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 28th

**Arizona Marketplace Enrollment Exceeds 120,000**

On Thursday, the federal government released final marketplace numbers, which included a breakdown on enrollment by states. Arizona’s final numbers were 120,071.

Twenty-one percent of those who enrolled were between the ages of 18-34, which was below the national average (28 percent). However, 43 percent of enrollees were below the age of 34, which exceeded the national average (34 percent).

Silver-level plans were most often chosen by those selecting a health plan (60 percent). The vast majority of those who enrolled in a Marketplace plan received financial assistance (77 percent). This was slightly lower that the national average (85 percent).

Reported data includes those who selected a plan from October 1st to March 31st, including special enrollment – related activity through April 19th.

For more information see <http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/pdf/az.pdf>

Also see

<http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf>

**State’s Medicaid ACA-Related Enrollment Numbers Nears 146,000**

On Thursday, AHCCCS also reported its latest enrollment numbers for our state’s Medicaid program. It reported a change in enrollment in the adult restoration category (0-100 FPL) of 129,486 from January through the end of April. It also reported that 16,319 had been added to AHCCCS in the adult expansion category (100-133 FPL). Added together, that equates to 145,805 Arizonans.

See <http://www.azahcccs.gov/reporting/Downloads/PopulationStatistics/2014/May/AHCCCS_Population_by_Category.pdf>

**Visualizing the Numbers**

When added to the Arizona Marketplace numbers, ACA-related enrollment for the state to date adds up to 265,876 Arizonans. *That exceeds the number of people that live in the City of Chandler, or approximately four times the population of Flagstaff.*

**Arizona Enrollment Tracks National Projections**

Arizona’s Marketplace enrollment numbers appear to track previous estimates made by the Congressional Budget Office (CBO).

In February 2014, CBO predicted that 25 million Americans would enroll in the Marketplace by 2018. They also predicted that 6 million would enroll nationally in the first year (24 percent).

Using that same methodology, Arizona should have expected to enroll 24 percent of the 496,000 Arizonans expected to enroll in the Marketplace by 2018. That equates to 119,040 Arizonans, roughly the same number that actually enrolled.

**Enrollment by Race/Ethnicity: Potential Disparities?**

Arizona marketplace enrollment by race/ethnicity was as follows:

|  |  |  |  |
| --- | --- | --- | --- |
| **Race/Ethnicity** | **Number Enrolled** | **Percentage of Total Marketplace Enrollment** | **Percentage Represented in Total Population** |
| American Indian/Alaskan Native | 514 | Under 1 percent | 5.3 percent |
| Asian | 6,207 | 5 percent | 3.6 percent |
| Native Hawaiin/Pacific Islander | 135 | Under 1 percent | .4 percent |
| African-American | 3,474 | 2 percent | 4.9 percent |
| Latino | 21,718 | 18 percent | 29.7 percent |
| White | 55,979 | 47 percent | 81.9 percent |
| Multiracial | 1,820 | 2 percent | 1.7 percent |
| Unknown/Other | 30, 224 | 25 percent |  |

Calculated using data from the US Census, American Community Survey 2008-2012 5-Year Estimates and Health Insurance Marketplace: Summary Enrollment Report

for The Initial Annual Open Enrollment Period For the period: October 1, 2013 – March 31, 2014

Comparison of enrollment data to general population data, at first glance, suggest disparities may exist. However, it is important to note that directly comparing race/ethnicity percentage of marketplace enrollment to race/ethnicity percentages for the general population can be misleading. Some racial/ethnic groups include higher percentages of people eligible for Medicaid rather than the Marketplace, for example. For example, 62 percent of non-elderly uninsured Blacks are likely eligible for Medicaid, compared to 31 percent that is likely eligible for Marketplace subsidies, according to a Kaiser Family Foundation study. Further analysis is likely needed.

See <http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk>

<http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf>

<http://kff.org/disparities-policy/fact-sheet/health-coverage-for-the-black-population-today-and-under-the-affordable-care-act/>

**Arizona Ranks in the Middle for Marketplace Enrollment among All States**

According to Kaiser Family Foundation, Arizona ranks 29th among states in the percent of the potential Marketplace population enrolled. As of April 19, Arizona enrolled 21.8 percent of the potential Marketplace population. That national average was 28 percent. State-run exchanges generally exceeded the national average. The federally-facilitated exchange states that exceeded the national average were Florida, Maine, North Carolina, Georgia and Wisconsin.

See <http://kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population/>

**Arizona at the Bottom among States Receiving Federal Funding for Enrollment Assistance**

A recent report from the Institute of Health Economics at the University of Pennsylvania and the Robert Wood Johnson Foundation shows that Arizona ranks fourth to last among states in the amount of consumer assistance funding it received per eligible uninsured from the federal government. The District of Columbia, Hawaii, Vermont, Maryland, Delaware, New Hampshire, Arkansas, Colorado and Minnesota were the areas that topped the list.

Federally-facilitated states received an average of $5.42 per eligible uninsured from the federal government. State-placed marketplaces received an average of $17.15. Federal partnership states received an average of $31.53.

See the report at: <http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf412855>

**Arizona Ranks at the Bottom among States for Children’s Health Coverage**

A new scorecard released Thursday by the Commonwealth Fund shows that Arizona ranked 47th among state for children’s health coverage. The ranking was based on 2011-2012 data. For adults, Arizona ranked 38th.

