Covered Clips

A Summary of News and Activities for the Cover Arizona Coalition

Weeks of November 17th, 24th

Weeks of December 1st and 8th

**Enrollment on Track to Hit or Exceed 2015 Enrollment Goal**

From Kaiser Health News

With less than a week until the deadline to buy individual health insurance that begins Jan. 1, experts say sign-ups are on course to hit or exceed the Obama administration’s projection of about 9 million enrollees in 2015. Several weeks into the second year of the Affordable Care Act’s insurance exchanges, about 1.5 million people have enrolled in coverage, according to data from state and federal exchanges. As of Dec. 5, almost 1.4 million had enrolled through the federal insurance exchange, which serves 37 states, the Centers for Medicare & Medicaid Services reported Wednesday. Another 183,000 chose plans through state exchanges, including nearly 49,000 in California, according to a Kaiser Health News analysis of state exchange data.  Enrollment figures were not available for exchanges in New York, Idaho and Rhode Island. ‘Exchange enrollment is far ahead of 2014’s pace due to improved technology performance,’ said Caroline Pearson, vice president of Avalere Health, a consulting firm. She said sign-ups are on track to ‘far exceed’ the Obama administration’s 9 million projection, made just before open enrollment began in November. If enrollment continues at this pace, she said, the federal and state exchanges should enroll between 4 and 5 million new participants, she said. That’s in addition to 6.7 million who got coverage for 2014, many of whom are expected to re-enroll for 2015.

<http://kaiserhealthnews.org/news/with-1-5-million-sign-ups-so-far-obamacare-enrollment-is-brisk/>

**Marketplace Enrollment Numbers Continue to Grow**

|  |  |  |
| --- | --- | --- |
| **Federal Marketplace Snapshot** | **Week 3Nov 29 – Dec 5** | **CumulativeNov 15 – Dec 5** |
| Plan Selections | 618,548 | 1,383,683 |
| *New consumers* | 48 percent | 48 percent |
| *Consumers renewing coverage* | 52 percent | 52 percent |
| Applications Submitted | 974,018 | 2,526,574 |
| Call Center Volume | 982,022 | 2,536,267 |
| Average Call Center Wait Time | 3 minutes 11 seconds | 2 minutes 31 seconds |
| Calls with Spanish Speaking Representative | 87,534 | 236,588 |
| Average Wait for Spanish Speaking Rep | 12 seconds | 9 seconds |
| HealthCare.gov Users | 3,023,301 | 7,942,195 |
| CuidadoDeSalud.gov Users | 98,336 | 244,016 |
| Window Shopping HealthCare.gov Users | 1,072,169 | 3,061,540 |
| Window Shopping CuidadoDeSalud.gov Users | 19,675 | 61,068 |

Source: <http://www.hhs.gov/healthcare/facts/blog/2014/12/open-enrollment-week-three.html>

**Identifying the Potential for Marketplace Enrollment**

Fun Fact:

In the FFM, there have been more plan selections in the first three weeks of OE2 than in the first three months of OE1.

Oct 1- Dec 28, 2013: nearly [1.2 million plan selections](http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib_2014jan_enrollment.pdf)

Nov 15- Dec 5, 2014: nearly 1.4 million plan selections

The Henry J. Kaiser Family Foundation has developed a great new resource for identifying the potential for Marketplace enrollment by zip code, including what percentage that actually signed up in 2014. The interactive tool even provides demographic information, further helping those who want to conduct outreach. It is a great tool for those conducting outreach, planning media efforts, or planning enrollment events. The tool can be found here:

<http://kff.org/interactive/mapping-marketplace-enrollment/?utm_campaign=KFF%3A+General&utm_source=hs_email&utm_medium=email&utm_content=15036428&_hsenc=p2ANqtz--6c3lXJVg4Vqc9Df0k4_cVE8rMsbnRHnKkG8g_vhmBtaAaC8CbFiHNADT8EYJFeh0Pa03wqRC09n6HoLQA16yqvwnpTw&_hsmi=15036428>

**Arizona’s Get Covered Connector Provides Consumers Many Assistance Options**

The Get Covered Connector, which can be found at <http://coveraz.org/connector/>, provides Arizona consumers and assisters with a means of identifying and scheduling enrollment assistance to apply for Marketplace or AHCCCS coverage in their local community. More than 1,500 appointments with assisters have been scheduled since its launch in mid-November. More than 15,000 appointments are available between now and the end of open enrollment, with more appointments being added every day.

**Polls: Half of Uninsured Plan to Obtain Coverage**

From The Hill

Half of uninsured people in the United States plan to buy health plans during ObamaCare's open enrollment period, while four in 10 say they will remain without coverage, according to a new survey released Friday.

About one-quarter of all uninsured people said they do not expect to find a plan they can afford and will not enter the exchanges as a result, the Kaiser Family Foundation reported in its monthly tracking poll.

The figures highlight challenges for the Obama administration now that the health law's second enrollment period is underway.

Health officials have just three months to convince people to enter the exchanges and to overcome impressions that medical insurance is too expensive for people with lower incomes.

The Department of Health and Human Services (HHS) and its allies emphasize that federal tax subsidies can make plans more affordable.

Groups are also starting to play up the healthcare law's penalty for not carrying insurance, which began this year and is designed to bring people into the exchanges.

Many uninsured people appear to be in the dark about open enrollment, however.

About nine in 10 (89 percent) people could not correctly identify the sign-up period's start date of Nov. 15, and only a handful said they had seen ads from insurers (40 percent) or other players (34 percent) about how to enroll in the marketplaces.

These activities are expected to ramp up in the coming months.

The poll was conducted from Nov. 5-13. Responses from the uninsured have a margin of error of 9 points.

<http://thehill.com/policy/healthcare/224969-half-of-uninsured-plan-to-obtain-coverage-poll-finds>

**Take Action: Network Adequacy Standards**

From Families USA

As a consumer health advocate, you know the importance of network adequacy standards that require health plans to offer consumers meaningful access to health care providers who can deliver the right care, at the right time, without consumers having to travel too far.

We wanted to alert you to **two immediate opportunities** to take action to affect network adequacy standards and provider network transparency.

**Immediate Opportunities to Engage on Network Adequacy**

* The US Department of Health and Human Services Proposed Rule on the [**2016 Notice of Benefit and Payment Parameters**](http://cts.vresp.com/c/?FamiliesUSAFoundatio/5cd79513b1/097ce12590/102d022480) is open for comment until December 22, 2014. In [**this rule,**](http://cts.vresp.com/c/?FamiliesUSAFoundatio/5cd79513b1/097ce12590/2e518f7e32) HHS outlines more specific network adequacy and transparency standards that will be required of qualified health plans in marketplaces. [**Click here**](http://cts.vresp.com/c/?FamiliesUSAFoundatio/5cd79513b1/097ce12590/df3bae05f9) to submit a comment.
* The National Association of Insurance Commissioners (NAIC) is currently updating its [**model act**](http://cts.vresp.com/c/?FamiliesUSAFoundatio/5cd79513b1/097ce12590/1459ed4624/1417739546034) on network adequacy. This model provides an example that states can use to enact their own legal protections to guarantee private insurance consumers an adequate provider network once they are enrolled in coverage. Advocates can email jmatthews@naic.org until January 12, 2015 to share their thoughts.

