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)

Weeks of April 14 and April 21st

**8 Million Have Signed Up for Marketplace Coverage**

Source: KidsWell

Two days after the extended enrollment period came to a close, President Obama announced that 8 million individuals have signed up for private health coverage through federal- and state-run health insurance Marketplaces, claiming a big win for his signature law. The numbers exceed by 2 million the Congressional Budget Office’s projected enrollment figures, but insurers have questioned whether the percentage of young adult signups – coming in at 28% of total enrollees -- will offset costs brought by older, sicker enrollees.

**Ruling: Arizona's Medicaid Expansion Law Can Be Challenged**

From Capitol Media Services

In a major victory for the legislative minority, the state Court of Appeals ruled (Tuesday) that lawmakers on the losing end of last year's Medicaid expansion have a constitutional right to challenge the law and the levy it imposes.

In a unanimous decision, the judges rejected arguments by Gov. Jan Brewer that only the hospitals subject to the levy have the ability to argue that it is a tax and therefore can be enacted with only a two-thirds vote. The assessment got only a bare majority.

More significant, the court rejected Brewer's contention that a simple majority of lawmakers have the constitutional power to decide when a measure needs a two-thirds vote. Appellate Judge John Gemmill said that ignores the actual language of the Arizona Constitution.

He pointed out that the voter-approved mandate for a two-thirds vote spells out that it applies to a host of changes in revenues, including the imposition of any new tax as well as the imposition of any new fee or assessment. It also applies to authorizing any state agency to set fees.

Gemmill said the plan language dictates that if a measure does anything spelled out in that provision, it can be enacted only by a two-thirds majority. He said, in essence, that allowing a simple majority to decide when to impose that two-thirds requirement would undermine the constitutional language.

"We reach this conclusion because the plain language of (the provision) reveals it is a limitation on the legislature's power to pass certain revenue raising measures," Gemmill wrote. Any other interpretation, he said, eviscerates the ability of the constitutional's "ability to act as a limiting provision on the legislature's power."

(Tuesday)'s ruling does not end the matter — and not only because Brewer is likely to seek Supreme Court review.

Even if the high court leaves the ruling undisturbed, all it does is give the go-ahead to the lawmakers opposed to the Medicaid expansion a chance to make their case that the levy — Brewer calls it an assessment — is in fact a tax and therefore subject to the two-thirds vote.

Hanging in the balance is the question of whether the tax on hospitals — an estimated $256 million this coming budget year — can be collected and, by extension, whether there is money for Brewer's Medicaid expansion.

Without that assessment, Arizona lacks the funds to expand Medicaid eligibility and take advantage of federal funds available through the Affordable Care Act.

**CBO Lowered Estimate of ACA Coverage Expansion Costs**

Source: KidsWell

The Congressional Budget Office (CBO) estimated that over the next 10 years, the ACA’s expansion of health insurance coverage will cost $104 billion less than originally projected, largely because of the slowdown of healthcare costs and lower-than-expected premiums. The cheaper premiums are primarily due to narrower networkers, lower payment rates for providers, and more care management. CBO also expects the federal government to see reduced savings of $61 billion for certain provisions it delayed or reduced in scope, such as the individual and employer mandates and the excise tax on high-cost plans. Notwithstanding the new figures, the CBO did not provide an updated estimate on whether the ACA would overall reduce federal deficits, which was last affirmed in July.

**CMS Released Guidance Clarifying Family Planning Related Services**

In a [State Medicaid Director letter](http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-003.pdf), CMS clarified coverage provisions under the optional family planning-related services group, as provided by the ACA. Effective immediately, diagnosis and treatment of sexually transmitted infections will be eligible for Medicaid as family planning related services, regardless of whether family planning was the initial intent of the visit, and contraception visits for men will be treated as a family planning visit, equivalent to how it is treated for women.

