Covered Clips

A Summary of News and Activities for the Cover Arizona Coalition

Weeks of June 2nd and June 9th

**New Navigator Grants Announced**

On Tuesday June 10th, HHS announced a funding opportunity for organizations and individuals to operate as Navigators in Federally-facilitated Marketplaces (FFMs) and State Partnership Marketplaces (SPMs)**.**

The total funding apportioned to Arizona as part of this funding opportunity is $1,888,386. In last year’s funding announcement, $1.5 million was apportioned to Arizona. The amount actually awarded exceeded that amount - $2.1 million.

In this year’s Funding Opportunity Announcement (FOA), Navigator applicants will be encouraged to discuss the community(ies) they expect to target, their relationships within their target communities, and how they intend to build on these relationships as part of their outreach efforts. Navigators are required under newly finalized regulations to maintain a physical presence in the community(ies) so that face-to-face assistance can be provided to consumers.  Applicants will also be encouraged to discuss plans to conduct criminal background checks on all Navigator staff that will be handling sensitive or personally identifiable information (PII).  Language is included in the FOA to ensure that applicants are aware of new rules regarding Navigator requirements that were finalized on May 27, 2014.

The Navigator program still requires that at least two types of entities serve as Navigators in each Marketplace, and that at least one of those Navigators be a community and consumer-focused nonprofit.  Entities or individuals serving as Navigators are also required to have expertise in the needs of underserved and vulnerable populations; eligibility and enrollment rules and procedures; the range of QHP options and insurance affordability programs; and privacy and security standards. HHS continues to encourage organizations interested in applying to form consortiums to cover a particular service area.

* Key Dates for Pre-Application Calls:
**-  Call #1:** Thursday, June 12, 2014 from 1:30 - 3:30 p.m. EDT
[https://goto.webcasts.com/starthere.jsp?ei=1036932](http://click.icptrack.com/icp/relay.php?r=41447228&msgid=290363&act=L25C&c=1185304&destination=https%3A%2F%2Fwebmail.hhs.gov%2Fowa%2Fredir.aspx%3FC%3DXsmwdYZT30qPyztd0kPU64wEliV1WNEIA3Acnk-Bx3kNhSMKJKYgH1jCH1x37V-4LuehLNIbdx0.%26URL%3Dhttp%253a%252f%252flinks.govdelivery.com%253a80%252ftrack%253ftype%253dclick%2526enid%253dZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjEwLjMyOTU1NjkxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYxMC4zMjk1NTY5MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDYwMTgwJmVtYWlsaWQ9ZXJuZXN0LnRhaUBjbXMuaGhzLmdvdiZ1c2VyaWQ9ZXJuZXN0LnRhaUBjbXMuaGhzLmdvdiZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm%2526%2526%2526100%2526%2526%2526https%253a%252f%252fgoto.webcasts.com%252fstarthere.jsp%253fei%253d1036932)
**-  Call #2:** Tuesday, June 17, 2014 from 1:30 - 3:30 p.m. EDT
 [https://goto.webcasts.com/starthere.jsp?ei=1036407](http://click.icptrack.com/icp/relay.php?r=41447228&msgid=290363&act=L25C&c=1185304&destination=https%3A%2F%2Fwebmail.hhs.gov%2Fowa%2Fredir.aspx%3FC%3DXsmwdYZT30qPyztd0kPU64wEliV1WNEIA3Acnk-Bx3kNhSMKJKYgH1jCH1x37V-4LuehLNIbdx0.%26URL%3Dhttp%253a%252f%252flinks.govdelivery.com%253a80%252ftrack%253ftype%253dclick%2526enid%253dZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjEwLjMyOTU1NjkxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYxMC4zMjk1NTY5MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDYwMTgwJmVtYWlsaWQ9ZXJuZXN0LnRhaUBjbXMuaGhzLmdvdiZ1c2VyaWQ9ZXJuZXN0LnRhaUBjbXMuaGhzLmdvdiZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm%2526%2526%2526101%2526%2526%2526https%253a%252f%252fgoto.webcasts.com%252fstarthere.jsp%253fei%253d1036407)
**-  Call #3:** Tuesday, June 24, 2014 from 1:30 - 3:30 p.m. EDT
[https://goto.webcasts.com/starthere.jsp?ei=1036408](http://click.icptrack.com/icp/relay.php?r=41447228&msgid=290363&act=L25C&c=1185304&destination=https%3A%2F%2Fwebmail.hhs.gov%2Fowa%2Fredir.aspx%3FC%3DXsmwdYZT30qPyztd0kPU64wEliV1WNEIA3Acnk-Bx3kNhSMKJKYgH1jCH1x37V-4LuehLNIbdx0.%26URL%3Dhttp%253a%252f%252flinks.govdelivery.com%253a80%252ftrack%253ftype%253dclick%2526enid%253dZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjEwLjMyOTU1NjkxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYxMC4zMjk1NTY5MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDYwMTgwJmVtYWlsaWQ9ZXJuZXN0LnRhaUBjbXMuaGhzLmdvdiZ1c2VyaWQ9ZXJuZXN0LnRhaUBjbXMuaGhzLmdvdiZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm%2526%2526%2526104%2526%2526%2526https%253a%252f%252fgoto.webcasts.com%252fstarthere.jsp%253fei%253d1036408)
**-  Call #4:** Tuesday, July 1, 2014 from 1:30 - 3:30 p.m. EDT
[https://goto.webcasts.com/starthere.jsp?ei=1036406](http://click.icptrack.com/icp/relay.php?r=41447228&msgid=290363&act=L25C&c=1185304&destination=https%3A%2F%2Fwebmail.hhs.gov%2Fowa%2Fredir.aspx%3FC%3DXsmwdYZT30qPyztd0kPU64wEliV1WNEIA3Acnk-Bx3kNhSMKJKYgH1jCH1x37V-4LuehLNIbdx0.%26URL%3Dhttp%253a%252f%252flinks.govdelivery.com%253a80%252ftrack%253ftype%253dclick%2526enid%253dZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjEwLjMyOTU1NjkxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYxMC4zMjk1NTY5MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDYwMTgwJmVtYWlsaWQ9ZXJuZXN0LnRhaUBjbXMuaGhzLmdvdiZ1c2VyaWQ9ZXJuZXN0LnRhaUBjbXMuaGhzLmdvdiZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm%2526%2526%2526105%2526%2526%2526https%253a%252f%252fgoto.webcasts.com%252fstarthere.jsp%253fei%253d1036406)
* Letter of Intent to Apply (required) Due: June 30, 2014
* Applications Due: July 10, 2014
* Anticipated Award Date: September 8, 2014