**Proposed Rule Would Establish Longer Open Enrollment Period for 2014-2015**

From NHelp

The Department of Health and Human Services recently released a [proposed rule](https://s3.amazonaws.com/public-inspection.federalregister.gov/2014-27858.pdf) on benefit and payment requirements for insurers and Marketplaces for 2016. Among other things, the proposed rule would:

·         Establish a yearly open enrollment period that would run from October 1 through December 15;

·         Change the default renewal process from one that re-enrolls individuals into their same plan to one that enrolls them into a lower cost plan;

·         Require all Marketplaces, QHP issuers, and web based insurance brokers to offer interpreter services via telephone in at least 150 languages;

·         Remind issuers that placing most or all of the prescriptions that treat a specific condition on a high cost tier may be considered discriminatory;

·         Codify existing essential community provider standards for the Federally Facilitated Marketplace; and

·         Clarify that QHP issuers must publish a current and accurate provider directory with information on which providers are accepting new patients.

There is a 30-day comment period for individuals and organizations wishing to submit comments. Please check the Federal Register tomorrow for the exact deadline for submitting comments.

**Obamacare Enrollment Data Comes Under Scrutiny**

From USA Today

It took a junior congressional staffer about 20 minutes to discover what the U.S. Department of Health and Human Services says it didn't know about its own health exchange enrollment data. Marilyn Tavenner, the administrator for the Centers for Medicaid and Medicare Services, told Congress in September that 7.3 million people had enrolled in coverage through Obamacare. What she did not say — and Obama administration officials say they did not realize — was that nearly 400,000 of them were standalone dental plans. That was revealed only after the House Oversight and Government Reform Committee asked for the data to back up those numbers. Even then, it took HHS a month to provide hundreds of pages of barely legible printouts. When the committee asked for spreadsheets, HHS provided 289 of them — all password protected. Republicans say the episode is part of a troubling pattern of transparency failures in implementing the Affordable Care Act, which allows Americans without insurance to buy it from government-run online exchanges. Rep. Darrell Issa, R-Calif., the oversight committee chairman, called Tavenner to testify Tuesday about the incident. HHS denied any deliberate attempt to obscure the health plan numbers.

<http://www.usatoday.com/story/news/politics/2014/12/08/house-oversight-gruber-tavenner-hearing/20091465/?utm_campaign=KHN:+First+Edition&utm_source=hs_email&utm_medium=email&utm_content=15207933&_hsenc=p2ANqtz--LlA6NKssQvNDpV9F5knme-HsZvklGGY8sHcg9>

**Understanding Changes in Consumers’ Marketplace Financial Assistance**

From CMS

As current Marketplace consumers prepare to renew their coverage for 2015, it is important to keep in mind changes that they may see to their financial assistance. Below is a consumer-facing explanation for changes that may occur.

If you are currently enrolled in a plan through the Marketplace and update your application for 2015, you will receive new eligibility results and may find that your eligibility for financial assistance has changed. There are several reasons that your tax credit might have changed, even if your income and other information has not changed.  Remember that your final tax credit amount will be reconciled on the tax return you file at the end of the year.

Benchmark Plan**:** Because tax credits are based in part on the benchmark plan (the second lowest cost silver plan), consumers’ tax credits may change if the benchmark plan changes. If the premium for the benchmark plan goes up, your tax credit may go up, even if your income will stay the same. If the premium for the benchmark plan goes down, your tax credit amount will go down as well because you are being asked to pay less.

Federal Poverty Level: The Federal Poverty Level is a measure used to help determine how much financial help you can get paying for coverage and it typically changes each year during open enrollment. And so, even if your personal situation- meaning your income and the number people in your household- didn’t change, the amount of the tax credit you are eligible for can change. If the Federal Poverty Level increases, as it did this year, this generally increases the amount of financial assistance you can receive, even if your income stays the same.

Age Change**:** Your age may impact your tax credit and plan rates as well.

**Obamacare Co-Ops Cut Prices, Turn Up Health on Rival Insurers**

From Kaiser Health News

When Anna Duleep went shopping recently for 2015 health coverage on the Connecticut insurance exchange, she was pleasantly surprised to find a less expensive plan.

To get the savings, the substitute math teacher had to change from for-profit giant Anthem Blue Cross and Blue Shield to a fledgling carrier she’d never heard of. Still, Duleep, 37, liked saving $10 on her monthly premium of about $400 and knowing that her new plan, HealthyCT, is a nonprofit governed by consumers. She also liked that all her doctors participate. “I just figured, ‘why not change?’” she said.

HealthyCT, which cut its 2015 premiums by an average of 8.5 percent, is one of at least a half dozen co-ops created through the Affordable Care Act that have lowered 2015 premiums in a bid to boost membership in their second year of operation. But those low premiums are upsetting so-called “legacy” insurance plans like Blue Cross and Blue Shield affiliates that have traditionally dominated insurance markets.

Idaho Blue Cross CEO Zelda Geyer-Sylvia said that while she welcomes competition, it’s not fair to have to compete against a carrier getting millions in low-interest federal loans.

“It’s unfortunate, because this is going to be very disruptive to the market,” Geyer-Sylvia said about Montana Health CO-OP, which moved into Idaho this year and undercut competitors’ rates.

The co-ops say that’s just what Congress intended when it tucked them into the health law to mollify those seeking a government-run insurance plan. “Lower prices for consumers are very good news,” said Jan VanRiper, chief executive of the [National Alliance of State Health CO-OPs](http://nashco.org/members-co-op/) (NASHCO), a trade group.

Two dozen co-ops, which received $1.9 billion in federal loans, were designed to compete with established carriers and lower prices.  For 2015 at least, co-ops are offering the lowest-cost silver plans in all, or large parts of Arizona, Connecticut, Colorado, Idaho, Illinois, Maine, Maryland, New Mexico and New Jersey, according to NASHCO. The silver-tiered plans are the most popular type of plan on the federal and state insurance exchanges.

VanRiper disputes that co-ops are competing unfairly, saying they have to pay back their start-up loans in five years and could not have met state solvency requirements for insurers or paid claims before generating premiums without that money.

Lagging First-Year Sign-ups

Nationally, [about 450,000 people are enrolled in co-ops](http://oversight.house.gov/wp-content/uploads/2014/06/ObamaCare-CO-OP-Enrollment-Figures-2014.pdf) in 26 states — far fewer than the 575,000 the government had projected for their first year. “Last year co-ops priced a little blindly because they did not have any claims experience and this year some are pricing more competitively,” VanRiper said.

But co-ops with low sign-up numbers in their first year have taken steps to lower their costs — and premiums.  In addition to HealthyCT, other co-ops that cut their rates for 2015 include Meritus of Arizona, Evergreen Health [Co-op](http://evergreenmd.org/) of Maryland, Oregon’s Health CO-OP, Colorado HealthOP, Land of Lincoln Health in Illinois and Health Republic Insurance of N.J.

Blue Cross’ Geyer-Sylvia argues that Montana Health CO-OP’s low rates are “unsustainable” because they won’t get enough premium revenue to pay claims over the long run. In the meantime, they could pull consumers away from Blue Cross and three other carriers on the Idaho exchange.