**Medicaid and Marketplace Eligibility Changes Will Occur Often**

An article in the April 2014 issue of Health Affairs asserts that changes in income and family circumstances are likely to produce frequent transitions in eligibility for Medicaid and health insurance Marketplace coverage for low- and middle-income adults. Researchers predicts frequent eligibility changes all fifty states if they each were to expand Medicaid. Even in states with the least churning, researchers estimate that more than 40 percent of adults likely to enroll in Medicaid or subsidized Marketplace coverage would experience a change in eligibility within twelve months.

Policy options for states to reduce the frequency and impact of coverage changes include adopting twelve-month continuous eligibility for adults in Medicaid, creating a Basic Health Program, using Medicaid funds to subsidize Marketplace coverage for low-income adults, and encouraging the same health insurers to offer plans in Medicaid and the Marketplaces.

See <http://content.healthaffairs.org/content/33/4/700.full?ijkey=7uOpqBDYqMVdM&keytype=ref&siteid=healthaff>

**As the Economy Improves, the Number of Uninsured Is Falling But Not Because of a Rebound in Employer Sponsored Insurance**

A new study by the Urban Institute finds that while the number of uninsured has fallen nationally in the post-recession period, it cannot be attributed to a rebound in employer-sponsored insurance.

The recession was marked by an increase of almost 6 million uninsured individuals between 2007 and 2010. The losses in coverage were mostly driven by large numbers of individuals losing employer-sponsored insurance, although gains in Medicaid coverage partly offset these losses. The recession caused an increase in the low-income population, a group that tends to have lower employer coverage rates, higher Medicaid coverage rates, and higher uninsured rates than other groups. Increased economic opportunities after the recession between 2010 and 2012 saw this population decrease, and correspondingly saw a decrease in national uninsured rates.

The main contributor to increasing post-recession coverage rates, even with increased employment, was Medicaid, not employer coverage. Employer coverage rates did stabilize after 2010 after long trends of decline predating the recession, but this change was likely caused by provisions in the Affordable Care Act (ACA) that allowed young adults to continue as dependents on parents’ private plans until age 26. Although full-time work increased and joblessness decreased after the recession, employer coverage rates continue to decline for many. This is especially true in small-to-medium firms and in firms that have historically low coverage rates. These firms grew the most among all firms in terms of employment after the recession.

See <http://kff.org/uninsured/issue-brief/as-the-economy-improves-the-number-of-uninsured-is-falling-but-not-because-of-a-rebound-in-employer-sponsored-insurance/>

