enrollment process for immigrant families.  Here are two updates for you regarding: 1) “Yellow Screen”; and 2) new and streamlined resources.

Over the last few weeks, some consumers have reported receiving a “yellow screen” at the end of the application, preventing consumers from successfully submitting their application.

The ‘Verification System Currently Unavailable’ Screen, known more commonly as the “yellow screen”, will appear at the end of the application when a data source (IRS, Social Security Administration or Department of Homeland Security) that is used to verify information entered on the application is unavailable.  This may be due to the Hub being down, the data source itself being down, or an error with the way the system handles the response received from a data source.

Some consumers reported seeing the “yellow screen” repeatedly when returning to their application to try to submit it again.

Recently a blocker for consumers who were repeatedly receiving this screen when returning to the application was fixed; **these consumers should go back into their application and try to submit their application again.**

New Resources Section for Assisters: “Immigration Issue Resources” on  Marketplace.cms.gov

Under the section “Resources for Assisters”, there is a new section entitled: “Immigration Issue Resources” (<http://marketplace.cms.gov/help-us/2-partner-with-us.html>).

This section includes the following resources:

* [Electronic Verification of Immigration Status](http://marketplace.cms.gov/help-us/electronic-verification-of-immigration.pdf) – clarifies that consumers can verify their status using only an alien number or I-94 number on HealthCare.gov.  A consumer-facing prompt will be added in the coming days.
* [DHS ICE: Clarification of Existing Practices Related to Certain Health Care Information (Immigration status) (English)](http://www.ice.gov/doclib/ero-outreach/pdf/ice-aca-memo.pdf) – clarifies that information obtained for the purposes of health coverage will not be used for immigration enforcement purposes.  Additional consumer-facing information will be added in the coming days.
* [DHS ICE: Clarification of Existing Practices Related to Certain Health Care Information (Immigration status) (Spanish)](http://www.ice.gov/espanol/factsheets/aca-memoSP.htm) – same, in Spanish
* [Public Charge (English)](http://www.uscis.gov/green-card/green-card-processes-and-procedures/public-charge) – link to Frequently Asked Questions
* [Public Charge (Spanish)](http://www.uscis.gov/es/noticias/carga-publica-hoja-de-datos) – link to Frequently Asked Questions, in Spanish
* [Citizenship & immigration questions on the Marketplace application (English)](http://marketplace.cms.gov/getofficialresources/publications-and-articles/citizenship-questions-on-marketplace-application.pdf) – provides information on how to answer questions about citizenship and immigration status when filling out a Marketplace application and where to get help, if needed.
* [Citizenship & immigration questions on the Marketplace application (Spanish)](http://marketplace.cms.gov/getofficialresources/spanish-materials/citizenship-and-immigration-questions-spanish.pdf) -  same information as above, in Spanish
* [Remote Identity Proofing, Remote Identity Proofing Failures and Application Inconsistencies](http://marketplace.cms.gov/help-us/remote-identity-proofing-faqs.pdf) - outlines information on identity (ID) proofing and on application inconsistencies—two different topics and two different stages in applying for health coverage through the Federally-facilitated Marketplace (FFM). ID proofing is one of the first steps to set up an online Marketplace account and must be completed in order to submit an online application for coverage through the FFM.  Application inconsistencies occur when some of the information in an application does not match information in data sources used to verify eligibility.

In addition to the Resources section, certain resources are located elsewhere at Marketplace.CMS.gov:

New Fact Sheet: Citizenship Questions on the Marketplace Application

Under Get Official Resources-Publications and Articles, under Fact sheets, there is information for those working with the immigrant community. (<http://marketplace.cms.gov/getofficialresources/publications-and-articles/publications-and-articles.html>)

* Citizenship & immigration questions on the Marketplace application: <http://marketplace.cms.gov/getofficialresources/publications-and-articles/citizenship-questions-on-marketplace-application.pdf>

Resources for Assisters: FAQ on Identity Proofing and Inconsistencies

Under Frequently-asked questions for Application, Eligibility, and Enrollment, we included a document that will help with identity proofing and inconsistencies, and includes additional information about application process and timing.