Consumers may not realize, she said, that the lower premiums will mean reduced government subsidies for everyone who is eligible for them. That’s because the subsidy is pegged to the second-lowest-cost silver plan.  That cost is decreasing in Idaho because the co-op has introduced lower-priced plans than its competitors.  As a result, consumers enrolled in more expensive options, such as Blue Cross’ plans, will have to pay more since they must cover the difference between the premium and the government’s financial help. On the flip side, consumers would save money by switching to the co-op’s plans.

Here’s how those price differences would play out for a 48-year-old man in Eagle, Idaho:  He can get a silver plan for as low as $266 a month with the Montana Health CO-OP, which markets itself as Mountain Health CO-OP in Idaho. The lowest-cost Blue Cross plan is $303. The Mountain Health CO-OP plan also has lower deductibles — $3,650 compared to $4,000 for the Blue Cross plan.

Sabrina Corlette, senior research fellow at Georgetown University, said many co-ops are increasing competition and driving down costs, as Congress intended. “There’s no question in many markets, co-ops are really driving some price competition and making legacy carriers more competitive in their pricing,” she said.

Corlette cautioned that the long-term financial health of the co-ops is uncertain because their first-year enrollment lags projections and they must repay their loans.  Low enrollment could hurt the plans if they don’t get enough premium revenue to pay their medical claims. Higher-than-expected enrollment could result in budget-breaking health costs, she said.

Brendan Buck, spokesman for America’s Health Insurance Plans, the industry’s trade group whose members do not include the Obamacare co-ops, is also dubious about their viability. “These plans do not offer the kind of stability that consumers are looking for,” he said.

Making Inroads?

Despite difficulty getting traction in some states, co-op officials say that they are gaining ground.

The experience of Land of Lincoln Health, the Illinois co-op, may be illustrative. After attracting just 3,800 members this year, [the co-op slashed premiums by an average of 20 to 30 percent](http://www.chicagotribune.com/business/ct-aca-insurance-rates-adv-biz-20141107-story.html), making it the lowest-priced silver plan in large portions of the state for 2015, company officials say.

As a result of those changes, President Jason Montrie said he expects enrollment to surpass 50,000 next year. The co-op, which was started by a Chicago-based hospital trade group, was able to drop premiums by partnering with large hospitals systems, he said.  If enrollees use providers affiliated with those systems, they will face lower costs, but if they go to other doctors and hospitals they will have to pay more.

Like Land of Lincoln, other co-ops said they lowered premiums without resorting to narrow networks that exclude many hospitals and physicians. Monthly premiums are only a portion of consumers’ costs— co-pays and deductibles usually apply. But premiums are usually the first thing potential buyers look at when they go to the online insurance exchange, Montrie said.

HealthyCT CEO Ken Lalime said his plan also decided to offer more competitive rates for 2015 to increase enrollment. “Bringing increased competition to the market was not an instantaneous thing to happen,” he said.

Co-ops that did price competitively in their first year saw robust enrollment. The Maine Community Health Options Co-Op grabbed 83 percent of the exchange market in 2014, largely because it offered the lowest-cost silver plans. Before 2014, Anthem was the dominant player in Maine’s individual market.

“It just goes to show you can do well by people and do well financially,” said CEO Kevin Lewis.

Montana Health CO-OP spokeswoman Karen Early — a former spokeswoman for Blue Cross of Idaho — said her plan will save consumers money without sacrificing care or service.

But she does agree with her old boss on one thing:  “We will disrupt the market,” she said.

<http://kaiserhealthnews.org/news/obamacare-co-ops-cut-prices-turn-up-heat-on-rival-insurers/>

**Investments in Treatment for Substance Use and Mental Health Disorders on Rise Due to ACA Coverage**

From Reuters

Investors are pouring money into the operators of U.S. rehab centers as many more Americans get health care coverage for addiction treatment, driving up valuations and triggering a consolidation of businesses in the fragmented sector. Under President Barack Obama’s healthcare law, new health plans must cover ten core health benefit areas. This includes substance abuse and mental health disorders, opening up services such as alcohol and drug detox or addiction therapy to many Americans who previously couldn’t afford them. The healthcare law also allows young adults to stay on their parents' insurance plans until age 26. This offers coverage to many young people struggling with drug abuse and eating disorders. And the economic recovery has helped as well, as it means more people can afford to pay the expenses that the plans won’t cover. There are now a growing number of major investors, led by private equity firms and healthcare companies, seeking to take advantage of a market for addiction services that experts say has grown to $35 billion a year now from $21 billion in 2003.

<http://www.reuters.com/article/2014/12/08/us-rehabclinics-m-a-privateequity-idUSKBN0JM0E420141208>

**Half of Doctors Listed as Serving Medicaid Patients Are Unavailable, Investigation Finds**

From The New York Times

Large numbers of doctors who are listed as serving Medicaid patients are not available to treat them, federal investigators said in a new report. ‘Half of providers could not offer appointments to enrollees,’ the investigators said in the report, which will be issued on Tuesday. Many of the doctors were not accepting new Medicaid patients or could not be found at their last known addresses, according to the report from the inspector general of the Department of Health and Human Services. The study raises questions about access to care for people gaining Medicaid coverage under the Affordable Care Act. The health law is fueling rapid growth in Medicaid, with enrollment up by nine million people, or 16 percent, in the last year, the department said. Most of the new beneficiaries are enrolled in private health plans that use a network of doctors to manage their care. Patients select doctors from a list of providers affiliated with each Medicaid health plan. The investigators, led by the inspector general, Daniel R. Levinson, called doctors’ offices and found that in many cases the doctors were unavailable or unable to make appointments. More than one-third of providers could not be found at the location listed by a Medicaid managed-care plan. ‘In these cases,’ Mr. Levinson said, ‘callers were sometimes told that the practice had never heard of the provider, or that the provider had practiced at the location in the past but had retired or left the practice. Some providers had left months or even years before the time of the call.’ About 8 percent of providers were at the locations listed, but said they did not participate in the Medicaid health plan with which they were supposedly affiliated. Another 8 percent participated in Medicaid, but were not accepting new patients.

<http://www.nytimes.com/2014/12/09/us/politics/half-of-doctors-listed-as-serving-medicaid-patients-are-unavailable-investigation-finds.html?emc=edit_tnt_20141208&nlid=58462464&tntemail0=y&utm_campaign=KHN:+First+Edition&utm_source=hs_email&utm_mediu&_r=1>

**Consumers May Miss Out on Subsidies Due To Confusion About Job-Based Coverage**

From Kaiser Health News

Confusion about whether some types of job-based coverage disqualify consumers from signing up for subsidized insurance through the health law’s marketplaces may lead some people to buy skimpier employer plans instead. In recent weeks, some assisters who help consumers find coverage say people are being told by their employers that their bare-bones plans – which, for example, may cover preventive benefits only — meet “minimum essential coverage” requirements. That’s the type of coverage most people must have to satisfy the health law’s requirement that they have health insurance. The problem is that consumers mistakenly think that having access to such coverage means they don’t qualify for subsidies if they want to buy a policy on the exchanges instead. But that’s not necessarily the case. Rather, they would be ineligible for subsidies if their employer plan is deemed affordable under the law and pays for 60 percent of allowed medical charges, on average.  Coverage is considered affordable if it costs no more than 9.5 percent of an employee’s income for self-only coverage. Some of the confusion relates to the similar-sounding bureaucratic names for these different health law standards.  Minimum value coverage means the plan pays for 60 percent of allowed medical charges, on average.