**Estimates Indicate Rapid Increase in Health Insurance Coverage under ACA**

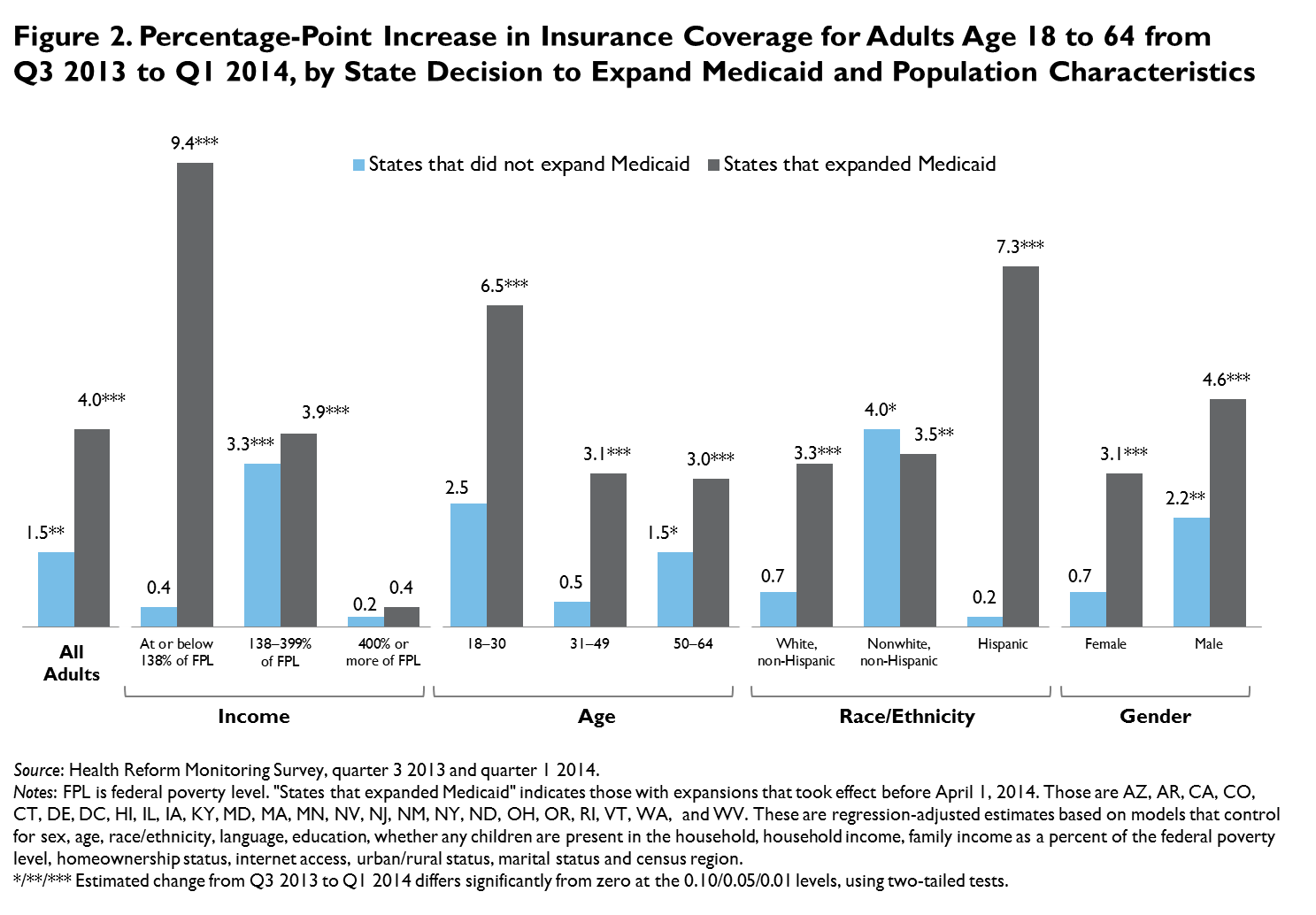
According to new estimates from the Urban Institute based on their Heath Reform Monitoring Survey, the number of uninsured nonelderly adults fell by an estimated 5.4 million between September 2013 and early March 2014.

Particularly strong gains in coverage were reported by the low- and middle-income adults targeted by the ACA's key coverage provisions. Insurance coverage increased by 4.7 percentage points for the adults with family income at or below 138 percent of FPL who were targeted by the ACA's Medicaid expansion and by 3.6 percentage for the middle-income adults (139 to 399 percent of FPL) who were targeted by the new subsidies available for health insurance coverage through the Marketplaces.

There were also strong gains in coverage for young adults (age 18 to 30) (up 4.3 percentage points )and nonwhite, non-Hispanic adults (up 3.8 percentage points) groups that have historically had higher than average uninsurance rates. Coverage rates increased for both men and women. Historically, men have had a higher rate of uninsurance than women.

States that implemented the ACA's Medicaid expansion saw a large decline in uninsurance. The uninsurance rate for adults in those states dropped 4.0 percentage points since September, compared with a drop of 1.5 percentage points for the nonexpansion states. The average uninsurance rate for adults in the 26 nonexpansion states was 18.1 percent in March 2014, well above the 12.4 percent average in the expansion states. The gap in the uninsurance rate between expansion and nonexpansion states widened between September 2013 and early March 2014, from 3.2 to 5.7 percentage points.