* Remote Identity Proofing, Remote Identity Proofing Failures and Application Inconsistencies (Federally-facilitated Marketplace): <http://marketplace.cms.gov/help-us/remote-identity-proofing-faqs.pdf>

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# New Resources for Assisters: Cancel and Terminate Plans PPT; Protect Against Fraud Tip Sheet

Cancel and Terminate Plans PPT.The slide deck on Consumer Options to Cancel Plans, Select Different Plans, or Terminate Plans that was presented as part of our Friday assister webinar series has been added to the [Assister page](http://marketplace.cms.gov/help-us/2-partner-with-us.html)on Marketplace.cms.gov.  We hope assisters find this resource useful for their staff as the slides cover many of the latest tips and updates.

The PPT can be found here:  [Consumer Options to Cancel Plans, Select Different Plans, or Terminate Plans – March 7, 2014 (slides)](http://marketplace.cms.gov/help-us/options-to-cancel-select-plans.pdf)

New Tip Sheet on Protecting Against Fraud.We also posted a new tip sheet found here: <http://marketplace.cms.gov/getofficialresources/publications-and-articles/protect-yourself-from-fraud-in-health-insurance-marketplace.pdf>

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# What Consumers May Want to Know About…Health Insurance Terms

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# From HHS:

Studies show that consumers have trouble understanding basic health insurance concepts.  As assisters, you are in an ideal position to educate consumers about common concepts and terms surrounding insurance that have implications for their health and their pocketbooks.

**What are my out-of-pocket costs?**

One of the most common areas of confusion for consumers is understanding the various cost sharing components associated with their health insurance.  The following are some common terms and definitions. (Note: Some of these terms might not have exactly the same meaning for each policy or plan.)

*Co-insurance:* Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan’s allowed amount for an office visit is $100 and you’ve met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

*Co-payment:* A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

*Deductible:* The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your plan won’t pay anything until you’ve met your $1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

*Out-of-network  Co-payment:* A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

*Out-of-Pocket Limit:*The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn’t cover. Some health insurance or plans don’t count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

*Premium:*The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

These common terms and definitions are from the [Uniform Glossary](http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/Summary-of-Benefits-and-Coverage-and-Uniform-Glossary.html). Insurance companies are now required to make this available upon request. The glossary is available in the following languages:

[English](http://www.cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf) [Spanish](http://www.cms.gov/CCIIO/Resources/Files/Downloads/sbc-uniform-glossary-spanish.pdf) [Tagalog](http://www.cms.gov/CCIIO/Resources/Files/Downloads/sbc-uniform-glossary-tagalog.pdf) [Chinese](http://www.cms.gov/CCIIO/Resources/Files/Downloads/sbc-uniform-glossary-chinese.pdf) [Navajo](http://www.cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf) (also available in Oral Translation)

How does it work in a real world situation?

It’s important to remember that consumers want to know the bottom line. That means adding up all the cost sharing amounts and figuring out how it plays out in the real world. The Uniform Glossary includes a breakdown of costs for a yearly plan with a $1,500 deductible, a co-insurance of 20% and out-of-pocket limit of $5,000.

Explaining how consumers and insurers share the costs for coverage can help consumers understand why sometimes the lowest premium isn’t always the best fit for their needs. Buying health insurance isn’t like buying a refrigerator. It’s more like buying a cell phone plan. Just like a cell phone plan, a consumer wants to know what coverage they have and for how many family members at what cost per month and year.

Another tool for consumers is the Summary of Benefits and Coverage, which requires issuers to summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions. People will receive the summary when shopping for coverage, enrolling in coverage (if there are any changes in the “shopper version” summary), at each new plan year, and within seven business days of requesting a copy from their health insurance issuer or job-based plan.

This summary of benefits and coverage will includes a health plan comparison tool for consumers called “coverage examples,” much like the Nutrition Facts label required for packaged foods. The coverage examples illustrate how a health insurance policy or plan would cover care for two common benefits scenarios—having a baby and managing type 2 diabetes.

Helpful Resources

HealthCare.gov’s page on [Using Your New Marketplace coverage](https://www.healthcare.gov/using-your-new-marketplace-coverage/) also includes great information to help a consumer when it comes to seeing a doctor, getting a prescription filled, using emergency services, and other common scenarios.

[The Health Insurance Marketplace: Know Your Rights](http://marketplace.cms.gov/getofficialresources/publications-and-articles/know-your-rights.pdf) is a helpful education tool for assisters to print out and give to consumers. It provides easy-to-understand information about what a plan covers, appealing a health plan decision, requesting coverage of a drug not typically covered by

# Consumer Options to Cancel Plans, Select Different Plans, or Terminate Plans

The Centers for Medicare and Medicaid Services (CMS) has created options for individuals to change or cancel their enrollment in a plan as well as terminate enrollments through the Federally-facilitated Marketplace (FFM).  These consumer options describe how a consumer who would like to change plans may use the Marketplace to enroll in a new plan before the coverage effective date of the previously chosen plan.