Small entities and individuals proposing to serve smaller, hard-to-reach or underserved populations are encouraged to apply, particularly by partnering with other entities and/or individuals to form a consortium which serves a larger total portion of the population.

To see the FOA for the Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Marketplacesgo to Grants.gov and search for CFDA **93.332**

**New Federal Rules on the Marketplace and Assisters**

Excerpts from Post by Timothy Jost on Health Affairs Blog, May 17th

On May 16, 2014, the Centers for Medicare and Medicaid Services released a [final rule](http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/508-CMS-9949-F-OFR-Version-5-16-14.pdf) on Exchange and Insurance Market Standards for 2015 and beyond. The rule was accompanied by a [fact sheet](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/marketstandards-5-16-2014.html) and a [set of Frequently Asked Questions](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/downloads/Final-Master-FAQs-5-16-14.pdf). (Highlights include):

**Navigators and Other Consumer Assistance Personnel**

Recognizing that enrolling millions of eligible individuals in qualified health plans through the exchanges was going to be a massive job, Congress created the navigator program. Under the ACA, navigators are supposed to educate the public as to the availability of coverage under the ACA, to provide fair and impartial information about ACA programs, and to “facilitate enrollment in qualified health plans.” By regulation, CMS has also created two additional programs–certified application counselors (CACs) and non-navigator assisters to [assist consumers with enrollment](http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/assistance.html%20). All three categories supplement traditional agents and brokers, as well as web-brokers and insurers that directly enroll applicants, who also help individuals obtain ACA coverage. The [federal regulations and guidance impose training and testing requirements](http://healthaffairs.org/blog/2013/08/31/implementing-health-reform-irs-announcement-on-same-sex-marriages/) on navigators, assisters, and CACs.

Preemption of state restrictions on consumer assistance personnel

 [A number of states have attempted to restrict the operation of navigators and CACs](http://www.commonwealthfund.org/Blog/2013/Oct/Under-Pressure.aspx%20). About a third of the states require navigators to be licensed. Restrictive state laws also require navigators and CACs to fulfill specific background check, education, testing, and financial responsibility requirements beyond those required under the federal law and regulations, and attempt to limit their communications with enrollees. Navigator restrictions have been challenged by litigation in at least two states, and earlier this year [a federal court in Missouri enjoined that state’s navigator restrictions](http://healthaffairs.org/blog/2014/01/23/implementing-health-reform-court-blocks-missouri-restrictions-on-aca-navigators/), holding that they were preempted by the ACA. There is [some indication that restrictive navigator laws may have reduced enrollment activities in some states](http://publichealth.gwu.edu/content/new-report-provides-first-look-how-states%E2%80%99-restrictions-aca-implementation-are-affecting).

The navigator provisions of the final regulation are the most lengthy and complex. The regulations clarify situations under which state regulations of consumer assistance personnel (navigators, assisters, and CACs) are preempted, but also impose new federal restrictions on the consumer assistance personnel and authorize civil money penalties (CMPs) for consumer assistance personnel who violate their federal obligations, breach the confidentiality of patient information, or assist in enrollment fraud.