<http://kaiserhealthnews.org/news/consumers-may-miss-out-on-subsidies-due-to-confusion-about-job-based-coverage/?utm_campaign=KHN:+First+Edition&utm_source=hs_email&utm_medium=email&utm_content=15207933&_hsenc=p2ANqtz-_4LYOExh72h52c7GRukXG4X6pI132mC>

[**Many States Will Be Unprepared if Court Weakens Health Law**](http://www.kintera.org/TR.asp?a=hlJUI4NVJmLRI8M4G&s=bfLLKRPpFcINIRNyFrG&m=ovJ2JaOUJsJ1KlL)

From The New York Times Upshot Blog

A Supreme Court ruling this spring could upend health insurance markets in at least 34 states, eliminating the federal subsidies that make coverage affordable for millions of Americans. State governments, theoretically, have ways to forestall this outcome. But few have taken action. If they wait until the court rules, it may already be too late for a state to get started on an exchange so that it is ready for 2016. The case, called King v. Burwell, concerns whether subsidies can be given to consumers in every state in the country or only in those that have established their own state marketplaces as part of the Affordable Care Act. So far, more than a dozen states and the District of Columbia have such marketplaces. Should the high court rule that subsidies can be distributed only in states running their own exchanges, markets in the remaining states would be substantially disrupted. Prices for insurance plans would sharply rise. Millions of people would drop their coverage. A decision in the court case is expected in June; a new marketplace would need to be ready for shoppers in October in order to sell health plans for 2016. If those states want to make sure that subsidies keep flowing to their residents, they can build their own marketplaces. But it won’t be easy.

<http://www.nytimes.com/2014/12/12/upshot/many-states-will-be-unprepared-if-court-weakens-health-law.html?abt=0002&abg=0&_r=0>

**Undocumented Immigrants Won't Get Obamacare - but Latino Coverage Could Rise**

From PoliticoPro

President Barack Obama’s immigration order won’t suddenly swell the rolls of Obamacare with undocumented immigrants, but it will open the door to many more Latinos getting health insurance.

Freed from deportation threats, more of the undocumented may be able to take regular jobs with health insurance for themselves and their families, instead of operating in shadow jobs without health insurance. They will not be covered by Obamacare, however.

And Latinos who are already legal residents – millions of whom remain uninsured – may feel more comfortable signing up for subsidized Obamacare coverage. There have been widespread reports that they had feared signing up might tip off authorities to family members who were undocumented, risking their deportation.

The president’s bold action on immigration “will spill over to the health care arena,” predicted Frank Rodriguez, executive director of the Latino Healthcare Forum, which enrolls Hispanics in Obamacare around Austin, Texas. Latinos are a big target for the second Affordable Care Act sign up season just getting underway, and Rodriguez said the executive action would build enthusiasm and trust.

Covering the undocumented, who are mostly Latinos, has been a flashpoint ever since the health reform debate began early in Obama’s first term. The “you lie” moment - when Joe Wilson (R-S.C.) interrupted Obama’s address to Congress - was one of the most rancorous in the whole health debate. But the health law specifically excludes the undocumented from the ACA exchanges - even if they could pay for it themselves — and from Medicaid. That ban was extended to the “DREAMers” in 2012, and now to the roughly 5 million covered in the president’s Thursday evening executive order.

The lack of access to health coverage for a population with an estimated 60 percent uninsurance rate remains a bitter pill for immigration reform activists who otherwise welcome Obama’s moves. But for the Latinos who are in the U.S. legally, the president’s new policy may spur more enrollment. Many people working on Hispanic enrollment have said people have voiced fears that signing up could somehow lead immigration officials to undocumented family members, threatening them with deportation. Obama himself went on Spanish-language television earlier this year to try to dispel those fears.

Many Latinos did end up enrolling; the rate of uninsurance in working-age Hispanic adults shrank from 36 percent to 23 percent after the first open enrollment, according to a Commonwealth Fund survey. By comparison, Commonwealth found the uninsured rate of the general population moved from 16 percent to 12 percent.

Bringing more legal Latinos into Obamacare coverage is a priority for this year. In the week before the start of open enrollment Nov. 15, Health and Human Services Secretary Sylvia Mathews Burwell participated in a online hangout with Latina bloggers and sat for interviews with Univision and Telemundo. She spent Saturday in Tampa, Fla., and Tuesday in Houston. Office of Personnel Management Director Katherine Archuleta – the first Latina to hold the post – was also in Houston, as well as San Antonio, last week. Labor Secretary Tom Perez hit Cleveland.

Last year, CuidadodeSalud.gov, the Spanish-language portal of HealthCare.gov, wasn’t up and running until December, and even then, people complained that its translation was hard to understand and its upload feature didn’t work. (More than 100,000 people who registered on the federal exchanges lost coverage at the end of September because of unresolved problems with matching up immigration records.) This year, there are still some complaints – it was unclear where to upload a green card, for example, and the application process for families that have a mixture of immigration statuses can feel like forever. But generally officials say the rollout en espanol has been smoother. New York, which has its own state exchange, also debuted a Spanish-language site this year after forgoing it in 2013.

Spanish-language media is also being pulled in. Young Invincibles, for example, designated one of its California-based staffers to be in charge of coordinating young adult enrollment messaging with Spanish-language media nationwide ahead of this year’s open enrollment. And Covered California, the state exchange, is running ads to reassure people in mixed-status families – those with combinations of citizens, legal residents, and undocumented members – that there is no risk of exposing relatives to deportation.

Read more: <http://www.politico.com/story/2014/11/obamacare-undocumented-immigrants-113076.html#ixzz3JjNrbTkQ>

**Poll: Majority Says Universal Healthcare is Not Government Role**

From The Hill

Slightly more than half of Americans believe that the federal government is not responsible for providing universal healthcare, according to a recent [Gallup poll](http://www.gallup.com/poll/179501/majority-say-not-gov-duty-provide-healthcare.aspx).

The survey reflects a different national attitude than just eight years ago, when nearly 70 percent of people believed the government should provide healthcare coverage for all.

http://thehill.com/policy/healthcare/224824-poll-majority-say-universal-healthcare-is-not-government-role

**Insurers Draw Health for Error-Riddled Provider Directories**

From Modern Healthcare

A ruling in California that two major health insurers failed to give consumers accurate information about providers participating in their plan networks could force others in the industry to quickly improve their protocols. The California Department of Managed Health Care released scathing reports Tuesday regarding plans sold by Anthem Blue Cross (a subsidiary of investor-owned WellPoint) and Blue Shield of California on Covered California, the state's Obamacare exchange. The report on Anthem (PDF) found that 12.5% of the physicians listed in the insurer's provider directory for exchange plans had inaccurate locations. Further, the state called thousands of doctor offices and found almost 13% did not take patients who had Anthem's exchange plans even though they were listed as in-network.

[http://www.modernhealthcare.com/article/20141119/NEWS/311199972&utm\_source=AltURL&utm\_medium=email&utm\_campaign=am?mh](http://www.modernhealthcare.com/article/20141119/NEWS/311199972%26utm_source%3DAltURL%26utm_medium%3Demail%26utm_campaign%3Dam?mh)

**As New Enrollment Period Starts, ACA Approval at 37 Percent**

From Gallup

As the Affordable Care Act's second open enrollment period begins, 37% of Americans say they approve of the law, one percentage point below the previous low in January. Fifty-six percent disapprove, the high in disapproval by one point.



