



# Helping Consumers Keep Affordable Health Coverage

By Sophie Stern and Dayanne Leal

Providing outreach and enrollment assistance is critical to maximizing the number of people who enroll in health coverage. However, it is just as important to educate consumers about their responsibilities once they are enrolled to ensure that they keep their coverage.

## Why Talking about Retaining Coverage Matters

### Once Consumers Are Enrolled, Staying Covered Isn't Guaranteed

Enrolling in health coverage doesn't guarantee that people will stay covered. Evidence from previous enrollment efforts proves this. For example, one study found that after losing Medicaid coverage at the time of renewal, only 28 percent of adults and 17 percent of children enrolled in Medicaid again within six months. The remaining adults and children stayed uninsured even though they were still eligible.<sup>1</sup>

There are many reasons that adults and children lose coverage despite the fact that they remain eligible. These reasons include administrative barriers, cost, and not knowing how to navigate the health coverage system.

It is important that consumers understand what they need to do to keep their health coverage, and it is important that they have access to clear information about the renewal process. This is one area where the work of navigators, assisters, and other community organizations can make a significant difference. Enrollment efforts should focus on ensuring that people who enroll in Medicaid or who buy coverage through the health insurance marketplaces retain their health coverage for as long as they are eligible. This work should take place not just during annual renewal periods, but throughout the year.

### Consumers Are Learning to Navigate a New Coverage System and New Rules

Many consumers will need to take action to avoid potential gaps in coverage and to continue to receive coverage that best meets their health care and financial needs.

Once consumers enroll in health coverage, they are required to report specific life changes (such as a change in household size or income) to the appropriate agency when those changes occur. Consumers must be made aware of this responsibility, because certain life

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changes may affect the type of health coverage or the level of financial assistance consumers can get. For consumers who are already receiving premium tax credits, certain life changes can also affect how much they owe in taxes—or whether they receive refunds at tax time.<sup>2</sup>

Those who help consumers apply for, enroll in, and retain health coverage have a critical role to play in ensuring that consumers understand the terms of their new health insurance and how to handle changes in their coverage. Consumers will need help understanding:

1. How to pay their premiums (if applicable)
2. How and where to report changes that may affect the type of coverage or level of financial assistance they are eligible to receive
3. The annual redetermination and open enrollment processes

## Maintaining Marketplace Coverage (Qualified Health Plans)

### Paying Premiums

If consumers do not pay their premiums, qualified health plans can cancel their coverage.<sup>3,4</sup> Consumers who've never had health coverage may not know about premiums or realize that not paying premiums on time can lead to their coverage being cancelled.

Consumers who are receiving advance premium tax credits have a three-month grace period before their coverage can be cancelled (as long as they have paid their premiums for at least one month).<sup>5</sup> If a consumer does not repay all outstanding premiums by the end of the grace period, the qualified health plan may cancel his or her coverage.<sup>6</sup> In addition, the consumer will likely have to pay for all health care services received during the second and third months of the three-month grace period.<sup>7</sup>

Navigators and assisters must help consumers understand how important it is to pay their premiums on time and how to submit payments to their health plans.

Consumers may use paper checks, cashiers' checks, money orders, reloadable pre-paid debit cards, electronic funds transfers from a bank account, or automatic deductions from a credit or debit card to pay their premiums.<sup>8</sup> But even though insurers are required to accept a variety of forms of payment, this hasn't always been the case. Consumers will need to be made aware of their options.

### TIP

Organizations may want to invest in financial literacy training for consumers who are newly insured and do not know how to navigate the process for paying premiums. About 27 percent of Americans who are eligible to receive financial assistance with marketplace plans are unbanked—they do not have a checking account.<sup>9</sup> African Americans and Latinos are more likely to be affected by this problem: They are 40 percent more likely than whites to be unbanked.<sup>10</sup>

## What Consumers Need to Do throughout the Year

People who enroll in marketplace plans must report any life changes that may affect their eligibility for coverage through their state's marketplace.<sup>11,12</sup>

- Certain life changes, called **qualifying life events**, may change which type of coverage a person is eligible for or how much financial assistance he or she can receive (see Box 1 on page 3). It's important that consumers notify their state's marketplace about any changes in income, address, or family size within 30 days.<sup>13</sup>
- Experiencing a qualifying life event could activate a **special enrollment period**, which allows individuals or families to enroll in or change their health coverage<sup>14</sup> (see Box 1).