See the full report at: <http://datacenter.commonwealthfund.org/scorecard/state/4/arizona/>

**Enrollment Extended for Sick Patients**

From LifeHealth PRO:

The Patient Protection and Affordable Care Act’s Pre-Existing Condition Insurance Plan — or at least the patients enrolled in it — is getting one last extension.

The Obama administration said Thursday that sick patients in the temporary, federal program now will have until June 30 to select an exchange health plan.

See also: [GAO eyes PCIP woes, exchange construction efforts](http://www.lifehealthpro.com/2013/05/30/gao-eyes-pcip-woes-exchange-construction-efforts)

After three previous extensions, coverage for PCIP enrollees will end April 30. But those left in the pool get another two months to enroll in a plan at HealthCare.gov.

The Centers for Medicare and Medicaid Services announced the move in a bulletin as a “60-day special enrollment period due to exceptional circumstances for individuals remaining in the program who have not found new coverage that begins on May 1.”

The CMS announcement said former PCIP patients who use the special enrollment period will have coverage that “will be effective back to May 1.”

Sign-ups in PPACA plans technically ended March 31, though the administration extended the date to April 15 to consumers who struggled to sign up using the website. Other state-based exchanges also have extended their deadlines.

The PCIP program — which offers coverage to patients once turned away by carriers — was due to end on March 31, the same day as open enrollment. But [last month the administration extended the program](http://www.lifehealthpro.com/2014/03/14/pcip-program-extended-one-month) another month amid concerns that some of the nation’s sickliest patients wouldn’t be able to find and buy health coverage ahead of the deadline.

At the time, Centers for Medicare and Medicaid Services spokesman Aaron Albright said the extension was “part of our continuing effort to help smooth consumers’ transition into marketplace coverage...while (PCIP patients) receive the ongoing care and treatment they need.”

http://www.lifehealthpro.com/2014/04/25/ppaca-enrollment-extended-for-sick-patients

**Premium Payment: The Numbers**

From “Implementing Health Reform: A Summary Health Insurance Marketplace Enrollment Report” by Timothy Jost, Health Affairs, May 1st blog

One of the most contentious issues concerning enrollment numbers has been how many individuals who have selected a plan have actually paid their premiums.  Although the report reveals how many individuals have selected a plan, individuals are not truly enrolled in a qualified health plan until they have paid their first month’s premium.  The report acknowledges that HHS does not have data on how many individuals who selected a plan in fact have paid their first month’s premium.

On April 30, 2014, as if launching a preemptive strike, the Republican members of the House Energy and Commerce [released a report](http://energycommerce.house.gov/press-release/committee-learns-who%E2%80%99s-paid-obamacare-april-15-only-67-percent-enrollees-federal) stating that only 67 percent of individuals who had selected a plan had in fact paid their first month’s premium as of April 15.   The report was based on information that the committee had requested and received from 160 insurers in the federal exchange.  Percentages varied from 42 percent in Texas to 88 percent in Arkansas.  It did not include information from state exchanges.  If this percentage accurately represents the total population of enrollees, however, the true enrollment number is closer to 5.5 than 8.1 million.

Democratic committee members responded immediately to the Republican report.  They noted that, in fact, because of the late enrollment surge, 3 million of those who were enrolled as of April 15 were not yet required to pay their premiums as of that date, as their coverage was not effective until May.

Enrollment in Texas, for example, grew from 295,025 at the end of February to 733,757 by mid-April, and it is not surprising that some had yet to pay their premiums for May 1 enrollment as of April 15.  The minority report also noted that insurers had raised this problem in their submissions to the committee.

Recent reports from Wellpoint, the Blue Cross and Blue Shield Association, and AHIP indicated payment levels in the 80 to 90 percent level.  California, which was not included in the Republican survey, had [reported payment levels of 85 percent in mid-April](http://acasignups.net/14/04/17/more-california-details-14m-qhps-19m-medicaid-85-paid-more).  An administration spokesperson responding to the report also claimed that the exchanges in fact included 300 insurers, so the Republican data was incomplete.

Payment rates, and thus enrollment rates, will never equal 100 percent.  Some of the shortfall is attributable to administrative difficulties with the exchanges, which have generated duplicate enrollments when individuals have enrolled in one plan and then cancelled and enrolled in another, and which have failed to send correct information to insurers, resulting in the exchange showing an enrollment for which the insurer does not have a record and thus does not bill.  Some of the shortfall is due to insurers, which also have had their administrative difficulties.  I have heard of a number of instances where individuals have tried to pay their premiums but have been unable to get insurers to accept them.

Some shortfall is undoubtedly due to the enrollment of people who have not been insured before and do not understand how insurance works, or who are among the 51 million Americans [who do not  have a relationship with traditional banks](http://www.kaiserhealthnews.org/stories/2013/may/20/insurance-marketplaces-bank-account-cash-unbanked.aspx) and are not able to pay their premiums in cash.  Some of those who fail to pay are also individuals who applied and chose a plan, but then gained access to employer-sponsored coverage or Medicaid.  [The individual market is notoriously unstable](http://content.healthaffairs.org/content/early/2014/04/14/hlthaff.2014.0005), and it is likely that many individuals who chose a plan but did not pay simply found another coverage option.  Again, it will be some time until we know how many are actually enrolled in a health plan, but it will probably be somewhere close to 7 million.

See <http://healthaffairs.org/blog/2014/05/01/implementing-health-reform-a-summary-health-insurance-marketplace-enrollment-report/>

**Governor Vetoes Measure Aimed at Limiting Eligibility for AHCCCS**

From the Arizona Daily Star:

Arizona won’t be asking the federal government to let it drop some people from the state’s Medicaid program.