**New Health Literacy Classes Announced**

Maricopa Integrated Health System recently announced new dates for health literacy classes for consumers:

**Understanding Health Coverage**

Jan 7, 1:30 pm - 3:00 pm

Maryvale Family Learning Center

4011 N. 51st Ave, Phoenix, AZ 85031

623-344-6955; mihs.org/flc

Jan 13th, 1:30 pm - 3:00 pm

Family Learning Center at the Comprehensive Healthcare Center (CHC)

2525 E. Roosevelt St., Phoenix, AZ 85008

602.344.1352; mihs.org/flc

Jan 20th, 1:30 pm - 3:00 pm

Chandler Family Learning Center

811 S. Hamilton St., Chandler, AZ 85225

480.344.6165; mihs.org/flc

Jan 30th, 11:00 am -  12:30 pm

South Central Family Learning Center

33 W Tamarisk St., Phoenix, AZ 85041

602.344.6460; mihs.org/flc

**SHOP Webinar Series**

* When: Tuesdays, December 2, 2014 – February 24, 2015 | 2:00 pm – 3:00 pm EST
* Sign up: [https://marketplace.cms.gov/technical-assistance-resources/training-materials/shop-training-webinars.pdf](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQxMjA5LjM5MTc0NTUxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MTIwOS4zOTE3NDU1MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzE4MzczJmVtYWlsaWQ9am9uLmxhbmdtZWFkQGNtcy5oaHMuZ292JnVzZXJpZD1qb24ubGFuZ21lYWRAY21zLmhocy5nb3YmZmw9JmV4dHJhPU11bHRpdmFyaWF0ZUlkPSYmJg==&&&100&&&https://marketplace.cms.gov/technical-assistance-resources/training-materials/shop-training-webinars.pdf)

The Centers for Medicare & Medicaid Services (CMS) is offering a webinar series for small business employers, agents and brokers, assisters and other interested stakeholders about important changes in the Small Business Health Options Program (SHOP). The presentation will focus on the federally-run SHOP Marketplace, and subject matter experts will take questions following the presentation. The webinar will be offered every Tuesday from 2:00 to 3:00 pm from December 2, 2014 to February 24, 2015 (except December 23 and 30). See the full schedule and sign up for a webinar using [**this link**](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQxMjA5LjM5MTc0NTUxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MTIwOS4zOTE3NDU1MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzE4MzczJmVtYWlsaWQ9am9uLmxhbmdtZWFkQGNtcy5oaHMuZ292JnVzZXJpZD1qb24ubGFuZ21lYWRAY21zLmhocy5nb3YmZmw9JmV4dHJhPU11bHRpdmFyaWF0ZUlkPSYmJg==&&&101&&&https://marketplace.cms.gov/technical-assistance-resources/training-materials/shop-training-webinars.pdf).

**Outreach Strategy for Immigrants Under 100% FPL who are Eligible for Tax Credits and not Eligible for Medicaid**

From CMS

Most applicants who have an annual income under 100% of the FPL are not eligible for advance premium tax credits (APTC) or cost sharing reductions (CSR); with one exception. As long as all other eligibility criteria are met, a lawfully present individual whose income is under 100% of the FPL and who is not eligible for Medicaid based on immigration status is eligible for APTC and CSRs.

Over the last year, CMS has made improvements to Healthcare.gov to make it easier for certain lawfully present immigrants to get the tax credits they are eligible for through the Marketplace. While the vast majority of eligible immigrants are being appropriately determined eligible for APTC and CSRs, we understand that some applicants have had trouble receiving an accurate eligibility determination. This generally occurs when the Department of Homeland Security’s SAVE system is unable to verify their immigration status, or when the consumer is unable to obtain an immigration-specific denial from Medicaid. CMS has identified a group of consumers who, based on our data, may be eligible for APTC and CSRs. CMS is conducting targeted outreach to determine if these individuals are indeed eligible for APTC and CSRs and if so, to facilitate enrollment.

Using 2014 application data, CMS has identified immigrant applicants who (1) have a resolved or unresolved QHP immigration data matching issue (2) have requested financial assistance, and (3) have an annual income under 100% of the FPL. Most of these applicants live in non-expansion states. Applicants who meet these three criteria should receive a notice from the Marketplace asking them for immigration documents.

The notice instructs applicants with an immigration data matching issue to send documentation proving immigration status. Once documentation is submitted, the Marketplace will review this documentation to verify the applicant has a Medicaid-ineligible and a QHP-eligible immigration status. Applicants who send documentation that is insufficient to prove immigration status will receive another letter requesting more specific documentation. Please note that the Marketplace will not send this notice to consumers who have previously submitted sufficient information to resolve their immigration data matching issue.

If an applicant is found to have QHP-eligible immigration status and Medicaid-ineligible status, based on the submitted documentation, the applicant will receive another notice. This notice will notify applicants of their data matching resolution and encourage the applicants to return to the Marketplace application to answer specific questions to determine if they are eligible for APTC and CSRs. Consumers can login to their Healthcare.gov account and follow detailed, step-by-step instructions in the notice or contact the Marketplace Call Center and speak to a trained representative. Please note that the Marketplace will send this notice only to applicants who provide sufficient documentation to show that they are potentially immigration-eligible for APTC or CSRs despite being under 100% FPL.

This outreach strategy will be used on an ongoing basis to help consumers get a correct eligibility determination when they apply for 2015 coverage.

**Agent & Broker FFM Registration Completion List**

From CMS

This list contains the national producer numbers (NPNs) for agents and brokers who have completed FFM registration for the 2015 plan year. CMS posts this list at the start of each calendar month, reflecting data as of the prior calendar month. NPNs can be searched by clicking the arrow in cell A2, or by using the “Ctrl + F” (or “Command +F) keystroke.  All NPNs are self-reported by the agent or broker during Part I of FFM registration, and should be validated against state and/or other NAIC records to confirm state licensure.

* <http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/a-b-resources.html#Agent%20and%20Broker%20Federally-Facilitated%20Marketplace%20%28FFM%29%20Registration%20Completion%20List>

**Re-enrollment FAQs to Share with Consumers**

From CMS

Below are seven questions and answers targeted to consumers to help you assist with the reenrollment and renewal process.

1. I like my current plan, and heard that I don’t need to do anything to keep it.  Is that right, and what happens next?
Response: Most people enrolled in a health plan for 2014 through the Health Insurance Marketplace won’t need to take any action to stay enrolled in their current plan for 2015.  You should have received a letter from your current health insurance company letting you know which of these situations applies to you for 2015:
* If your current plan will still be available in 2015, you don’t need to do anything to stay enrolled. In this case, the letter stated the amount of your monthly premium for 2015.
* If your current plan isn’t being offered in 2015, and you take no action on or before December 15, 2014, your health insurance company generally will place you in a different plan with benefits similar to your 2014 coverage.
* You need to come back to the Marketplace to choose a new plan.