See <http://hrms.urban.org/briefs/early-estimates-indicate-rapid-increase.html>



**Study Questions Obamacare Impact on Canceled Plans**

From Politico

Millions of the plans that were canceled because they did not meet Affordable Care Act requirements probably would have been canceled anyway — by the policyholders, a new study suggests.

Last fall, as cancellation letters arrived in mailboxes around the country, opponents of the law cited them as evidence that President Barack Obama had lied to Americans when he promised, “If you like your health care plan, you can keep it.”

But most individuals who lost plans probably would not have continued them even without the law, according to the study, which was published online Wednesday in Health Affairs. Its author questions whether those cancellations contributed much to the nation’s ranks of short-term uninsured.

The study looked at people who bought non-group, or individual, insurance plans — a market that was relatively unstable even before Obamacare took effect. Between 2008 and 2011, fewer than half the people who started out with such coverage still had it after a year. And 80 percent of those who changed policies had a new plan within a year, usually through an employer, the study found.

Given this baseline, author Benjamin Sommers says, “the effects of the recent cancellations are not necessarily out of the norm.”

An estimated 10.8 million people had non-group coverage in 2012, according to the Congressional Research Service. Based on his own findings, Sommers estimated that 6.2 million Americans leave non-group coverage each year under typical circumstances. News reports that as many as 4.7 million adults had their policies canceled in 2013 “are likely capturing a great deal of the normal turnover in this market,” he concludes.

Writing in Health Affairs, Sommers says his examination of data from the Census Bureau’s Survey of Income and Program Participation showed that non-group coverage is transitional for most people. They often buy it while in between jobs or waiting for employer benefits to kick in. A year after dropping their individual plans, Sommers found, 50 percent had employer-sponsored insurance, 20 percent had reacquired non-group coverage, 6 percent joined Medicare or Medicaid and 4 percent had other coverage.

However, Sommers did identify a group most likely to face a genuine, unwanted disruption from the ACA’s requirements: white, self-employed Americans between the ages of 36 and 64. They were likely to maintain their non-group coverage for three years or more.

Young adults ages 19 to 35 were unlikely to fall in that same category, with only a third holding non-group coverage for at least 12 months.

About 65 percent of people with non-group plans had incomes below 400 percent of poverty, so “many, if not most” of those whose plans were canceled last fall are now eligible for subsidies, Sommers writes.

Sommers, an assistant professor at Harvard University’s medical and public health schools, serves as a part-time adviser in the Office of the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services.

http://www.politico.com/story/2014/04/obamacare-affordable-care-act-canceled-plans-105964.html#ixzz2zp5hNmPY

**Changes in Health Insurance Enrollment since September 2013**

RAND’s Health Reform Opinion Study recently reported changes in enrollment between September 203 and March 2014. Among the findings:

* Of the 40.7 million who were uninsured in 2013, 14.5 million gained coverage, but 5.2 million of the insured lost coverage, for a net gain in coverage of approximately 9.3 million. This represents a drop in the share of the population that is uninsured from 20.5 percent to 15.8 percent.
* At least 4.5 million previously uninsured adults have signed up for Medicaid.
* Fewer than a million people who had health plans in 2013 are now uninsured because their plans were canceled for not meeting the new standards set by the law. While the survey cannot tell if the people in the latter group lost their insurance due to cancellation or because they felt the cost was too high, the overall number is very small, representing less than 1 percent of people between the ages of 18 and 64.

See <http://www.rand.org/pubs/research_reports/RR656.html>

# Eligibility Appeals Process

# From CMS:

Here is a 1) a refresher on how to submit an eligibility appeal, 2) information on what is happening to appeals pending as of March 31st and appeals submitted timely after March 31st, and 3) information about effectuation dates based on appeals decisions.

1. How to submit a Marketplace eligibility appeal -Consumers may file a Marketplace eligibility appeal in two ways.  The first way is to use the form that can be found on the eligibility appeals website (<https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/>).  The consumer should download the paper form, complete it and send it in.  Assisters should remind consumers  that while the form looks complicated and has many pages, only two pages or so need to be completed and it’s not hard to fill in.    
     