- People who qualify for a special enrollment period will typically have 60 days from the date of the qualifying event to enroll in or update their coverage.<sup>15</sup> Generally, that coverage will begin on the first day of the following month (as long as the consumer has paid the first month's premium).<sup>16</sup> Health plans must tell individuals when their coverage will begin.<sup>17</sup>
  - People who experience a change in income qualify for a special enrollment period only if they become newly eligible or ineligible for financial assistance.<sup>18</sup>
  - Changes in income that affect *how much* financial assistance someone will receive will not activate a special enrollment period. However, consumers in this situation are still required to report changes in income. Reporting this information will allow consumers to adjust how much of their premium tax credit they receive in advance, which will minimize the chances that they'll have to pay back that money at tax time (during the premium tax credit reconciliation process).

Marketplaces are required to mail notices to consumers about how to report changes (consumers can also opt to receive electronic notices).

Health insurance marketplaces are also required to periodically review information that is collected by and/or reported into their systems that may affect people's coverage.<sup>19</sup> For example, a marketplace could receive information indicating that a consumer has become newly eligible for a public program such as Medicaid.

Regardless of who identifies the life change, the consumer or the marketplace, the marketplace must tell the consumer about any changes in coverage and next steps that need to be taken.<sup>20</sup> If the marketplace identifies the life change, it will give the consumer 30 days to review and contest any information that will be factored into making a decision about a change in coverage or their level of financial assistance.<sup>21</sup>

## Box 1.

### Qualifying Life Events Include:

- Moving to a new service area
- Losing another type of health coverage, such as job-based health insurance
- Changes in citizenship or immigration status
- A change in income if it leads to a change in eligibility for financial assistance
- A change in household status, such as getting married
- A change in family size (for example, the birth of a child, the death of a family member, marriage, etc.)

### Special Enrollment Periods

A qualifying life event may trigger a special enrollment period. A special enrollment period is when an individual or family may enroll in, or change enrollment in, a qualified health plan through the marketplace outside of the initial and annual open enrollment periods.

### TIP

- Enrollment assisters may want to provide consumers with specific written information that explains what qualifying life events are, why consumers should report them, and how to do so, especially for populations that have frequent changes in income (such as farm workers, artists, hair stylists, servers, and people who are self-employed).
- Enrollment assisters may also want to provide information on how special enrollment periods work and what consumers should do if their eligibility changes during the year.
- People who experience a qualifying life event that makes them eligible for Medicaid can keep their marketplace coverage, but they will lose their financial assistance. *Losing financial assistance may make coverage unaffordable for many families, and they will likely look to enrollment assisters for help with changing from marketplace coverage to Medicaid.*

## The Annual Renewal Process

Each year, people who have bought coverage through the marketplaces will be told whether they are able to continue that coverage the following year and whether their options for financial assistance have changed (see Figure 1). As a part of this notification process, their state's marketplace will send them an "annual redetermination notice" in the mail (or electronically if the consumer opted to receive electronic notices).<sup>22</sup> This notice will explain what their eligibility is projected to be the following year, including whether they are eligible for Medicaid or the Children's Health Insurance Program (CHIP), and information about the annual open enrollment period.<sup>23, 24</sup>

Consumers will need to review, sign, and return these notices promptly. If any of the information in the notices is inaccurate, consumers should contact their marketplace immediately. A consumer may also need to provide additional authorization for the marketplace to verify tax information that will help determine the consumer's financial assistance options for the following year.<sup>25</sup>

If a consumer does not sign and return the notice within 30 days, the marketplace will assume the information in the notice is correct.<sup>26</sup> Therefore, it is important for consumers to carefully review these notices to make sure there are no errors.

If any information in the notice is incorrect, or if the marketplace needs authorization to verify tax information to make a decision about the consumer's financial assistance for the following year, the consumer should closely follow the directions in the notice about how to proceed and/or contact the marketplace for more information. If the consumer does not respond within 30 days, the marketplace will proceed with the information it has on file. If the consumer reports information after 30 days and the marketplace cannot verify this information, the marketplace will need to make a new eligibility redetermination once it has verified the information.

The marketplace then notifies consumers about final decisions regarding eligibility for coverage or financial assistance, including whether consumers are eligible for other coverage programs, such as Medicaid or CHIP.<sup>27</sup>

Only people who have already applied for financial assistance through the marketplace will receive information on their financial assistance options for the following year.

Each year, qualified health plans will decide whether they want to continue offering coverage through the marketplace. If a consumer's health insurance company decides to stop selling coverage through the marketplace, the qualified health plan must notify the consumer of this change.<sup>28</sup> The consumer will be able to enroll in new coverage.