Even if your current plan will be available in 2015 and you choose to stay in it, you should come back to the Marketplace to make sure you don’t have any updates to report from the previous year, like changes to income or address. There may also be plans offered in 2015 that better meet you and your family’s needs and budget, so we encourage you to come back to the Marketplace to compare plan options in your area. The Marketplace will send an Enrollment Confirmation Message after December 15, 2014, to let you know if you were automatically re-enrolled for 2015.

1. It is past December 15 and I haven’t heard from my current health insurance company about January coverage.  I thought I didn’t have to do anything to keep my current plan.  What should I do to make sure I stay covered?
Response: Contact your current health insurance company. They can tell you if your current plan is still available and if you will be re-enrolled automatically for 2015.
2. I have gone to HealthCare.gov and have been exploring my health plan options, because I know I have until December 15 to switch plans for coverage to start on January 1, 2015.  Yet, I just got a bill from my current insurance company for January coverage.  Why did that happen and what should I do?
Response: The Marketplace wants to ensure that people who are covered now don’t have a gap in coverage starting in January. You can still choose a new plan or end your enrollment in your current plan anytime on or before December 15, 2014 and still have coverage in the new plan effective January 1, 2015. After that, if you haven’t taken action and your current plan or a similar one is available for 2015, the Marketplace will automatically re-enroll you, to help you stay covered.

If you already received a bill from your current insurance company for January, that is part of their effort to make sure you don’t have any gap in your health coverage in January.  If you choose a new plan on or before December 15, 2014, coverage in your current plan will end on December 31, 2014, and you can ignore the bill you received.  Your new insurance company will contact you about paying your January 2015 premium.

1. Even though I picked a more affordable health plan for January, my current insurance company just deducted a premium payment for January 2015 from my bank account.  I can’t afford to pay two premiums.  What should I do?
Response: If you changed plans for 2015, the Marketplace will notify your 2014 health plan that they shouldn’t collect premiums from you for 2015. If your current health insurance company already deducted a premium payment for January 2015, they should refund or return this payment as soon as they are notified that you’ve changed plans. You can call your 2014 insurance company to make sure that their records are up to date and ask for a fast refund of any 2015 premiums that were deducted.
2. I keep getting reminders and bills from my current health insurance company even though I already switched plans and got a bill for January from my new insurance company.  How do I stop this from happening?
Response: Starting December 2, the Marketplace is sending information to health plans to let them know who changed plans for 2015.  However, your 2014 health plan may have billed you before receiving and processing the information that you switched plans. You don’t need to pay any 2015 premiums for the 2014 plan that you’ve dropped. Just make sure to make your 2015 premium payments for the plan you chose for 2015.
3. I don’t want to renew my coverage in the Marketplace for 2015 because my job now offers health insurance, yet I got a bill from my current insurance company.  What should I do?
Response: You need to end your health coverage through the Marketplace when your new coverage from your employer begins.  To do this, you can log in to your Marketplace account on HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. The effective date when your coverage will end can be as soon as 14 days from the day you make the request.  Therefore, if you end your current coverage on or before December 17th, you can avoid any overlap in coverage for 2015. You don’t need to pay the bill for January 2015 coverage from the 2014 plan that you’ve dropped.
4. I wanted to keep my current plan through the Marketplace, so I didn’t shop or take any action on HealthCare.gov before December 15.  I got a notice that I was re-enrolled in the same plan for 2015, but I just received a premium bill with a higher 2015 premium that I can’t afford.  Can I still switch plans and get a lower premium for January?

Response: If you missed the December 15, 2014 deadline to change plans for coverage beginning January 1, 2015, you can still change plans through the Marketplace until February 15, 2015, but your coverage in the new plan won’t be effective until February 1, 2015 or March 1, 2015, depending on the date you make the change. You MUST make the change by February 15, 2015 or you’ll likely have to wait until 2016 before you have another chance to change plans. As long as you pay your premiums for your current plan until your new one is effective, you can avoid a gap in health coverage.

**New Phone Line for Employers Seeking Information about the ACA**

From CMS

There are now 3 separate phone lines to help small employers get information about health insurance coverage for their employees. The Federally-facilitated SHOP Call Center line is available to help employers, employees, assisters, and agents and brokers get assistance with the Federally-facilitated SHOP Marketplace; the Cancellation Call Center line is available for employers whose grandfathered plans have been canceled to get help understanding their options; and the ACA Employer Call Center line is available for employers to get help understanding their responsibilities under the Affordable Care Act. Call center representatives are available to help Mon - Fri, 9 a.m. to 7 p.m.; Sat - Sun, 9 a.m. to 5 p.m. EST.

* The General SHOP Call Center line: 1-800-706-7893 TTY: 711
* The Cancellation Call Center line: 1-866-837-0677 TTY: 711
* The ACA Employer Call Center line: 1- 800-355-5856 TTY: 711

**Assisting Consumers who Submit an Application via the Call Center or Use the Paper Application and Wish to Access their Online Applications**

From CMS

In some cases, consumers who begin the application process with the Call Center or use paper applications will want to access their applications online.  To do so, it is important that they have their application ID number (which they can get from the Call Center) and that they complete the identity proofing process, if they haven’t done so already.  To access their applications online, consumers should click on “find my application” on the login screen of the MyAccount page on HealthCare.gov and enter this information.

Please remind consumers that all information - first name, last name, city, state and zip code - for the person listed as **the household contact** on the original application must match the contact information used for identity proofing when creating an account on HealthCare.gov. This information must match in order to successfully find the application and continue to the plan compare and enrollment stages.

Short Summary of the Paper Application Process

Consumers submitting paper applications for new coverage will receive a phone call notifying them that their paper application is complete.  Consumers will then receive an eligibility notice in the mail that will include their application ID number and indicate their eligibility and options for enrolling in coverage.  Once consumers have this eligibility notice, the Call Center can help them create an online account or access their application and help them select a plan over the phone.

**Slides from Household/Family Section of the Application**

From CMS

On Friday, November 21, 2014, we presented an application spotlight on the Family & Household section of the Federally-facilitated Marketplace and State Partnership Marketplace online application. This section of the application captures information on a consumer’s family and household composition. The application collects information about each family member in order to make eligibility determinations for all applicants. The amount of assistance or type or program applicants qualify for depends on several factors, including the number of people in the family and their incomes.

* Use this link to view the presentation slides: [https://marketplace.cms.gov/technical-assistance-resources/household-section-of-application.pdf](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQxMjA0LjM5MDAxMjkxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MTIwNC4zOTAwMTI5MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzEwOTU2JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&115&&&https://marketplace.cms.gov/technical-assistance-resources/household-section-of-application.pdf)
* To view the slides on our Technical Assistance Resources page along with other resources on the application process, use this link to the “Application process assistance” page: [https://marketplace.cms.gov/technical-assistance-resources/application-process-assistance.html](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQxMjA0LjM5MDAxMjkxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MTIwNC4zOTAwMTI5MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzEwOTU2JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&116&&&https://marketplace.cms.gov/technical-assistance-resources/application-process-assistance.html)

**Immigrants and the Marketplace**

From the Alliance of Community Health Centers



One of the Alliance of Community Health Center’s Navigators saw this new question (on 11/24) while filling out a Marketplace application for a consumer. This new question should limit consumers from “looping” between the Marketplace and AHCCCS. In addition, another Navigator from a different organization let us know that she was finally able to enter text into the “Green Card Number” field when she’s been unable to do so for the past year. She was also able to secure APTC and/or CSR for legal residents with fewer than five years’ residency whose incomes were below 138% FPL.