In general the ACA and implementing regulations preempt state laws that “prevent the application” of the ACA. State laws regulating or restricting the activities of navigators, assisters, and CACs, therefore, are preempted insofar as these laws prevent them from carrying out their responsibilities under the ACA. Earlier federal regulations stated this principle but did little to clarify what it meant. The proposed rule attempted to clarify the application of the rule by drawing brighter lines. Unfortunately, the final rule is significantly vaguer and provides less protection against hostile state laws than the proposed rule.

The final rule, like the proposed rule, recognizes that states may regulate consumer assister personnel to protect consumers — they may license or certify consumer assistance personnel and require them to undergo fingerprinting and background checks, for example — as long as the state regulations do not prevent them from carrying out their federally required responsibilities or conflict with federal law. The regulation also identifies, however, certain requirements states may not impose.  It makes clear that the list is non-exhaustive — state requirements that unduly restrict consumer assistance programs may be preempted even though they are not specifically identified in the regulations. The preface to the regulation states that HHS is committed to continuing to monitor state regulatory activities to ensure that they do not prevent the application of federal consumer assistance requirements.

The biggest change from the proposed rules concerns state restrictions on who may serve as a consumer assister. One of the proposed restrictions on state regulation would have prohibited states from “imposing standards [in a federal exchange] that would prohibit individuals or entities from acting as Navigators that would be eligible to participate as Navigators under standards applicable to the Federally-facilitated Exchange.” In the final rule, CMS concluded that this provision could be construed as unduly restricting state regulation, and therefore eliminated it.

The final regulations, rather, prohibit specific state restrictions on who may serve as consumer assisters. States may not require that navigators, non-navigator assisters, or CACs maintain their principal place of business in an exchange’s state (since some are national organizations). States may require that navigators and non-navigator assisters (but not CACs) maintain a physical presence in the exchange service area (although navigators and assisters are not required necessarily to be physically present to every consumer they serve in every instance). States may also not interpret conflict of interest restrictions to prohibit providers from operating assistance programs simply because they receive consideration from health insurers for health care services that they provide.

Under the proposed rule, some of the restrictions on state regulation of consumer assistance programs applied to both state and federal exchanges and some only to the federal exchange. The final rule applies the preemption provisions to all exchanges, state and federal. The final rule also extends the preemption provisions in most instances to protect CACs and non-navigator assisters, as well as navigators.

On the other hand, the rule clarifies that CACs and non-navigator assisters may be regulated by the states and must meet state requirements that are not preempted by federal law. HHS specifically does not adopt the position of the court in the Missouri litigation that states may not regulate CACs unless the state operates its own exchange.

The final regulations preempt five specific types of state consumer assistance program restrictions. First, the regulation preempts state laws that require navigators to refer consumers “to other entities not required to provide fair, accurate, and impartial information.” This preemption provision seemed to be aimed at laws in some states that require consumer assistance personnel to refer consumers to agents and brokers. The preface to the final rule clarifies that this rule is not intended to prohibit referrals to agents and brokers in situations where the advice and assistance of an agent or broker would be helpful to the consumer.

Indeed, the preface suggests that state laws that required a referral to agents and brokers who are required by state law to provide information in “a fair, accurate, and impartial manner,” would not be preempted. Of course, no state is going to admit that agents and brokers do not provide fair, accurate, and impartial advice, even though they may only be appointed by certain insurers and may receive larger commissions from some insurers than others. The preface, therefore, would seem to vitiate any effect this preemption provision may have had on state laws that can substantially undermine consumer assistance programs by limiting their ability to act independently to assist consumers, and that transparently serve to protect the business interests of agents and brokers.

The preface does, however, identify as specifically preempted state laws that require consumer assistance personnel to refer consumers who were previously insured, or had a previous relationship with an agent or broker, back to that agent or broker for service. It also rejects the argument that consumer assistance personnel are supposed to serve only the uninsured and must not assist consumers who already have health insurance. It seems to me to leave the scope of preemption of state mandated-referral laws wholly unclear.

The final regulation attempts to draw a line between providing advice regarding the substantive and comparative benefits of different health plans — which is the proper role of navigators, non-navigators assisters, and CACs — and advising consumers to choose a particular plan, which they are prohibited from doing. Consumer assistance personnel must provide fair, accurate, and impartial advice and “facilitate” plan enrollment; they may not tell consumers which plan to choose or which plan is best for the consumer.

Consumer assisters may, however, provide comprehensive information to consumers about the substantive benefits and features of plans, clarifying similarities and differences among plans, and assist consumers in making informed decisions consistent with the consumers’ expressed interests and needs. The final regulation specifically allows consumer assisters to give “advice” to consumers, despite requests from commenters that they be limited to giving “information”; state laws that would prohibit them from giving advice are preempted.