Gov. Jan Brewer on Tuesday vetoed legislation that would have required the Arizona Health Care Cost Containment System to seek ways of cutting future costs by limiting who gets care.

Brewer said kicking people out of the Medicaid program — potentially close to half a million — would not only harm them but bring the state’s health-care system “to a breaking point.”

“As we all know, their medical needs will still exist,” Brewer wrote in her veto message. Those who are not getting health insurance through Medicaid instead will show up in hospital emergency rooms, get care and then be unable to pay their bills, she said.

The legislation would have asked the U.S. Department of Health and Human Services, which provides most of the state’s Medicaid funding, to allow the state to put a five-year lifetime limit on benefits for adults. HB 2367 also would have required those who can work to have a job, be looking for one or be in a job-training program.

Federal Medicaid regulations currently do not allow such limits. But the federal agency has permitted states to seek waivers from their rules to find better ways to provide care.

This legislation would have required state officials to seek those waivers every year.

The legislation, crafted by House Speaker Andy Tobin, did have some exceptions to the five-year lifetime limit, including if the person is pregnant or the sole caregiver for a family member younger than 5. It also would have waived the five-year limit if someone remains employed full-time but in a low-wage job where the earnings still qualify them for Medicaid benefits.

Tobin’s voted against Brewer’s plan last year to expand eligibility for the state’s Medicaid program by using cash from the federal Affordable Care Act. And he has made several statements opposing what has become known as Obamacare.

But Tobin said it became obvious that both the federal program and the state expansion are here to stay, at least for the time being.

His concern is the cost down the road for the state.

The Affordable Care Act currently picks up virtually all of the cost of Arizona having expanded eligibility from those below the federal poverty level to take in those 38 percent above that.

But Tobin said it will be impossible for Washington to keep enough money flowing to the states to do that forever, meaning some of the new costs of an expanded program eventually would be shifted back to the state.

Tobin said the waivers he sought would have given Arizona a chance to scale back the program if the federal funds dry up.

Brewer, in vetoing the legislation, said she shares his concerns about relying on the federal government. But she said his alternative of denying care is not an option.

She said a five-year lifetime enrollment cap could mean kicking more than 212,000 people out of the program. And she said another 253,000 children would lose coverage when they turn 18 “as the bill makes no exception for enrollment during childhood when determining the five-year limit.”

Separate from the lifetime limit and the work requirement, Tobin’s legislation also would have required AHCCCS officials to try to get federal permission to impose “meaningful copayments” to deter the use of hospital emergency rooms for non-emergency medical conditions and the use of ambulance services when they are not medically necessary.

<http://azstarnet.com/news/state-and-regional/governor-vetoes-measure-aimed-at-limiting-eligibility-for-ahcccs/article_eea42d82-f141-5ce8-b4c4-04a6f39a3eb5.html>

**Navigator Law Signed by Governor**

**From the Phoenix Business Journal:**

For those worried that standards were too low for navigators who help the uninsured find health coverage on the exchange, Gov. [Jan Brewer](http://www.bizjournals.com/phoenix/search/results?q=Jan%20Brewer) signed the Navigator Bill into law.

The goal is to keep criminals from gaining access to personal information of [those seeking health coverage](http://www.bizjournals.com/phoenix/blog/health-care-daily/2014/04/federal-officials-in-arizona-to-examine.html) under the Arizona Insurance Marketplace, created under the Affordable Care Act.

Under House Bill 2508, it is required that navigators or certified application counselors be licensed through the Arizona Department of Insurance. They must be:

* At least 18 years old
* Have not committed certain acts, felonies, or misdemeanors
* Have provided proof of certification the [U.S. Department of Health and Human Services](http://www.bizjournals.com/profiles/company/us/dc/washington/us_department_of_health_and_human_services/3347768)
* Has successfully completed the ADOI’s background check requirements, or has completed one required by their employer to be a navigator or CAC.

The licensing requirements for navigators and CACs are effective Oct. 1.

[Michael Ward](http://www.bizjournals.com/phoenix/search/results?q=Michael%20Ward), president of the Greater Phoenix Association of Health Underwriters, said he is pleased to see the bill enacted to protect consumers.

[Henry GrosJean](http://www.bizjournals.com/phoenix/search/results?q=Henry%20GrosJean), a small business insurance broker, is not so impressed.

“The bill represents the path of least resistance from HHS, which has deterred any states from mandating that the navigators be insurance-licensed,” he said. “So, the impression that consumers will be protected from someone who is unlicensed and also does not have errors and omission insurance will be an illusion.”

<http://www.bizjournals.com/phoenix/blog/health-care-daily/2014/04/new-arizona-law-assures-insurance-navigators-cant.html>

**For Assisters: Reasons to Appeal**

**From Families USA**

You may be working with health care consumers for whom it would be beneficial to [appeal](http://cts.vresp.com/c/?FamiliesUSAFoundatio/83bc475451/35135f202b/c8a1955d43) a marketplace decision. Consumers always have the right to appeal a marketplace decision up to 90 days after they receive the decision.