**Out2Enroll Webinars & Resources**

According to [research conducted by the Center for American Progress](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQxMTI1LjM4NjU3MTIxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MTEyNS4zODY1NzEyMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzAwMTg5JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&155&&&https://cdn.americanprogress.org/wp-content/uploads/2014/11/LGBTandACA-report.pdf), one in four—26 percent—of lesbian, gay, bisexual, and transgender (LGBT) people eligible for financial assistance to gain coverage through the health insurance marketplaces or Medicaid were uninsured in 2014.  Navigators and other assisters are essential to making sure that the benefits of the ACA reach everyone who needs them—and [80 percent of low- and middle-income LGBT people say they want application and enrollment help from assisters who have experience and training in working with LGBT communities](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQxMTI1LjM4NjU3MTIxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MTEyNS4zODY1NzEyMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzAwMTg5JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&156&&&https://cdn.americanprogress.org/wp-content/uploads/2014/11/LGBTandACA-report.pdf) (see page 19 of the report).

1. [Recent clarification and language from healthcare.gov](https://www.healthcare.gov/married-same-sex-couples-and-the-marketplace/) on what marriage equality means for same sex couples seeking insurance coverage.
2. [Guidance issued by CMS](https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/frequently-asked-questions-on-coverage-of-same-sex-spouses.pdf) last fall on tax credits, Medicaid, and insurance coverage for same sex married couples.
3. [A collection of best practices](http://www.communitycatalyst.org/resources/publications/document/LGBT20Cultural20Competency20Enrollment2020Issue20Brief.pages.pdf) regarding culturally competent enrollment strategies compiled by Community Catalyst.
4. Out2Enroll is available to provide web-based or in-person trainings to Navigators and consumer application counselors to support LGBT culturally competent enrollment practices. Upcoming webinars will be held on:
* Tuesday, December 16th at 2:00pm ET (RSVP [here](https://cc.readytalk.com/cc/s/registrations/new?cid=g87vud9v7qwh))
* Monday, December 22nd at 2:00pm ET (RSVP [here](https://cc.readytalk.com/cc/s/registrations/new?cid=7j7037ebxed2))
* Monday, December 29th at 2:00pm ET (RSVP [here](https://cc.readytalk.com/cc/s/registrations/new?cid=jyx153z8zm5h))

The training webinar is facilitated by Out2Enroll Steering Committee members and includes:

* An introduction to key LGBT terms and concepts, including transgender-specific issues
* Answers to commonly asked LGBT-specific questions
* An overview of evidence-based ways to effectively promote LGBT outreach and enrollment
* An interactive discussion aided by case study scenarios based on the experiences of same-sex couples, people with HIV, and transgender people in enrollment

Out2Enroll also offers fully customizable webinar trainings, as well as in-person trainings (typically 2 hours) for organizations that want to dive more deeply into LGBT enrollment issues. Contact Kendall Bills, Out2Enroll’s Director of Programs, at kendall@out2enroll.org for more information and to coordinate a time for a customized training for your staff and partners!

**CMSzONE Community Online Resource Library for Marketplace Assisters**

From CMS

As discussed on the Friday, November 21 assister webinar, the Centers for Medicare & Medicaid  Services (CMS) has created a new online resource to allow assisters and other stakeholders in Federally-facilitated and State Partnership Marketplaces to share and find materials developed around enrollment and application issues, including materials in languages other than English. The Online Resource Library for Assisters is an online community housed at CMSzONE, which is a social platform for organizations and individuals partnering and working with CMS to collaborate on initiatives. The library is intended to serve as a resource for members to share and use assister and stakeholder-developed materials and to learn about events they are hosting to promote enrollment.

CMS is hosting this library as a courtesy to the assister community and to partner with the advocate community. Please note that the inclusion of any materials in this library does not imply an endorsement by CMS.  Assisters and users are encouraged to review all materials prior to using them.

Assisters who have questions about the online assister resource library should send questions to: assisterlibrary@cms.hhs.gov.

If you are having technical issues with joining the CMS Enterprise Portal or CMSzONE, you should call 855-267-1515 or email CMS\_FEPS@cms.hhs.gov.

**CMS Tips for Assisters on Password Reset**

From CMS

CMS has posted two new resources to help consumers troubleshoot password resets and unlock their Marketplace accounts. The updates include information on how to gain access to forgotten usernames. Below is a summary of these tips. For more information, view the new content on HealthCare.gov:

* Tips for resetting your password and unlocking your account: [https://www.healthcare.gov/blog/tips-for-resetting-your-password-and-unlocking-your-account/](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQxMTI1LjM4NjU3MTIxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MTEyNS4zODY1NzEyMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzAwMTg5JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&105&&&https://www.healthcare.gov/blog/tips-for-resetting-your-password-and-unlocking-your-account/)
* Marketplace tips and troubleshooting: [https://www.healthcare.gov/apply-and-enroll/tips-and-troubleshooting/](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQxMTI1LjM4NjU3MTIxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MTEyNS4zODY1NzEyMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzAwMTg5JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&106&&&https://www.healthcare.gov/apply-and-enroll/tips-and-troubleshooting/)

Tips for Unlocking Accounts

* If a consumer tries to reset his or her password and does not get an email from the Marketplace, the consumer may be using the wrong username. To make sure the consumer is using the correct username, he or she should use the “Forgot your username?” option to retrieve it, and then reset the account password. Consumer may be using the wrong username. To make sure the consumer is using the correct username, he or she should use the “Forgot your username?” option to retrieve it, and then reset the account password.
* Consumers who created their Marketplace account before February 2014 probably do not have their email addresses as their usernames. By clicking on "Forgot your username?" the consumer will be able to retrieve his or her username after correctly answering three security questions.
* If a consumer answers his or her security questions incorrectly, he or she should contact the Marketplace Call Center to have his or her account unlocked.
* After contacting the Call Center, the consumer will receive an email at the email address that he or she selected when initially setting up a Marketplace account.  If he or she does not receive an email, the consumer should check the account’s spam folder as well as any other email accounts that the consumer has.
* The email from the Marketplace will contain the consumer’s username; the consumer should use that username to log back into his or her Marketplace account. At that point, the consumer will be directed to change his or her password.

Tips for Password Reset

* If a consumer forgets his or her Marketplace account password or needs to change it, he or she should click on the “Forgot your password?” option.
* An email will be sent to the address that the consumer provided when initially setting up an account. If he or she does not receive an email, the consumer should check the account’s spam folder as well as any other email accounts that the consumer has.
* The email will contain a link that the consumer should click on.  If that doesn’t work, the consumer can cut and paste the link into their web browser. The consumer should follow the directions and then choose a new password. Next, the consumer should use the correct username and new password to log into his or her Marketplace account.

Important: If consumers are having trouble logging in, they should not try to create a new account. They will not be allowed to create a duplicate account using the same Social Security Number.

If these tips don’t work, please contact the Marketplace Call Center. Customer service representatives can reset passwords and unlock accounts.