If asked to recommend a specific plan, consumer assistance personnel must say they are prohibited by federal law from doing so, and may then refer the consumer to an agent or broker who can make a recommendation. The assister must not, however, refer to the consumer to a specific agent or broker, but rather to a listing of agents and brokers, which is available for the federal exchange on its website and call center and may be available from agent and broker trade associations. Consumer assisters may not fulfill their consumer assistance obligations generally, including to SHOP exchange enrollees, by simply referring consumers to agents and brokers, but CACs are not required to assist employers with SHOP enrollment, and states that operate SHOP-only exchanges can permit navigators to fulfill their responsibilities through referrals to agents or brokers.

The proposed regulation would have preempted state laws requiring navigators to hold errors and omissions insurance. The proposal was based on the reasoning that the ACA prohibits states from requiring navigators to be agents and brokers (since it requires at least two navigator programs in each exchange, only one of which may be run by agents and brokers), and that errors and omissions insurance is agent and broker insurance. Commenters asked that this provision be extended to cover surety bonds and other financial responsibility requirements, and to protect other consumer assistance personnel.

The final rule contains the prohibition against state laws that would require navigators to be agents and brokers, but drops the prohibition against requiring errors and omissions insurance, based on the premise that such insurance is in fact not available only to agents and brokers. The final regulation would also allow states to require non-navigator assisters and CACs to be licensed as agents and brokers, although this could significantly impair the operations of these programs and their ability to supplement the assistance offered by agents and brokers. The preface notes, however, that if financial responsibility requirements would prevent consumer assistance personnel from fulfilling their federal duties, such requirements may be preempted.

Finally, the final regulations generally preempt state laws or regulations that would, as applied, prevent the implementation of a navigator program. Recognizing that state licensure conditions, such as fingerprinting, background checks, or additional educational requirements, may be facially permitted, it notes that if these requirements or other conditions such as credit checks or high school diplomas are imposed in such a way that consumer assisters cannot meet federal requirements or exchanges cannot implement their consumer assistance programs, such state laws are preempted. This applies to both the federal exchange and the state exchanges. This final preemption provision is quite vague, and it is difficult to see how it will be enforced, but presumably states must understand that laws and regulations adopted simply to harass consumer assisters or to protect the business interests of agents and brokers are not permitted under federal law.

Federal restrictions on consumer assistance personnel

While preempting some state consumer assister restrictions, the final rule also imposes new federal restrictions on consumer assistance personnel and extends existing requirements. All consumer assistance personnel must obtain consumer authorization before accessing a consumer’s personally identifiable information (and the authorization must be retained for six years). No consumer assisters may charge an applicant or enrollees for application or other assistance, or request or receive any remuneration from or on behalf of an applicant or enrollee for providing these services. They are also prohibited from receiving remuneration from health insurers or stop-loss insurers with respect to the enrollment of any individual. Consumer assisters must complete required training and be recertified on at least an annual basis.

New restrictions require navigators and non-navigator assisters (but not CACs) to maintain a physical presence in their exchange service area. This does not prohibit the use of remote communications, such as the telephone or internet, to communicate with some consumers. New regulations also provide that federal exchange consumer assistance personnel may not be compensated on a per-application, per-individual assisted, or per-enrollment basis. Consumer assistance personnel may not provide applicants with gifts, including gift cards or cash, unless they are of nominal value (under $15); they also may not offer promotional items from third parties to any applicant or potential applicant in connection with or as an inducement to apply or enroll in a qualified health plan. They are additionally prohibited from going door-to-door or from making unsolicited direct contacts with consumers, including robocalls, to provide application or enrollment assistance, unless the consumer initiates the contact.

The final rule, however, meliorates somewhat the restrictions that had been proposed. While consumer assistance personnel may not charge for application or enrollment services, they may charge for unrelated services, such as medical care or legal services that they also provide. State exchanges may compensate consumer assistance personnel on a per-application, per-individual assisted, or per-enrollment basis. Some state exchanges are already doing so, and although CMS does not regard this as a best practice, it is not going to force the states to change, but will rather just prohibit these practices in the federal exchange.

The final regulation clarifies that the prohibition against provision of promotional items that might be of value to consumers only applies if these items are provided to induce enrollment. Diabetic testing supplies, for example, could perhaps be provided as part of an outreach campaign. Reimbursement for legitimate consumer expenses, such as travel or postage, is also permitted. The use of exchange funds to purchase gifts or promotional items by navigators or non-navigator assisters, however, is clearly prohibited.

Door-to-door or robocall outreach efforts — as opposed to enrollment efforts — are not prohibited, and in-home enrollment assistance that has been requested by the consumer is permitted (although the preface suggests that two personnel should go for home visits rather than just one for security reasons). Finally, more scope is permitted for contacts with consumers with whom a relationship already exists, such as the use of robocalls by a health center to remind consumers of appointments.