Consumers may benefit from filing an appeal if they:

* Were denied eligibility for a marketplace health plan and think they may qualify
* Were denied eligibility for a special enrollment period to enroll in a marketplace plan
* Were found ineligible for the amount of financial assistance they thought they would receive
* Were denied eligibility for Medicaid or the Children’s Health Insurance Program (CHIP) and think they may be eligible
* Were denied eligibility for an exemption from the penalty for not having health insurance
* Were not able to complete identity proofing to submit their application, subsequently delaying the application process
* Were not able to enroll in health insurance because of a circumstance that makes them eligible for a special enrollment period and they need retroactive coverage

**Consumer-Friendly Resources/Calculators**

* Cover Me AZ- <http://covermeaz.org/>
* Financial Help for Health- <http://www.financialhelpforhealth.org/>
* Putting Patients First- <http://www.puttingpatientsfirst.net/>
* Individual/Family Subsidy Calculator- <http://kff.org/interactive/subsidy-calculator/>
* SHOP Full-time Equivalent Calculator- <https://www.healthcare.gov/fte-calculator/>
* SHOP Tax Credit Estimator- <https://www.healthcare.gov/shop-calculators-taxcredit/>
* Tax Penalty Calculator- <http://taxpolicycenter.org/taxfacts/acacalculator.cfm>

**Fact Sheet on Applying for Medicaid for People with Disabilities**

The American Association on Health and Disability (AAHD) announced the publication of a revised fact sheet for the National Disability Navigator Resource Collaborative (NDNRC). “Process for Medicaid Eligibility” is intended to give Navigators, Assisters and Certified Application Counselors an idea of the questions and informational needs that people with disabilities may have about Medicaid when they are looking into purchasing private insurance in the Marketplace. Previously, this fact sheet had been released in draft form, but the final version with downloadable PDF is now available. The fact sheet can be found [here](http://click.icptrack.com/icp/relay.php?r=85705601&msgid=2349127&act=NEXU&c=926524&destination=http%3A%2F%2Fwww.nationaldisabilitynavigator.org%2Fndnrc-materials%2Ffact-sheets%2Ffact-sheet-12%2F).

This fact sheet provides additional assistance for those assisting consumers with disabilities as it adds to the series of fact sheets which have addressed issues such as a health plans’ summary of benefits and coverage, rehabilitation and habilitation therapies and devices, and prescription medication benefits. The entire list of fact sheets is available [here](http://click.icptrack.com/icp/relay.php?r=85705601&msgid=2349127&act=NEXU&c=926524&destination=http%3A%2F%2Fwww.nationaldisabilitynavigator.org%2Fndnrc-materials%2Ffact-sheets%2F).

# HealthCare.gov Updates

# From CMS:

Find Local Help. HealthCare.gov’s home page has been changed to reflect the end of open enrollment. As a result, the Find Local Help hyperlink is now available in a new location on the website. It’s now posted on the home page of the “Individual and Families” page under “Getting Coverage” as well as in other places throughout the website. You can access it directly [here](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDIyLjMxNTI2ODMxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQyMi4zMTUyNjgzMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTg4MjY3JmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&103&&&https://localhelp.healthcare.gov/).

Premium Estimator Tool. As a result of the home page changes, the tool can be found [here](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDIyLjMxNTI2ODMxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQyMi4zMTUyNjgzMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTg4MjY3JmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&104&&&https://www.healthcare.gov/find-premium-estimates/).

Protecting your Marketplace account. Recently, you may have heard about a new internet security weakness, known as Heartbleed, which is impacting some websites. HealthCare.gov uses many layers of protections to secure your information. While there’s no indication that any personal information has ever been at risk, we have taken steps to address Heartbleed issues and reset consumers’ passwords out of an abundance of caution. This means the next time a consumer visits the website, they’ll need to create a new password. We strongly recommend consumers create a unique password – not one that they’ve already used on other websites.  We are sending emails inviting consumers to come back and reset their password.

For more information on protecting a consumer’s Marketplace account and steps to reset his or her password, see: [https://www.healthcare.gov/heartbleed/](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDIyLjMxNTI2ODMxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQyMi4zMTUyNjgzMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTg4MjY3JmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&105&&&https://www.healthcare.gov/heartbleed/).  If a consumer hasn’t reset his or her password yet, he or she should click on “Forgot your Password” and follow the steps.  After the consumer resets their password, if he or she still has trouble logging in, he or she can call the Marketplace call center for help.

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# New Resource Posted: Overview of Assisting People with Disabilities in the Marketplace

# From CMS:

The link to the slide deck on assisting people with disabilities in the Marketplace has been added to the [Assister page](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDIyLjMxNTI2ODMxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQyMi4zMTUyNjgzMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTg4MjY3JmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&106&&&http://marketplace.cms.gov/help-us/2-partner-with-us.html)on Marketplace.CMS.gov.  The recently posted resource can be found here:

* [Overview of Assisting People with Disabilities in the Marketplace – February 28, 2014 (slides)](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDIyLjMxNTI2ODMxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQyMi4zMTUyNjgzMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTg4MjY3JmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&107&&&http://marketplace.cms.gov/help-us/assisting-people-with-disabilities.pdf)

# Reminder on Coverage Effective Dates

# From CMS:

Assisters have requested clarification on coverage effective dates when a consumer is reporting a loss of Minimum Essential Coverage, or MEC.  We want to remind assisters that if a consumer states that they will lose Minimum Essential Coverage or MEC on the application, when he or she selects a plan, his or her coverage will be effective the first day of the following month. Note that the earliest possible effective date is established based on both the day the consumer reports losing MEC and the date the consumer selects a plan. For example:

* If a consumer reports on April 2 that he or she is losing coverage April 30 and makes a plan selection on April 2, he or she will receive a Marketplace coverage effective date of May 1.
* If a consumer reports on April 17 that he or she is losing coverage May 1 and makes a plan selection on April 18, he or she will receive a Marketplace coverage effective date of June 1.
* If a consumer reports on May 14 that he or she is losing coverage May 31 and makes a plan selection on May 16, he or she will receive a Marketplace coverage effective date of June 1.
* If a consumer reports on May 5 that he or she lost coverage April 30 and selects a plan on May 5, he or she will receive a Marketplace coverage effective date of June 1.