Cancel Plans

To cancel plans before the coverage effective date, the consumer should complete the following steps:

* Log into “My Account” on HealthCare.gov;
* Go to “My Plans and Programs”; and
* Select “End/Terminate All Coverage”.

Select Different Plans

To select a different plan prior to the coverage effective date, the consumer should end coverage in the original selection by going to “My Plans & Programs” and selecting “End Coverage.”  (Note that this step will cancel both health and dental plans.)

The consumer should then go to “Eligibility & Appeals” and scroll down to the “Continue to Enrollment” button.  On the Plan Compare section, the consumer should confirm a new qualified health plan and/or dental plan, if desired. (Note that the new selection may have a later start date.)

Regardless of whether the premiums have been paid or not, consumers are allowed to select different plans by canceling enrollment and then re-enrolling into a different plan via HealthCare.gov before the coverage effective date.  As long as it is before the effective date of the plan, consumers can use this option.  However, if consumers have paid the premium, the consumer should contact the issuer for a refund of any premium paid.

Terminating Plans

Consumers may voluntarily terminate their enrollment upon request.  Some common reasons a consumer would want to terminate their enrollment include: obtaining other minimum essential coverage, such as Medicare, Medicaid, or job-based coverage; or qualifying for an exemption from coverage.

To terminate enrollment, the consumer should:

* Log into “MyAccount” on HealthCare.gov and navigate to the “My Plans & Programs” tab;
* Click the “End (Terminate) All Coverage” button;
* Select an effective date of termination that is 14 days from the present date or greater; and
* Click on the red button labeled “Terminate Coverage”.

The red “Terminated” status should then appear above the plan that was terminated.  It is important to note that these steps will terminate the entire enrollment group.  This process will apply when the enrollee represents an enrollment group of 1 or requests termination of the entire enrollment group.   If the enrollee would like to terminate less than a full enrollment group, such as removing one dependent from a plan, the consumer must use the “report a life change” functionality.

Changing Plans after the Effective Date

After the effective date of coverage, there are two options for changing plans:

* Consumers can change plans, if they are eligible for a special enrollment period; or
* Consumers can change plans during the initial open enrollment period after the effective date of their enrollment under certain, discrete circumstances.

If consumers are not eligible for a special enrollment period, they must meet the four criteria for allowing changes in plans after the coverage effective date:

1. Change is to another plan offered by the same issuer;
2. Change is to another plan offered at the same metal level and Cost Sharing Reduction (CSR) level, if applicable (i.e. bronze to bronze, silver to silver, 87% actuarial value (AV) silver plan variation to 87% AV silver plan variation, etc.);
3. Change is made in order to move to a plan with a more inclusive provider network or for other isolated circumstances determined by CMS; and
4. Change is being requested within the initial open enrollment period.

This process can be used for individuals who have paid their first month’s premium and whose coverage is already effective as long as they meet all four criteria. Any changes to plans after the effective date are made through the issuer.

Please be advised that all out-of-pocket costs incurred by the consumer in the initial plan should be credited towards the deductible and annual maximum out-of-pocket cost limit in the new plan. Also, since eligibility is not being re-determined for enrollees, advance payments of the premium tax credit (APTC) amounts will not change. Advanced cost sharing reduction (CSR) amounts will change as CSR amounts are qualified health plan specific. CMS is currently collecting information from issuers to make APTC and advanced CSR payments.

Consumers Who Have Not Paid the First Month’s Premium

Consumers who have not paid their contribution to the first month’s premium and their coverage is past the effective date during open enrollment, should do the following:

* Terminate their coverage in HealthCare.gov;
* Create a new account; and
* Apply again.

In this circumstance, the issuer has cancelled the coverage since the premium has not been paid and the coverage is past the effective date. Please note that HealthCare.gov may not indicate that the issuer has cancelled the coverage.

Please be advised that all out-of-pocket costs incurred by the consumer in the initial plan should be credited towards the deductible and annual maximum out-of-pocket cost limit in the new plan. Also, since eligibility is not being re-determined for enrollees, advanced premium tax credit (APTC) amounts will not change. Advanced cost sharing reduction (CSR) amounts will change as CSR amounts are qualified health plan specific. CMS is currently collecting information from issuers to make APTC and advanced CSR payments.

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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).