The final regulation also permits CMS to impose civil money penalties (CMPs) on consumer assistance personnel within the federal exchange who violate federal obligations, including regulatory requirements and contractual or grant terms and conditions. CMS will not exercise this authority with respect to state exchanges. CMPs can amount to $100 per day for each individual directly affected. Where CMS determines, based on a preliminary investigation, that a potential violation exists, it will provide a notice to the consumer assistance entity, giving it 30 days to refute the allegations. The entity can request an extension if necessary.

Depending on various factors, such as the gravity and frequency of the violation, the harm incurred by consumers, and the culpability of the consumer assistance entity, CMS may enter into a corrective action plan rather than impose a CMP. CMS also will not impose a CMP if the entity did not know or, exercising reasonable diligence, could not have known of the violation, and the violation is corrected within 30 days of the time the entity knew or should have known of the violation. A six-year statute of limitations applies to CMP actions. CMP assessments can be appealed.

The final regulation also creates CMPs for improper use and disclosure of personally identifiable information or the provision of false or fraudulent information to an exchange. Penalties for providing false information can be imposed whether false information is provided negligently or willfully, and they apply to consumer assisters and agents and brokers who encourage or facilitate the provision of false information. The rule lists factors that should be taken into account in determining the amount of the penalty, such as the nature and extent of the harm resulting from the violation or whether the person received compensation associated with the violation. No penalty will be imposed if CMS concludes that there was reasonable cause for a failure to provide correct information or that the person acted in good faith.

Penalties of up to $25,000 per application can be imposed for negligent provision of false information or for improper use and disclosure of personally identifiable information; penalties of up to $250,000 can be imposed for knowing and willful provision of false information. HHS must send a person on whom it intends to impose a penalty a notice of the factual basis and reason for the penalty and the amount of the penalty. The person subject to the penalty then has 60 days to appeal the imposition of the penalty. HHS can offer a corrective action plan in lieu of a penalty or settle or compromise a penalty.

See: http://healthaffairs.org/blog/2014/05/17/implementing-health-reform-final-2015-exchange-and-insurance-market-standards-rule/

**FAQ’s**

From Families USA

**Q: Do special enrollment periods apply to family members?**

A: In most cases, if one person in a family qualifies for a special enrollment period because of a qualifying life event, individuals in their family can also enroll in health coverage. For example, if a woman gets married or has a baby, she can enroll in a marketplace health plan, and her spouse and children can also enroll. Similarly, if a woman loses employer-based coverage, she can enroll in a marketplace health plan, and her spouse and children can also enroll.

There are a few special enrollment periods that have different rules. Special enrollment periods granted for the following reasons only apply to current enrollees: 1) a marketplace health plan violated their contact with an enrollee, 2) individuals currently enrolled in a marketplace plan newly qualify for financial assistance (premium tax credits or cost-sharing reductions), and 3) changes to job-based coverage result in health insurance that fails to meet the Affordable Care Act standards for providing adequate coverage, or that is unaffordable for the employee.

From In the Loop

Q: I have had several consumers who face gaining and losing insurance 2 to 3 times per year. Does anyone know of a provision in the law about this situation? ESI for construction, unions and other trades seems to be quite different from the kind folks who work in an office have. For example: Consumer works driving heavy equipment and is a union member. His work is dependent on the weather (rain stops the work). His health insurance only kicks in when the employer has a specific level of billable hours of work for the "job" he is working on. Apparently this is because the ESI is a fringe cost added to the hourly rate charged for the work they do. So, not enough work hours means no insurance. I am working with a consumer who says he has coverage gaps several times a year. He says he often will not know until the last week of a given month that he will not have insurance the following month.

A: (from[**Center for Health Insurance Reforms**](http://chir.georgetown.edu/)**):** There are a couple of things to keep in mind for folks like these (individuals who have a change in their coverage status because of their work status over the course of the year). Individuals who are in a waiting period to enroll in employer-sponsored coverage are eligible for premium tax credits. That may be a regular waiting period (which can be up to 90 days under the ACA) or one like the union worker has, in which he must accrue a minimum number of hours worked to qualify for coverage under a so-called Taft-Hartley plan (for which employers pay an hourly contribution toward the cost of coverage; this is also allowed under the ACA). Once the waiting period is over and the individual can enroll in the employer plan, they are no longer eligible for premium tax credits. If an employee is eligible to enroll in an employer plan and it is affordable and adequate, under the rules of the ACA, the individual is not eligible for premium tax credits, even if they forego that employer coverage.