   The second way a consumer can submit an eligibility appeal is to write a letter.  The consumer should include the reason he or she is appealing, and we strongly urge the consumer to attach a copy of his or her eligibility determination letter to the appeal. Consumers should send the letter to:   
   Health Insurance Marketplace   
   465 Industrial Blvd.   
   London, KY 40750-0061   
     
   In either case, while it’s not required, the more information a consumer can provide the easier it will be to help the consumer.   
   Reapplications - A very effective way CMS is informally resolving eligibility appeals is to ask consumers to reapply or use the Change in Circumstances functionality in HealthCare.gov to obtain accurate eligibility determinations.    
   -  Consumers who’ve asked for eligibility appeals may be asked to undergo this process.    
   -  CMS will walk through it with consumers; nobody is left on their own.    
   -  Assisters can help by encouraging consumers to cooperate when asked to do this.    
   -  If consumers are already enrolled in a plan, CMS uses a process that preserves their enrollment yet allows them to pick a new plan, when appropriate, when reversing  the original eligibility determination and changing their initial eligibility determination through the appeal decision.
2. Appeal processing timing -This is important:  Any individual will have their timely eligibility appeal processed, no matter when they filed an appeal.  The Marketplace will let them know of the decision, including whether they are eligible to obtain health insurance coverage through the Marketplace, and whether they qualify for any subsidies. It’s worth repeating: Any individual will have their eligibility appeal processed, no matter when they filed an appeal.    
     
   If they receive a favorable eligibility appeal decision, they will be given a special enrollment period to enroll in or to switch plans within the Marketplace.
3. What is happening to appeals after March 31, 2014 -We will continue to process eligibility appeals filed before March 31, 2014 and which are still pending after March 31, 2014.  We will process eligibility appeals received after March 31, 2014 according to normal eligibility appeals procedures.   
     
   CMS will let appellants know of the decision, including whether they are eligible to obtain health insurance coverage through the Marketplace, and whether they qualify for any subsidies.  If they receive a favorable eligibility appeal decision, they will be given a special enrollment period to enroll in or to switch plans within the Marketplace.
4. Retroactive enrollment - If the decision is favorable and retroactive coverage is judged to be appropriate, consumers may choose to have their insurance coverage and any subsidies retroactively.  They may be able to select a retroactive date based upon the date of their application to the Marketplace.   
     
   Please note that an eligibility appeal decision that does not change the original eligibility determination will not give individuals a special enrollment period to enroll after the March 31st deadline.

For more information on the appeals eligibility process, please check out: <https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/>.

**Special Enrollment Period for Victims of Domestic Abuse through June 1st**

From CMS

* A consumer who is married but living apart from his or her spouse and is a victim of domestic abuse, and is not filing a joint tax return with their spouse (for instance, it could be dangerous or prohibited by law to contact their spouse), can obtain APTC and CSRs -- as long as they are otherwise eligible. Due to system limitations, consumers in this unique circumstance should indicate on the Marketplace application that they are not married. (As of April 1, the consumer should call the Call Center to explain the situation and activate the SEP. When completing the application, the **consumer should indicate that they are not married** on the application.)  They are **eligible to enroll through the Marketplace using a SEP through June 1**.
* CCIIO Guidance- <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/victims-domestic-violence-guidance-3-31-2014.pdf>
* CMS Tip sheet- <http://marketplace.cms.gov/help-us/assisting-consumers-domestic-abuse.pdf>
* U.S. Department of Treasury Fact sheet- <http://www.treasury.gov/press-center/press-releases/Pages/jl2334.aspx>