**Coverage Effective Dates for Consumers with a Loss of Minimal Essential Coverage**

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 month following the loss of coverage. When consumers report a loss of MEC, it is important that they enter the last day that they will have coverage, rather than the first day they will be without coverage. For example, if a consumer will have coverage through December 2014, but will no longer have coverage beginning January 1, 2015, he or she should report that he or she is losing coverage on December 31, 2014. 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 November 24 that he or she is losing coverage November 30, and makes a plan selection on November 24, he or she will receive a Marketplace coverage effective date of December 1.
* If a consumer reports on November 24 that he or she is losing coverage on January 1, and makes a plan selection on November 24, he or she will receive a Marketplace coverage effective date of February 1.
* If a consumer reports on November 24 that he or she is losing coverage on December 31, and makes a plan selection on November 24, he or she will receive a Marketplace coverage effective date of January 1.
* If a consumer reports on November 24 that he or she lost coverage October 31 and selects a plan on November 24, he or she will receive a Marketplace coverage effective date of December 1.

**Best Practices for Reporting Issues to CMS**

From CMS

Assisters are a valuable resource in reporting issues affecting consumers to CMS, including technical issues related to the Marketplace. When reporting issues to contacts within CMS, such as a Navigator Project Officer, the “CACQuestions” mailbox, or other CMS personnel, as a best practice, we recommend including the following information:

* When reporting online application issues, please include screenshots, error codes, time/date, operating system, application ID, and user name.
* When reporting online account issues, please include username and email addresses, whether the consumer is accessing a new or returning account.
* When reporting issues with the plan information displayed on HealthCare.gov, please include plan ID, zip code, and identify which part of the plan selection flow seems to be affected (i.e. the premium estimator tool).
* When reporting issues with the Call Center, please include the date and time of the call, the number the call was made from.

As a general rule of thumb, the more information you can provide, the better able we’ll be to fully investigate and address the issue.

We realize that the information you share with us to troubleshoot issues may contain consumers’ personally identifiable information (PII), which is information that, whether alone or in combination with other information, can be used to identify an individual.  As a best practice, CMS recommends that organizations protect emails containing consumer PII, such as by using encryption methods. If you are a Navigator or CAC that is sending PII through email, please note that there is nothing in your privacy and security standards that requires you to use email encryption systems.  Rather, the privacy and security standards require Navigators and CACs to generally keep PII private and secure and share PII with others only to the extent necessary. Unless your organization is required to encrypt emails containing PII under other federal or state laws or regulations, your organization should look to its own policies and procedures to determine whether emails containing PII should be sent using email encryption methods.

**Renewal and Re-enrollment Process for 2015 Coverage, Including Timeline for Consumer Action**

From CMS

On the Friday, November 14 assister webinar, we shared a refresher on the Renewal and Re-enrollment Process for 2015 Coverage.  You can view the slides here:

* Assisting Consumers with the Renewal and Re-enrollment Process for 2015: [**https://marketplace.cms.gov/technical-assistance-resources/renewal-reenrollment-process.PDF**](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTQxMTI1LjM4NjU3MTIxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE0MTEyNS4zODY1NzEyMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzAwMTg5JmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&139&&&https://marketplace.cms.gov/technical-assistance-resources/renewal-reenrollment-process.PDF)

Timeline for Consumers

We recommend assisters use the following timeline to help consumers understand the deadlines they need to meet and the actions they should take to ensure that they remain or get covered by a Marketplace health plan with the right amount of financial assistance in 2015.

Act between November 15 - December 15, 2014 for Coverage Effective January 1, 2015

* Current enrollees**:** Consumers should update their applications for 2015, shop for and enroll in a plan to ensure that they receive the right amount of financial assistance, and are enrolled in the best plan for them and their families for coverage to begin January 1, 2015.
* The majority of consumers who do not complete plan selection by December 15, 2014 will automatically be re-enrolled in their current plan or a plan that is “most similar” to their current plan.
* Some consumers who cannot be auto re-enrolled, for example, because their health insurance is not being offered to any enrollees in 2015 and they couldn't be matched with a different plan, will be required to update their Marketplace application and make a plan selection by December 15 to have coverage beginning January 1, 2015.
* Some consumers will be auto re-enrolled without financial assistance if they do not return to the Marketplace to update their eligibility information by December 15, 2014, including consumers with 2013 tax return information that shows a household income above 500% of the Federal Poverty Level and those who did not give the Marketplace permission to check updated tax information for annual eligibility redetermination purposes on their 2014 Marketplace application.
* Other consumers with financial assistance who authorized the Marketplace to check their 2013 tax return information, but who do not return to update their eligibility information, will be auto re-enrolled using their 2014 financial assistance level.
* New consumers: Most new consumers you assist after November 15, 2014 will be looking at coverage options for 2015. Consumers who select a plan by December 15 will have coverage effective beginning January 1, 2015.
* Consumers with SEPs: Some consumers with certain qualifying life events (loss of minimum essential coverage, and birth/adoption) may be eligible for a special enrollment period (SEP) to enroll in 2014 coverage after November 15. Please note that although these consumers will be providing their current information to enroll in 2014 coverage, they should still return to the Marketplace before December 15 to review and update their application for 2015 coverage. Otherwise, like other consumers who are enrolled in a 2014 plan and who do not return to update their application for 2015 coverage by December 15, 2014, most of these consumers will be automatically re-enrolled in the same plan (if available) for coverage starting January 1, 2015. These consumers will receive their 2014 financial assistance levels, assuming they allowed the Marketplace to check their tax data and that their tax data did not show that their 2013 income was above 500% of the Federal Poverty Level.

Open Enrollment Continues Through February 15, 2015

* Current enrollees: Consumers can still shop for and change plans until the end of Open Enrollment, even after their coverage has become effective.  Throughout Open Enrollment, consumers can also update their application information to be assessed for their 2015 financial assistance level.
* New consumers: Consumers can still shop for and enroll in 2015 coverage. For consumers who enroll between December 16, 2014 and January 15, 2015, their coverage will be effective February 1, 2015. For consumers who enroll between January 16, 2015 and February 15, 2015 their coverage will be effective March 1, 2015.

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| Table 1 |

**Data Matching and Renewals FAQ’s**

Q: If a consumer has an unresolved income data matching issue and the consumer didn’t authorize the Marketplace to check their tax data from the IRS, will the consumer lose their federal subsidies when they are re-enrolled?

A: Individuals who didn’t send in documents to resolve their income data matching issue and for whom we don’t have tax data will lose their APTC/CSR subsidies. These consumers will be auto re-enrolled for 2015, but without any federal assistance.

Q: Will consumers with expired income data matching issue and adjusted APTCs, be auto-reenrolled with their 2014 APTC adjustment or the APTC adjusted from their income data matching letter?

A: Individuals with income data matching issues will be re-enrolled with their adjusted APTC amount noted in their Marketplace Data Matching notice. This information is based on information collected by the Marketplace from trusted data sources.

Q. Will consumers with income data matching issues who did not submit documents to verify their household income lose coverage?

A. No.  Marketplace coverage will not be terminated because of a household income data matching issue alone.  Unresolved household income data matching issues can only alter the eligibility for financial assistance a consumer gets to pay for their coverage.  These consumers will have their eligibility for financial assistance re-determined based on trusted data sources and this may affect their advance premium tax credit and cost-sharing reductions, but they will not lose their eligibility to purchase coverage through the Marketplace for an income data matching issue.

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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.