Also, in the second example provided, such month-to-month coverage changes will not be allowed under the ACA. Employers have some flexibility in determining whether variable hour employees meet the test for full-time status (working on average 30 hours a week). They can average the hours a variable hour employee worked over the previous 3-12 months. If, over that time frame (called a “look-back” period), the employee meets the 30-hour test, then the employer must provide coverage for at least 6 months. If, over the look-back period the employee doesn’t average 30 hours per week and isn’t eligible for the employer-sponsored plan, then they would be eligible for premium tax credits on the marketplace. Under federal rules, employees qualify for premium tax credits during the “look back” period while they are waiting for a determination of whether they qualify for coverage."

Q: If a consumer completes an application with the Marketplace Call Center and cannot access it online, what should the consumer do?

A: (1) Contact the Call Center and ask to switch communication preferences to email. (2) The consumer should then log in to her online account and enter the application number to link the application to her account. (3) The consumer can then switch her communication preferences to the method she prefers.

From CMS

Q: If a consumer is enrolled in COBRA through his or her spouse and the spouse is now going to be on Medicare, would the consumer be eligible for a Special Enrollment Period (SEP) in the Marketplace?

A: It depends. If the spouse’s Medicare eligibility results in a loss of coverage for the consumer, the consumer will be eligible for an SEP and can enroll in Marketplace coverage. If the consumer can continue COBRA when the spouse becomes Medicare eligible, the consumer will not be eligible for an SEP because the spouse’s Medicare eligibility did not result in a loss of coverage for the consumer. For more information about reporting life changes, please see: [https://www.healthcare.gov/how-do-i-report-life-changes-to-the-marketplace/](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjAzLjMyNzU2ODYxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYwMy4zMjc1Njg2MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDQ5OTQxJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&115&&&https://www.healthcare.gov/how-do-i-report-life-changes-to-the-marketplace/) and [http://marketplace.cms.gov/help-us/report-life-event.pdf](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjAzLjMyNzU2ODYxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYwMy4zMjc1Njg2MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDQ5OTQxJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&116&&&http://marketplace.cms.gov/help-us/report-life-event.pdf).

Q: Some consumers who are eligible for COBRA but have not yet enrolled in COBRA are being determined ineligible for tax credits because they indicate they are eligible for COBRA on the Marketplace application. Please clarify how consumers in this situation should answer the application questions.

A: The Marketplace application asks: “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. Additional questions in this section of the application will collect information about the coverage the consumer is eligible for to determine eligibility for APTC.  For more information please see “Tips Regarding Employer-sponsored Coverage Application Questions” which appeared in the April 8, 2014 edition of the Weekly Assister Newsletter.

Q: If a consumer enrolled in COBRA in spring 2013 and COBRA will not be exhausted until August 2014, can he or she voluntarily end COBRA, and qualify for a special enrollment period (SEP) under the May 2, 2014 COBRA SEP guidance?

A: Consumers who currently have COBRA continuation coverage may qualify for a one-time SEP for a limited time. Consumers who are currently enrolled in COBRA continuation coverage have the option of switching to a Marketplace plan between now and July 1, 2014. If interested, COBRA enrollees should call the Marketplace Call Center at 1-800-318-2596, and inform the Call Center that they are calling about their COBRA benefits and the Marketplace. Once determined eligible, consumers can view all plans available to them and continue the enrollment process over the phone or online, by creating an account on HealthCare.Gov or logging into their existing account. Assisters should be sure to remind consumers that aside from this limited time SEP, generally consumers cannot voluntarily drop their COBRA coverage and enroll in Marketplace coverage outside of the open enrollment period, unless they are otherwise eligible for an SEP. For more information please see [http://marketplace.cms.gov/help-us/sep-for-consumers-with-cobra.pdf](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjAzLjMyNzU2ODYxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYwMy4zMjc1Njg2MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDQ5OTQxJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&117&&&http://marketplace.cms.gov/help-us/sep-for-consumers-with-cobra.pdf) and [https://www.healthcare.gov/what-if-i-currently-have-cobra-coverage/](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjAzLjMyNzU2ODYxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYwMy4zMjc1Njg2MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDQ5OTQxJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&118&&&https://www.healthcare.gov/what-if-i-currently-have-cobra-coverage/).

Q: Is there a worksheet tool or online calculator available for consumers to use when determining whether employer-sponsored coverage exceeds the 9.5% affordability threshold?

A: Currently there is not a worksheet or online calculator available outside the application to calculate affordability of employer-sponsored coverage. The affordability of a consumer’s employer-sponsored coverage is calculated by the Marketplace based on the information a consumer enters into his or her application. The consumer responds to questions about whether the coverage meets the minimum value standard and the cost of premiums for the lowest-cost self only plan. The cost of coverage is then compared to household income (based on the tax household’s projected income for the coverage year.) A consumer completing the paper application should fill in Appendix A to answer questions about their employer sponsored coverage.  For more information about affordable coverage please see: [https://www.healthcare.gov/glossary/affordable-coverage/](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjAzLjMyNzU2ODYxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYwMy4zMjc1Njg2MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDQ5OTQxJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&119&&&https://www.healthcare.gov/glossary/affordable-coverage/).