**Q: How are victims of domestic abuse who meet the criteria for a Limited Circumstance SEP supposed to proceed with their application? Do they need to call the Call Center or can they use the online application?**  
A: If a victim of domestic abuse thinks they meet the criteria for this Limited Circumstance SEP, the consumer should call the Marketplace Call Center to explain the situation and activate the SEP. The consumer can then complete their application on HealthCare.gov or through the Marketplace Call Center; they should indicate that they are not married on the application. For more information, see [http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/victims-domestic-violence-guidance-3-31-2014.pdf](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDA5LjMxMDg3MzkxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQwOS4zMTA4NzM5MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTY4NDgyJmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&117&&&http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/victims-domestic-violence-guidance-3-31-2014.pdf)  and [http://marketplace.cms.gov/help-us/assisting-consumers-domestic-abuse.pdf](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDA5LjMxMDg3MzkxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQwOS4zMTA4NzM5MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTY4NDgyJmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&118&&&http://marketplace.cms.gov/help-us/assisting-consumers-domestic-abuse.pdf).

**Q: If a victim of domestic abuse has already enrolled in a plan but did not receive APTCs because they marked on their application that they were married but not filing jointly, should they edit their application to say that they are not married? Will reporting this change in circumstances trigger a SEP which may then result in them being found eligible for APTCs and CSRs?**  
A: Yes, a consumer who is a victim of domestic abuse may report that they are not married as a life change either online, using the Change in Circumstances functionality, or by calling the Marketplace Call Center. Their eligibility will be re-determined and if they are found eligible for APTC, they will get a special enrollment period. If the consumer does not see a special enrollment period on their eligibility determination notice, they should call the Marketplace Call Center to activate the SEP.

**Weekly FAQs**

From CMS

**Q: Please explain what would qualify as an “unexpected hospitalization” that would trigger a Limited Circumstance SEP?**  
A: An unexpected hospitalization is one that is the result of a medical emergency or serious medical condition of the consumer trying to enroll in coverage. Consumers in this category who demonstrate that they were prevented from selecting a plan prior to the plan selection cutoff date due to an unexpected hospitalization may be granted a limited circumstance SEP.

**Q: Are appeal forms available in Spanish? If so where?**

A: Yes. You can find appeal forms in Spanish here: <https://www.cuidadodesalud.gov/es/can-i-appeal-a-marketplace-decision/>.

**Q: Is there going to be an online appeal form?**

A: Currently appeals requests must be mailed to Health Insurance Marketplace, 465 Industrial Blvd., London, KY  40750-0061. We are in the process of working on implementing ways for appeals to be requested online.

**Q: If a consumer missed the most recent open enrollment period, but would like to be enrolled in a Marketplace plan during the next open enrollment period, do they have to wait until the first day of the next open enrollment period to begin the application process?**

A: No, a consumer may set up an account in the Marketplace and complete an eligibility application at any time during the year. However if the consumer is eligible to enroll in a Qualified Health Plan they can only select a plan during the next open enrollment period, unless they qualify for a special enrollment period.  There’s no limited enrollment period for either Medicaid or the Children’s Health Insurance Program (CHIP), so if a consumer applies for and is found eligible for Medicaid, that consumer can enroll in Medicaid or CHIP any time of the year.  If a consumer qualifies, the consumer’s coverage can begin immediately.

**Q:  A consumer is enrolled in both dental and medical coverage through the Marketplace but no longer wants to have dental insurance. Can they just cancel the dental coverage and keep the medical coverage?**

A: The Marketplace does not currently have the capability of allowing a consumer or one of their dependents to be removed from a Marketplace dental plan while maintaining his or her enrollment in a medical plan.

**Q:  A consumer is enrolled in both dental and medical coverage through the Marketplace, but has stopped paying their dental premiums because they cannot afford the additional cost. When the issuer cancels the dental coverage, will the medical coverage be cancelled too?**

A: The Marketplace does not currently have the capability of allowing a consumer to be removed from a Marketplace dental plan while maintaining their enrollment in a medical plan. Assisters should advise the consumer that non-payment of their dental premium will result in the termination of their medical and dental coverage.