## The Annual Open Enrollment Period

The annual open enrollment period for marketplace coverage for the 2015 calendar year will run from November 15, 2014, through January 15, 2015. During open enrollment, uninsured consumers can buy marketplace plans. Those who are already enrolled in marketplace plans have the option to change plans.

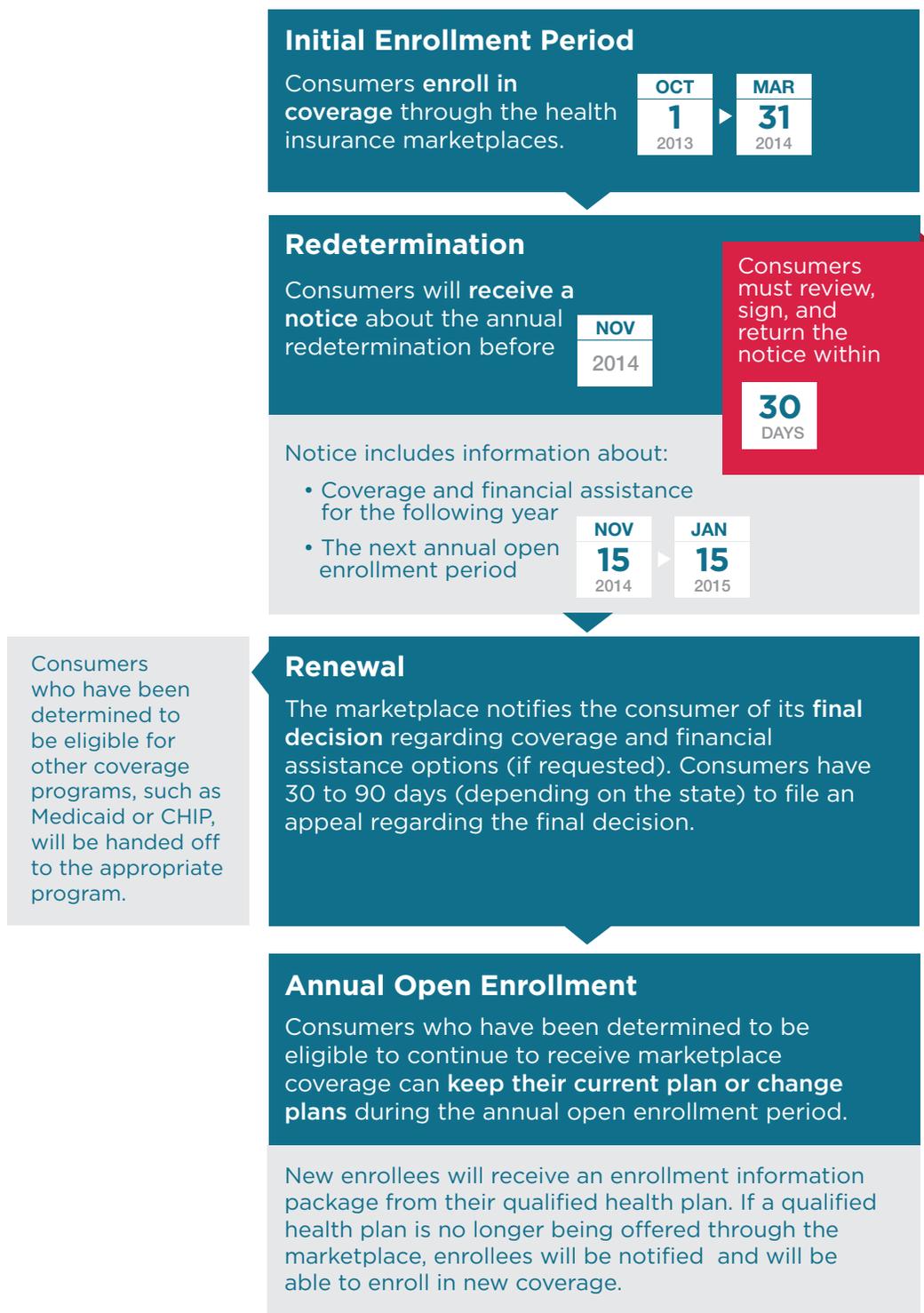
Enrollees who remain eligible for marketplace coverage will be re-enrolled in their current health plan unless they select a new plan or terminate their coverage.<sup>29</sup>

New enrollees will receive an information package from their health insurance company.<sup>30</sup>

### TIP

It is important for enrollment assisters to make sure that people who are renewing coverage have the tools they need to assess whether their coverage is working for them and how to change their coverage.