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# Reminder: Protecting Against Fraud

# From CMS:

As assisters, you must ensure that your computer is secure by installing reputable and up-to-date security software, removing malicious software (such as viruses and spyware that can get installed on your computer, phone or mobile device without your consent), creating strong passwords, and taking other measures. (See the full tip sheet on Protecting Against Fraud here: [http://marketplace.cms.gov/getofficialresources/publications-and-articles/protect-yourself-from-fraud-in-health-insurance-marketplace.pdf](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDIyLjMxNTI2ODMxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQyMi4zMTUyNjgzMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTg4MjY3JmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&108&&&http://marketplace.cms.gov/getofficialresources/publications-and-articles/protect-yourself-from-fraud-in-health-insurance-marketplace.pdf)).

Assisters should also continue to remind consumers to stay alert for fraud. You can help consumers protect themselves from fraud in the health insurance marketplace by recommending that they:

* Protect their private health care and financial information by never giving out banking, credit card, or account numbers to someone who calls or comes to their home uninvited even if they say they are from the Marketplace.
* Report suspected fraud if someone other than the insurance company they’ve chosen contacts them about health insurance and asks for payment—or asks for financial or personal health information.  If the consumer suspects fraud, report it by calling: the Marketplace Call Center at 1-800-318-2596, his or her local, state, or federal law enforcement agencies, and/or his or her State Department of Insurance. If the consumer suspects identity theft, or feels like he or she gave personal information to someone he or she shouldn’t have, report it by calling his or her local police department or calling the Federal Trade Commission’s ID Theft Hotline at 1-877-438-4338 (TTY: 1-866-653-4261).  Please visit [www.ftc.gov/idtheft](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDIyLjMxNTI2ODMxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQyMi4zMTUyNjgzMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTg4MjY3JmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&109&&&http://www.consumer.ftc.gov/features/feature-0014-identity-theft) to learn more.

Other consumer tips to prevent fraud are included in this link:  [https://www.healthcare.gov/how-can-i-protect-myself-from-fraud-in-the-health-insurance-marketplace/](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDIyLjMxNTI2ODMxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQyMi4zMTUyNjgzMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTg4MjY3JmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&110&&&https://www.healthcare.gov/how-can-i-protect-myself-from-fraud-in-the-health-insurance-marketplace/).

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# Tips for Applications where Household Contacts are Tax Dependents

From CMS:

Currently, when the household contact for an application is claimed as a tax dependent those listed on the application are unable to select a QHP on HealthCare.gov. Specifically, when the consumers get to plan compare and select the APTC amount, they will see a red box error with the message “Unable to access HUB Error ID: 500.100” and they will be unable to proceed to select a plan. For example this occurs in the following scenario: A daughter is the household contact applying for herself and her mother. The daughter indicates that she files taxes and also lists that her mother claims her as a dependent. (Note: the error will occur regardless of whether the daughter indicates she files taxes.)

We are currently working to address this issue. In the interim, we recommend removing the application and starting over with one of the claiming tax filers listed as the household contact on the “Get Started” page.

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# Limited Circumstance or “Complex Case” SEPs

# From CMS:

CMS provided additional details about Limited Circumstance or “complex case” SEPs last Friday. These are SEPs that, in limited circumstances, allow consumers who were blocked from enrolling in coverage by March 31 (i.e., were “in-line”) and continue to be blocked after April 15 to enroll in a plan. If, post-April 15, these consumers are able to successfully complete an application and receive an eligibility determination from the Marketplace, they may be eligible for an SEP to allow them to select a Marketplace plan for prospective coverage in 2014.

Eligible consumers include those who have experienced any of the following:

Enrollment errors. For example:

Consumers who enrolled through the Marketplace but the insurance company didn’t get their information due to technical issues including:

* Consumer’s information is received by the insurance company and may be processed, but the enrollment file contains defective or missing data which makes the insurance company unable to enroll the consumer.
* The insurance company was unable to process the consumer’s enrollment because of a technical error between the Marketplace and the insurance company.

Exceptional circumstances. For example:

* Consumer experienced a serious medical condition which prevented them from selecting a plan prior to the plan selection cutoff date (e.g., unexpected hospitalization, temporary cognitive disability)
* Consumer prevented from enrolling because of a natural disaster (e.g., earthquake, massive flooding, hurricane)

Misinformation, misrepresentation, or inaction. This includes misconduct by individuals or entities providing formal enrollment assistance (including an insurance company, a Navigator, Certified Application Counselor (CAC), Enrollment Assistance Program assister (EAP assister), Call Center representative, or agent or broker) that resulted in one of the following:

* Failure to enroll the consumer in a plan
* Consumer enrolled in wrong plan
* Consumer was eligible for but did not receive Advance Payments of the Premium Tax Credit (APTC) or Cost-sharing Reductions

Specific system issues. These include system errors related to immigration status; plan display errors on HealthCare.gov; application transfer issues between Medicaid/CHIP and the Marketplace; error messages; unresolved casework issues; and other system issues. For example:

* Errors related to immigration status: An error in the application submitted by immigrants caused the consumer to get an incorrect eligibility result (for example, immigrant with income less than 100% FPL in non-Medicaid expansion state was incorrectly denied APTCs).   
  **-** Tip: The application filer may be the one to call the Call Center and activate the SEP, even if they are not the person impacted by the defect. However, the Call Center will need the impacted consumer’s name to process this SEP.
* Display errors on HealthCare.gov: Plan data display errors (premiums, benefits, co-pay/deductibles, service area).   
  -  The consumer will receive a notice from the insurance company informing the consumer that there was a display error and they are eligible for an SEP. If the consumer believes there is a display error and has not received a notice they should contact the insurance company.
* Medicaid/CHIP transfer: Consumers who were found ineligible for Medicaid or CHIP and their applications weren’t transferred between the State Medicaid/CHIP agency and the Marketplace in time for the consumer to enroll in a plan during open enrollment.   
  -  These consumers do not need to call the Call Center. They may “activate” this SEP either online orthrough the Call Center.   
  -  A question on the online application asks whether applicants who were denied. Medicaid/CHIP by the state originally applied (either at the state or FFM) before 3/31/14.  The consumer should select all appropriate applicants in the answer to be considered for SEPs.
* Error messages: A consumer is not able to complete enrollment due to error messages (for example, error or box screen indicating that the data sources were down and they could not proceed with enrollment).
* Unresolved casework: A consumer is working with a caseworker on an enrollment issue that was not resolved prior to April 15.
* ID proofing failures: Consumers who were required to submit supporting documentation to the Marketplace in order to clear their identity proofing failure by April 15.
* Other system errors, as determined by CMS, which hindered enrollment completion.
* Survivors of domestic violence. A consumer who is married but living apart from his or her spouse and is a survivor of domestic violence, 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.) These consumers must select a plan by May 30.

**What is the process for activating a Limited Circumstance SEP and enrolling?**

In general, a consumer who wants a Limited Circumstance SEP must call the Call Center. There are some circumstances in which the Marketplace, insurance company, or state Medicaid or CHIP agency may be able to contact some consumers that may be eligible for a Limited Circumstance SEP granted by the Marketplace. In these cases, the consumer will be contacted. These consumers should then call the Call Center to activate the SEP.

Note: In the case of system defects, the consumer and assister should monitor that the system defect is fixed by continuing to try to reprocess the application independently or through the call center. Once the defect is fixed and the consumer gets an eligibility determination, the consumer or assister should contact the Call Center to activate the SEP.

The steps to complete the Limited Circumstances SEP are:

Step 1: Consumer completes the Marketplace application (online or through the Call Center (1-800-318-2596; TTY 1-855-889-4325) ) and receives an eligibility determination.

Step 2: Consumer calls the Marketplace Call Center and requests an SEP (note that the Medicaid/CHIP transfer SEP can be activated online).

Step 3: Call Center will ask the consumer a variety of questions to help understand if the consumer is eligible for an SEP. The Call Center will forward cases that need additional review to CMS caseworkers.

Step 4:  If an SEP is granted, Call Center activates the SEP and allows the consumer to complete the enrollment. (If approved from a caseworker, the consumer will have to call the Call Center to activate the SEP.)

Step 5: Consumer enrolls online or through the Call Center.

Step 6: If the SEP is denied, the consumer can appeal the decision.

After following the process above, in most cases, consumers will have 60 days to select a plan from the date they are granted the SEP, which could be one of the following “triggering events”:

1. The date that the consumer receives a letter informing them that they are eligible for an SEP;
2. The date that the consumer contacts the Call Center and is found eligible for an SEP; or
3. The date that the caseworker finds an individual eligible for an SEP.

Coverage effective dates will generally follow the regular effective dates:

* Consumers who select a plan between the 1st and 15th of the month will have coverage effective the first of the following month.
* Consumers who select a plan between the 16th and the end of the month will have coverage effective the second following month.

Note that qualifying life event or exceptional circumstance SEPs may have different effective dates.

**What are consumers' options if they were denied a Limited Circumstance SEP?**

Consumers always have a right to appeal. A consumer has 90 days to request an appeal with the Marketplace from the date their SEP is denied or 90 days from the date of an eligibility determination.

How to file an appeal:

Visit [HealthCare.gov/can-i-appeal-a-marketplace-decision/](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDIyLjMxNTI2ODMxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQyMi4zMTUyNjgzMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTg4MjY3JmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&111&&&http://www.healthcare.gov/can-i-appeal-a-marketplace-decision/) to find and complete the appeal request form for the consumer’s state.

Mail appeal documents to:   
Health Insurance Marketplace   
465 Industrial Blvd.   
London, KY 40750-0061