**Q: What happens if the consumer has paid their plan premiums and later wants to select a different plan?**

A: It depends on whether the coverage has become effective. A consumer may change his or her plan selection after paying their premium if it is before the coverage effective date. To change plan enrollment after coverage becomes effective, a consumer must first qualify for a special enrollment period. Note that changing plans shortly before an effective date may change the effective date.

**Q: Can a consumer terminate a Marketplace plan enrollment at any time?**

A: Yes.  While a consumer may voluntarily terminate a Marketplace plan enrollmentat any time, the consumer will not be able to select a new plan until the next open enrollment period, unless the consumer is found eligible for a SEP. Open Enrollment for 2015 coverage starts November 15, 2014. Also, assisters should remind consumers that they should be careful to avoid a substantial gap in coverage (more than 3 months) or the consumer may face the shared responsibility payment from IRS.

**Q: How does a consumer terminate a Marketplace plan enrollment?**

A: The consumer should log into “My Account,” navigate to “My Plans and Programs,” click on “End/Terminate All Coverage,” select an effective date of termination that is 14 days or greater from the present date, and then push the red button labeled “Terminate Coverage.”

Please note that this step is final, and the consumer will have to wait until the next open enrollment period to enroll in coverage again unless he or she becomes eligible for a special enrollment period. The consumer may also face an individual shared responsibility payment for not being enrolled in minimum essential coverage. Also note that this termination will cancel all of the consumer’s enrollments; a consumer cannot terminate just dental or just health coverage if they are enrolled in both. It is also 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 “change in circumstance” functionality.

**Federal Resources for Health Consumers with Their (New) Health Insurance**

* Common coverage questions- <https://www.healthcare.gov/using-your-new-marketplace-coverage/>
* Getting prescription medications- <https://www.healthcare.gov/using-your-new-marketplace-coverage/#part=2>
* Getting regular medical care- <https://www.healthcare.gov/using-your-new-marketplace-coverage/#part=3>
* Getting emergency care- <https://www.healthcare.gov/using-your-new-marketplace-coverage/#part=4>
* Using coverage and improving your health- <https://www.healthcare.gov/using-your-new-marketplace-coverage/#part=5>
* Appealing an insurance company’s decision- <https://www.healthcare.gov/using-your-new-marketplace-coverage/#part=5>
* Coverage to care (English/Spanish)- <http://marketplace.cms.gov/help-us/c2c.html>

# Tips Regarding Employer-Sponsored Coverage Application Questions

From CMS

CMS has received reports that some consumers are being determined eligible for advanced payment of the premium tax credit (APTC) when they may not actually be eligible because they have access to affordable job-based coverage. Here are some tips for assisters as you help consumers answer Marketplace application questions about job-based coverage:

TIP 1: When a consumer is answering the question “Is [the consumer] currently eligible for health coverage through a job?”

When a consumer is answering this question, remember, if a consumer could have enrolled in health coverage through a job for 2014 but the enrollment period for the job-based coverage is closed, the consumer should answer “Yes” to the application question: “Is [the consumer] currently eligible for health coverage through a job (even if it’s through COBRA or from another person’s job, like a spouse)?”

Answering the question in this way does not mean that the consumer will be ineligible for APTC, though. Additional questions in this section of the application will collect information about the coverage the consumer is eligible for to determine eligibility for APTC.

TIP 2: When a consumer is answering the question “How much would [the consumer] have to pay in premiums for this plan?”

When a consumer is answering this question, remember, if a consumer is eligible for health coverage through someone else’s job, enter how much the coverage would cost the employee for a plan that would only cover the employee. This should be answered regardless of whose name appears in the question. We are aware of a current system issue that may display the wrong name in this question. This work- around is temporarily necessary because the screen is incorrectly displaying the name of the applicant in that question, not the name of the employee. CMS is working to resolve this issue as soon as possible.