# Figure 1. Renewing Marketplace Coverage



## Maintaining Medicaid Coverage

### Paying Premiums

Some consumers who have Medicaid or CHIP coverage may be required to pay premiums, depending on their household income and state of residence.<sup>31, 32</sup> If these consumers do not pay their premiums, their health coverage can be terminated. However, Medicaid and CHIP enrollees have a grace period during which their coverage cannot be terminated.<sup>33</sup>

- Medicaid enrollees have a 60-day grace period before their coverage can be cancelled, and they must be given reasonable notice.<sup>34</sup>
- Children, young adults, and pregnant women who are enrolled in CHIP have at least a 30-day grace period before their coverage can change.<sup>35</sup>
  - If they (or their families) *do not* pay their outstanding premiums within the grace period, they may not have access to their CHIP coverage for up to 90 days.<sup>36</sup>
  - If enrollees *do* pay their premiums before the end of the 90 days, their CHIP coverage will be reinstated.
  - If they do not pay their premiums before the end of the 90-day period and their coverage is cancelled, families can re-apply for CHIP and will not be required to pay their outstanding premiums as a condition of re-enrollment prior to disenrollment.<sup>37</sup>

Note: If a CHIP enrollee's premium is past due by 30 days, and the enrollee's family can show that its income has decreased, the enrollee will be reassessed for lower CHIP cost-sharing or for Medicaid eligibility prior to disenrollment.<sup>38</sup>

### Reporting Changes

Just as in the past, consumers with Medicaid coverage must report any life changes that may affect their eligibility, such as a change in household income, household size, or mailing address.<sup>39</sup> Consumers may report these changes by phone, by mail, in-person, or online.<sup>40</sup>

Any consumer with Medicaid who is found to be ineligible for Medicaid based on reported changes will be assessed for eligibility for other insurance programs, such as their state's marketplace, and the consumer's account information will be transferred.<sup>41</sup>

### The Annual Renewal Process

Individuals and families who are enrolled in Medicaid based on MAGI, or Modified Adjusted Gross Income, will have their eligibility reassessed every 12 months.<sup>42</sup> This includes most children, parents, and non-disabled adults without dependent children.<sup>43</sup>

### Administrative Renewals

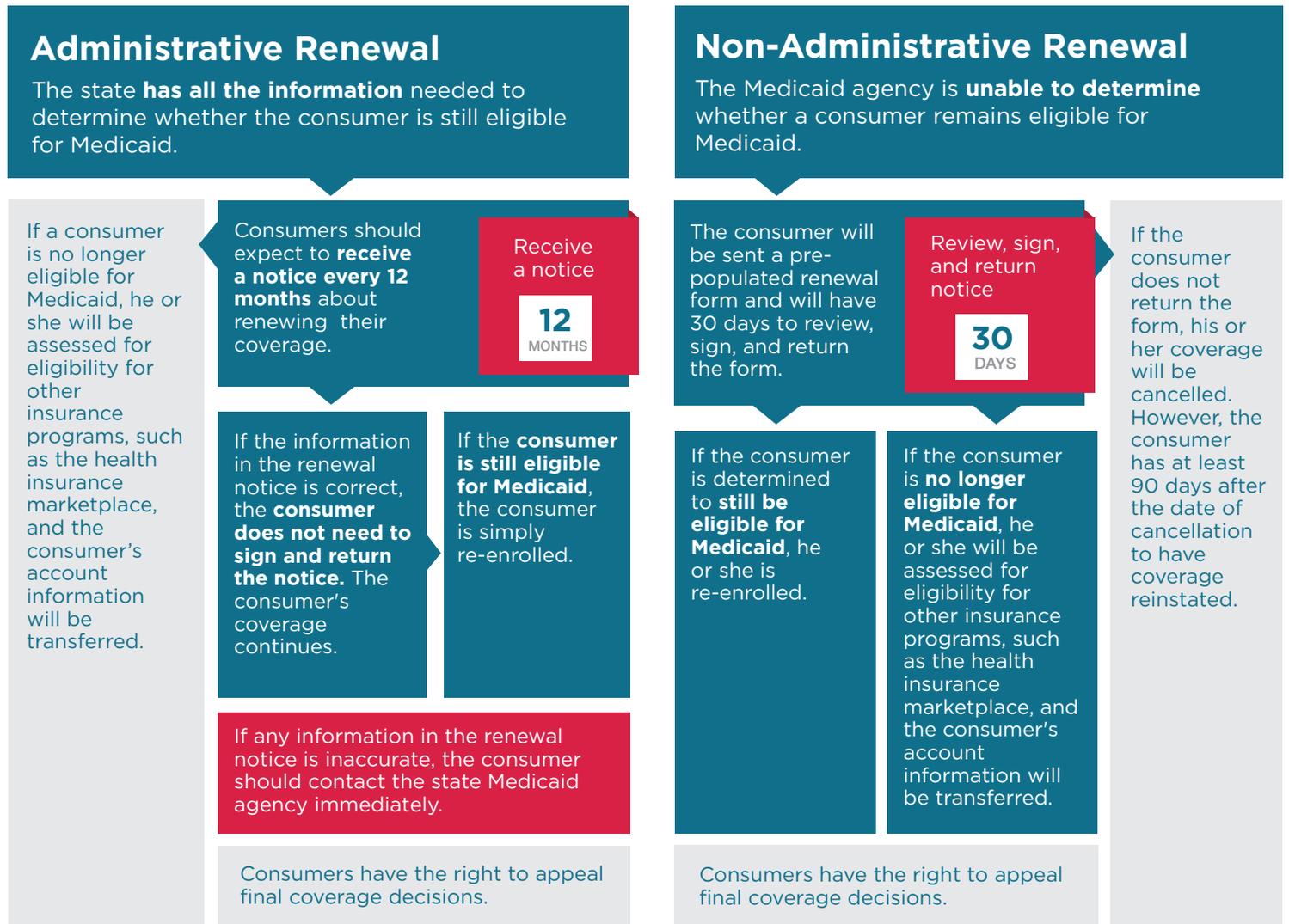
Unlike in the marketplaces, people can enroll in Medicaid at any time during the year. But the Affordable Care Act changed how the renewal process works for these consumers (see Figure 2).