Q: To qualify for a Special Enrollment Period (SEP) for moving to a new service area, must the consumer already be enrolled in coverage before the move?

A: No. A consumer that moves to a new service area is eligible for an SEP whether or not he or she was enrolled in coverage before the move.

For more information about reporting life changes, please see: [https://www.healthcare.gov/how-do-i-report-life-changes-to-the-marketplace/](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjAzLjMyNzU2ODYxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYwMy4zMjc1Njg2MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDQ5OTQxJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&120&&&https://www.healthcare.gov/how-do-i-report-life-changes-to-the-marketplace/) and [http://marketplace.cms.gov/help-us/report-life-event.pdf](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjAzLjMyNzU2ODYxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYwMy4zMjc1Njg2MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDQ5OTQxJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&121&&&http://marketplace.cms.gov/help-us/report-life-event.pdf).

Q: If a consumer moves to a new area of the state where the same insurance plans are offered, but the plans are a different price than where he or she is moving from (or have somewhat different networks), does that trigger an SEP?

A: The same insurance company may offer plans throughout the state, but different prices or networks may indicate a new service area. Consumers that permanently move to a new service area are eligible for an SEP. The consumer should make sure to check the provider directory for their new service area. For more information see: [https://www.healthcare.gov/how-do-i-report-life-changes-to-the-marketplace/](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjAzLjMyNzU2ODYxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYwMy4zMjc1Njg2MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDQ5OTQxJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&122&&&https://www.healthcare.gov/how-do-i-report-life-changes-to-the-marketplace/) and [http://marketplace.cms.gov/help-us/report-life-event.pdf](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjAzLjMyNzU2ODYxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYwMy4zMjc1Njg2MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDQ5OTQxJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&123&&&http://marketplace.cms.gov/help-us/report-life-event.pdf).

Q: Sally is losing employer coverage and therefore qualifies for an SEP. Sally’s spouse, Bob, was not eligible for Sally’s employer coverage and chose to be uninsured.  Is Bob also eligible for an SEP or is just Sally eligible for an SEP?

A: Sally is eligible for an SEP for loss of minimum essential coverage and Bob is eligible for the SEP based on the fact that he is a dependent of Sally. Sally and Bob may apply to the Marketplace and enroll in coverage. For more information see: [https://www.healthcare.gov/how-can-i-get-coverage-outside-of-open-enrollment/](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjAzLjMyNzU2ODYxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYwMy4zMjc1Njg2MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDQ5OTQxJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&124&&&https://www.healthcare.gov/how-can-i-get-coverage-outside-of-open-enrollment/) and [http://marketplace.cms.gov/help-us/assisting-consumers-losing-coverage.pdf](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjAzLjMyNzU2ODYxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYwMy4zMjc1Njg2MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDQ5OTQxJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&125&&&http://marketplace.cms.gov/help-us/assisting-consumers-losing-coverage.pdf)

Q: Can people buy health insurance outside of the Marketplace at any time throughout the year?

A: In some limited cases some insurance companies may sell private health plans outside the Marketplace and outside Open Enrollment that count as [minimum essential coverage](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjAzLjMyNzU2ODYxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYwMy4zMjc1Njg2MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDQ5OTQxJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&126&&&https://www.healthcare.gov/glossary/minimum-essential-coverage). These plans meet all the requirements of the health care law, including covering pre-existing conditions, providing free preventive care, and not capping annual benefits. If you have one of these plans, you won’t have the pay the [fee](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjAzLjMyNzU2ODYxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYwMy4zMjc1Njg2MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDQ5OTQxJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&127&&&https://www.healthcare.gov/how-can-i-get-coverage-outside-of-open-enrollment/#part=5) that some people without coverage must pay.

Insurance companies, agents, brokers, and online health insurance sellers may offer these health plans outside the Marketplace. The Marketplace does not list or offer these plans. You can’t get premium tax credits or lower out-of-pocket costs for plans you buy outside the Marketplace. Insurance companies can tell you if a particular plan counts as minimum essential coverage. Each plan’s [Summary of Benefits and Coverage](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjAzLjMyNzU2ODYxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYwMy4zMjc1Njg2MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDQ5OTQxJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&128&&&https://www.healthcare.gov/glossary/summary-of-benefits-and-coverage) also includes this information.

For more information: [https://www.healthcare.gov/how-can-i-get-coverage-outside-of-open-enrollment/#part=4](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjAzLjMyNzU2ODYxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYwMy4zMjc1Njg2MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDQ5OTQxJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&129&&&https://www.healthcare.gov/how-can-i-get-coverage-outside-of-open-enrollment/#part=4)

**New Guidance on Same-Sex Marriage and Medicaid**

From CMS

Last week, [CMS issued guidance](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjAzLjMyNzU2ODYxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYwMy4zMjc1Njg2MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDQ5OTQxJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&106&&&http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-005.pdf) advising states about implications for certain populations of the 2013 Supreme Court decision United States v. Windsor, which invalidated Section 3 of the Defense of Marriage Act (DOMA). The guidance related to populations such as the elderly and people with disabilities whose eligibility for Medicaid is not determined on the basis of modified adjusted gross income (MAGI) methodologies.