# Reminders and Tips

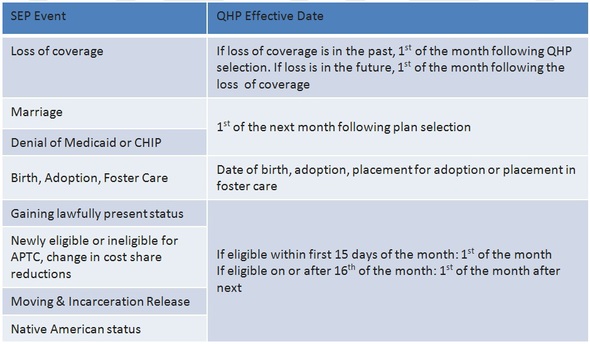
* For Limited Circumstance SEPs, the Call Center generally must activate the SEP. Consumers will then be able to complete enrollment through the Call Center or on HealthCare.gov.
* In most circumstances, to select a plan and complete enrollment after March 31, a consumer must receive an SEP. Consumers may always enroll in Medicaid or CHIP year-round if they are determined eligible.
* If the consumers you are assisting continue to experience difficulty enrolling due to system errors, please contact the Call Center, continue to help consumers keep a record of those issues, and tell us about the issues, as you have been doing for the past several months.
* For issues related to system defects, consumers and assisters will need to monitor their HealthCare.gov application to see if the defect is fixed by continuing to process the application. Be aware that the Call Center will not be able to resolve a system defect and will not be able to submit the application, or approve a SEP, until the Marketplace fixes the defect.   
  -  Consumers and assisters should continue to attempt to reprocess the application.   
  -  When the defect is fixed, the consumer will be able to submit their application without error.   
  -  Once the consumer receives an eligibility determination, they should call the Call Center to activate their SEP and “unlock” Plan Compare.   
  - For system defects and immigration related issues, the name of the consumer on the application who was impacted by the defect will need to be provided.
* Once the SEP is granted, and the consumer can select a plan to enroll, the consumer will have 60 days to enroll.
* A consumer who has already enrolled in coverage and then receives an SEP has the option to change plans or stay in their current plan, depending on what is offered to them on the Marketplace.
* If a consumer does not qualify for any type of SEP, such as the ones we’ve highlighted in detail or by experiencing a qualifying life event, the consumer should be aware that the online application will allow them to create an account or begin a Marketplace eligibility application. However, since this consumer doesn’t qualify for an SEP (and is not a AI/AN), they will not be able to select a plan and complete enrollment until the next open enrollment period begins on November 15, 2014 for 2015 coverage.

**Reminder: For Qualifying Life Event SEPs**

From CMS:

As we’ve mentioned before, if a consumer has a qualifying life event (i.e., losing minimum essential coverage, having a baby, adoption, foster care, or getting married), they can enroll or change coverage outside of open enrollment.

* The consumer activates the special enrollment period through the “change in circumstance” function through HealthCare.gov or through the Call Center.
* You may also visit [www.healthcare.gov/how-can-i-get-coverage-outside-of-open-enrollment](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDIyLjMxNTI2ODMxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQyMi4zMTUyNjgzMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTg4MjY3JmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&112&&&http://www.healthcare.gov/how-can-i-get-coverage-outside-of-open-enrollment)  to learn more about these qualifying life events. (This document is written for consumers; assisters can print and provide to consumers, as needed.)



# Resources

Be sure to check out materials on the [Resources for Assisters](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDIyLjMxNTI2ODMxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQyMi4zMTUyNjgzMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTg4MjY3JmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&106&&&http://marketplace.cms.gov/help-us/2-partner-with-us.html) page of [Marketplace.CMS.gov](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDIyLjMxNTI2ODMxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQyMi4zMTUyNjgzMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTg4MjY3JmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&113&&&http://marketplace.cms.gov/) relating to SEPs, including:

* [Helping Consumers with Complex Cases Enroll in Special Enrollment Periods in the Health Insurance Marketplace](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDIyLjMxNTI2ODMxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQyMi4zMTUyNjgzMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTg4MjY3JmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&114&&&http://marketplace.cms.gov/help-us/complex-cases-sep.pdf)
* [Helping Consumers with Complex Cases Enroll in the Health Insurance Marketplace – March 28, 2014 (slides)](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDIyLjMxNTI2ODMxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQyMi4zMTUyNjgzMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTg4MjY3JmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&115&&&http://marketplace.cms.gov/help-us/helping-consumers-complex-cases.pdf) Note this slide deck link will soon be updated to include the content from Friday’s presentation, so please check back.

HealthCare.gov also has information for consumers:

* [Special Enrollment Periods for complex cases in the Marketplace](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDIyLjMxNTI2ODMxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQyMi4zMTUyNjgzMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTg4MjY3JmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&116&&&https://www.healthcare.gov/sep-list/)

We also posted guidance for issuers on this topic on the CCIIO website:

* [Guidance for Issuers on People “In Line”](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDIyLjMxNTI2ODMxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQyMi4zMTUyNjgzMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTg4MjY3JmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&117&&&http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/in-line-SEP-3-26-2014.pdf)
* [Guidance for Issuers on Complex Cases](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDIyLjMxNTI2ODMxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQyMi4zMTUyNjgzMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTg4MjY3JmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&118&&&http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/complex-cases-SEP-3-26-2014.pdf)

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# Change in Circumstances Functionality on HealthCare.gov

From CMS:

Consumers need to report changes in their lives and households throughout the year directly to the Marketplace – either by reporting that change through MyAccount in Healthcare.gov or by calling the Call Center.

Some changes may result in (1) changing a consumer’s program eligibility (e.g., change between private insurance and Medicaid), (2) the consumer’s receiving a Special Enrollment Period to change plans, and/or (3) different premiums.

**Examples of Changes**

The table below shows examples of changes consumers should report to the Marketplace, particularly if they are getting help paying for coverage (APTC, CSR, Medicaid or CHIP). Communication Preferences (last row) are not sent to the insurance company by the Marketplace, so if consumers want their insurance company to have their updated communication preferences, they should inform their insurance company of those preferences directly.