* For example: Susan is applying for coverage, but is eligible for coverage through her husband’s job. Even though the application says, “How much would Susan have to pay in premiums for this plan?” she should enter the amount that the employee (her husband) would pay for a plan that would ONLY cover him.

When determining eligibility for APTC, the employee-only cost of coverage is what matters, even if the employee isn’t asking for the tax credit for him- or herself.

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# Tips for Entering Hourly Income

# From CMS

When helping consumers estimate their income based on hourly wages, please be sure the consumer enters whole numbers (for example, 20 hours versus 20.5 hours). If entering the information in this way results in an imprecise amount, consumers have the option to report the hourly income as a weekly, biweekly, monthly or yearly amount. This will allow the system to properly calculate.  Another good tip: have a calculator on hand to help with the math!

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# Reminder: Eligibility Notice Shows Maximum APTC

# From CMS

A consumer’s eligibility notice is only designed to show what the consumer is eligible for (the maximum APTC), not the actual amount of APTC that is applied. The actual APTC is only available and displayed to consumers after plan selection has occurred.  It is not on the eligibility notice because that is generated before plan selection has occurred. After plan selection, the actual APTC is available on the plan confirmation screen in My Account and also on the monthly bill from the plan. Again, the eligibility notice will not have the actual amount of APTC that is applied.

**Limited Circumstance/Complex Case SEP Questions**

From CMS

\*For more information, see [http://marketplace.cms.gov/help-us/complex-cases-sep.pdf](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDA5LjMxMDg3MzkxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQwOS4zMTA4NzM5MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTY4NDgyJmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&107&&&http://marketplace.cms.gov/help-us/complex-cases-sep.pdf)

**Q: If a consumer enrolled in a plan and there are no providers in the plan’s service area that are accepting new patients, will the consumer be allowed to switch plans even if he or she has paid the premium?**  
A: It depends on the situation.  Generally, this will not be a special enrollment period for consumers. If there was an error in the information displayed on HealthCare.gov, impacted consumers will receive a notice from their issuer that they are eligible for a SEP. Consumers are not required to stay with their current plan or issuer if they are determined eligible for a SEP.

**Q: If a consumer is denied the request to get a Limited Circumstance SEP, does he or she use the same appeal form that consumers use to appeal eligibility decisions?**  
A: Yes, the consumer should use the same form. To file an appeal, a consumer should visit [https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDA5LjMxMDg3MzkxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQwOS4zMTA4NzM5MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTY4NDgyJmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&127&&&https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/) to find and complete the appeal request form for the consumer’s state. Next, the consumer should mail the form to: Health Insurance Marketplace; 465 Industrial Blvd; London, KY 40750-0061.

**Q: If a consumer experienced an enrollment error or other problem that fits the criteria for a Limited Circumstance SEP when applying for coverage through the Marketplace, may he or she still request a SEP if he or she had already filed an appeal?**   
  
A: Yes. A consumer may ask for a Limited Circumstance SEP regardless of whether or not an appeal was filed. Please contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

**Q: For consumers who are granted Limited Circumstance SEPs, does the 60 day period begin on the date the consumer is granted the SEP?  How does this work when there is a system defect preventing the enrollment?**   
A: In most cases, consumers will have 60 days to select a plan from the date they are granted the Special Enrollment Period, which could be one of the following: the date that the consumer receives a letter informing them that they are eligible for a Special Enrollment Period; the date that the consumer contacts the Marketplace Call Center and is found eligible for a Special Enrollment Period; or the date that the caseworker finds an individual eligible for a Special Enrollment Period.   
  
Regarding consumers who were prevented from selecting a plan prior to March 31 due to system issues, once the consumer can successfully reprocess and submit his or her application, the consumer should call the Marketplace Call Center to be granted the SEP. The consumer has 60 days after being granted the SEP to select a plan. We suggest that the assister or consumer continue to keep a record of those issues and continue to tell the Marketplace.

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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). As always, special thanks to Meryl Deles for much of the content.