[The IRS and the Federally-facilitated Marketplace](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjAzLjMyNzU2ODYxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYwMy4zMjc1Njg2MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDQ5OTQxJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&107&&&https://www.healthcare.gov/married-same-sex-couples-and-the-marketplace/) already treat same-sex married couples the same as opposite-sex married couples for the purpose of determining eligibility for advance premium tax credits (APTCs) and cost-sharing reductions (CSRs), no matter what state they live in. CMS issued guidance last fall on how the Supreme Court decision applies to people whose Medicaid determinations are based on MAGI. This [September 27, 2013 guidance](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjAzLjMyNzU2ODYxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYwMy4zMjc1Njg2MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDQ5OTQxJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&108&&&http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-006.pdf) noted that while we believe that it is appropriate to recognize same-sex marriages that were celebrated in accordance with the laws of any state, territory, or foreign jurisdiction, in view of the unique federal-state relationship that characterizes the Medicaid and CHIP programs, states may apply their own laws in deciding whether a couple is lawfully married.

Last week’s guidance extends this policy to Medicaid determinations not based on MAGI, such as those for the elderly and people with disabilities. As a result, states will be permitted to apply the state law definition of marriage in the context of Medicaid eligibility determinations for both MAGI and non-MAGI populations. Last week’s guidance is available here: [http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-005.pdf](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQwNjAzLjMyNzU2ODYxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MDYwMy4zMjc1Njg2MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDQ5OTQxJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&109&&&http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-005.pdf).

**Webinars: Latino Language Access and the ACA**

This is a three-part webinar series on outreach and enrollment for the Latino population starting with a webinar on Latino Language Access and the Affordable Care Act (ACA), sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) Office of Behavioral Health Equity.

Participants will learn about language access issues identified through recent community discussions in El Paso, Los Angeles and Tampa; and language access challenges and successes in outreach and enrollment of uninsured Latinos.

Presenters will speak on the issues and feedback shared by Latinos with limited English proficiency to help community based organizations and other groups develop or re-evaluate their outreach and enrollment strategies to ensure meaningful language access by Latino communities.

Please mark your calendars for this important webinar series, and use the following call information and webinar link to participate on June 26:

***“Latino Language Access and the ACA”***

Thursday, June 26, 2014

2:00 – 3:00 pm EST

Dial-in: 888-324-9647

Passcode: SAMHSA

Participant webinar link:

https://www.mymeetings.com/nc/join.php?i=PW2572602&p=SAMHSA&t=c

The other webinars in this series will be held on July 24 and August 22. For additional information about this upcoming webinar and the webinar series, please contact Fred Sandoval at triozia1@aol.com or Silvia Sierra at cultivatingcommunitiesllc@gmail.com

**Health Net Proposes Rate Increases**

From the Arizona Department of Insurance

**Health Net Life Insurance Company has filed a threshold rate increase with the Arizona Department of Insurance (“ADOI”).  The requested rate increase affects coverage for Small Group Major Medical Health Insurance-On and Off Exchange.  The filing is under review at this time.**

**Health Net's Requested Average Increase:  15.900%**
**Health Net's Requested Implementation Date: January 1, 2015**
**SERFF Tracking No:  HNAZ-129554036**

**To view the filing, please go to** [**http://www.azinsurance.gov/RateReview/HFAIpage.html#**](http://azinsurance.us5.list-manage.com/track/click?u=c35918f3e6c539c859d7ed329&id=1fa7e37e48&e=efd95d5a4b) **.**
**On that page, click on “Click here to search Health Insurance Filings.”**
**(There also is a link for directions if needed.)**

**(Alternatively, go to** [**www.azinsurance.gov**](http://azinsurance.us5.list-manage1.com/track/click?u=c35918f3e6c539c859d7ed329&id=8737ab6403&e=efd95d5a4b)**; click on Rate Review on the lower right hand column, then click on “ATTN:  RATE DETECTIVE! Click here to access,” then Click “Click Here to Search Health Insurance Filings.”)**

**When on the SERFF page, Click I Agree if desired, then enter** HNAZ-129554036 **under Tracking Number and click SEARCH at the top of the page.  When the filing appears, click on “View Filing” on the left hand side.**

**You can submit a comment on the proposed rate increase by e-mailing ADOI at** **Ratereview@azinsurance.gov** **.  Please put "Comment on Health Net Small Group PPO 2015 Rate Increase" in the subject line of the e-mail.**

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