Process

The consumer should follow the process outlined below 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, consumers select the type of change they want to make in order to be directed to the right page in their Account. If consumers are reporting changes that require them to update their application, they will be directed to their application, which is prepopulated based on information they previously submitted. Consumers should review their application information and add, remove, or edit any information that has changed. Once consumers have completed and submitted their revised application, they should view their updated eligibility results.
3. If consumers are eligible for an SEP, their eligibility determination notice will tell them they are eligible, and will give the timeframe they have to select a plan.  Consumers who are eligible for a SEP can enroll or change plans.  If enrolled consumers still qualify for their existing plans, and want to keep them, they must select them again. Otherwise they must select new plans. Consumers can view their existing plans by navigating to My Plans and Programs.
4. Consumers who are not eligible for an SEP will not be able to enroll or change to a different plan. Enrolled consumers who are not eligible for an SEP must review and confirm their existing plan, in order for their application changes to take effect.
5. Consumers who are determined eligible for APTC can set and adjust the amount of APTC, after completing their revised application, regardless of whether they are eligible for an SEP. They can slide the bar to get their maximum or less than their maximum APTC amount.
6. A consumer MUST confirm a plan to make sure their changes actually go to the issuer. Once the consumer confirms their plan selection, whether it’s the same or a new selection, the Marketplace will display a “congratulations” message, and will send any changes to the insurance companies.

Call Center Assistance

Please note that at any point, if consumers need additional assistance with reporting a change to the Marketplace, a consumer can always call the Call Center at 1-800-318-2596 for additional assistance.

For past slide deck on Change in Circumstance functionality, please see [Overview of the New Change in Circumstances Functionality – February 7, 2014 (slides)](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDIyLjMxNTI2ODMxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQyMi4zMTUyNjgzMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTg4MjY3JmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&119&&&http://marketplace.cms.gov/help-us/cic-for-assisters-v2.pdf). Note this slide deck link will soon be updated to include the content from Friday’s presentation, so please check back.

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# FAQs

# PLEASE NOTE THAT THE FOLLOWING TWO FAQS ARE CLARIFICATIONS TO TWO FAQs INCLUDED IN APRIL 15, 2014’s ASSISTER NEWSLETTER.

Q:  A consumer is enrolled in both medical and stand-alone dental coverage through the Marketplace but no longer wants to have dental insurance. Can the consumer just terminate the stand-alone dental coverage and keep the medical coverage?

A: The Marketplace does not currently have the capability to allow 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.  We are working on the capability to allow this action to be taken by the consumer.

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

A: It depends. The Marketplace does not currently have the capability to allow 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. If the consumer is enrolled in separate medical and dental (called a stand-alone dental plan) plans, the dental issuer can terminate the consumer’s dental plan for nonpayment of their dental premium while still allowing the consumer to remain enrolled in the medical coverage.

As a reminder, at this time the Marketplace is unable to process the terminations for nonpayment of premiums from issuers.  This means the consumer’s MyAccount will still show the status for the plan as being active even if the issuer has terminated the consumer’s coverage.  Also, termination for nonpayment of premiums does not qualify an individual for a special enrollment period.

Q: Are consumers who were “in-line” to apply for or enroll in a plan by March 31 but did not complete their plan selections by April 15, able to select a plan for 2014 coverage?

A: The special enrollment period (SEP) for consumers “in-line” as of March 31 ended on April 15 for Qualified Health Plan coverage effective in 2014.  However there’s no limited enrollment period for either Medicaid or the Children’s Health Insurance Program (CHIP). Apart from individuals determined eligible for Medicaid or CHIP, most consumers will have to wait until the next open enrollment period begins on November 15, 2014 to enroll in Qualified Health Plan coverage effective in 2015 unless they are otherwise eligible for a special enrollment period. Life changes such as marriage, birth and adoption, or loss of other minimum essential coverage, may allow a consumer to be eligible for an SEP. To report a life change, consumers should log into their Marketplace account and use the “Report a Life change” function, or call the Call Center.

As a reminder, 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.

For more information, see: [Special Enrollment Periods for complex cases in the Marketplace](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDIyLjMxNTI2ODMxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQyMi4zMTUyNjgzMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTg4MjY3JmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&116&&&https://www.healthcare.gov/sep-list/)

Q: Did “in-line” consumers who already submitted paper applications received by the Marketplace by April 7 miss the deadline to enroll for coverage in 2014?

A: No.  The Marketplace is processing paper applications received by April 7 to capture those consumers who were “in line” to apply for or enroll in coverage through either the Federally-facilitated Marketplace or a state Medicaid or CHIP agency by 11:59 p.m. EDT on March 31, 2014.  Consumers whose paper applications were received by the Marketplace by April 7 must select a plan by 11:59 p.m. EDT, April 30, 2014. These consumers need to call the Call Center to do so.

For more information, see: [http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/in-line-SEP-3-26-2014.pdf](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDIyLjMxNTI2ODMxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQyMi4zMTUyNjgzMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTg4MjY3JmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&117&&&http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/in-line-SEP-3-26-2014.pdf).

Q: If consumers were unable to complete identity proofing before April 15, are they eligible for a limited circumstances SEP?

A: Yes, consumers who were required to submit supporting documentation to the Marketplace in order to clear their identity proofing failure by April 15 will be eligible for a SEP. These consumers will have to call the Call Center at 1-800-318-2596 (TYY: 1-855-889-4325) to initiate their SEP for failed ID proofing.

For more information, see [http://marketplace.cms.gov/help-us/complex-cases-sep.pdf](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNDIyLjMxNTI2ODMxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDQyMi4zMTUyNjgzMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTg4MjY3JmVtYWlsaWQ9YWxsZW5nQGFhY2hjLm9yZyZ1c2VyaWQ9YWxsZW5nQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&114&&&http://marketplace.cms.gov/help-us/complex-cases-sep.pdf).

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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.