States are required to make the renewal process as seamless as possible. If a consumer is still eligible, he or she will be re-enrolled in coverage automatically.<sup>44</sup> This is called an *administrative renewal*. The consumer will not be required to fill out any forms to complete this process unless the state Medicaid agency has difficulty verifying the consumer's information.<sup>45</sup>

Near the end of the 12-month enrollment period, consumers should receive a notice from their state's Medicaid agency about their renewal. They should read these notices carefully to make sure that all of the information is correct.

- If consumers see any information in these notices that is inaccurate, they should contact their state Medicaid agency immediately.<sup>46</sup>
- If consumers read their notices and all of the information is correct, they do not need to sign and return the notice.<sup>47</sup> Their work is done.

**Figure 2. Medicaid Renewals for the MAGI Population:  
The Process for Administrative Renewals and Non-Administrative Renewals**



Any consumer with Medicaid who is found to be ineligible for Medicaid at renewal time will be assessed for eligibility for other insurance programs, such as their state's marketplace, and the consumer's account information will be transferred.<sup>48</sup>

### **Non-Administrative Renewals**

If the Medicaid agency is unable to determine on its own whether a consumer is still eligible for Medicaid at renewal time, the agency will send the consumer a pre-populated renewal form.<sup>49</sup>

- The consumer has at least 30 days (this timeframe varies by state) to review and return the form.<sup>50</sup>
- Once the information on the form is verified by the Medicaid agency, the consumer's coverage is renewed.<sup>51</sup>
- If the consumer is no longer eligible for Medicaid, he or she will be assessed for other insurance programs, and the consumer's account information will be transferred.<sup>52</sup>
- If the consumer does not return the form promptly, his or her coverage will be cancelled.<sup>53</sup> However, consumers have at least 90 days after the date of termination to have their coverage reinstated.<sup>54</sup>

States are no longer allowed to require consumers to complete an in-person interview as a part of the renewal process.<sup>55</sup>

## **Strategies for Educating Consumers about the Renewal Process**

Those who are providing enrollment assistance have an important role to play in helping consumers understand how to keep their coverage and what to expect with the renewal process. Assisters should consider taking the following steps:

- Establish a systematic way for staff to remind consumers about their coverage renewal date and/or the open enrollment period. One way to do this is to use an automated system, such as robocalls or voice broadcasting, emails, or text messages. The information in these messages will vary depending on what kind of coverage the consumer has.
- Use appointment cards or rewritable magnets as reminders.
  - Staff and volunteers who are helping consumers apply for health insurance can write down the consumer's renewal date or the month when the consumer should expect to receive an annual redetermination notice or eligibility review form in the mail.

## **Helping Families with Multiple Types of Coverage**

Some families will need information about how to stay enrolled in several different kinds of health coverage, including marketplace plans, Medicaid, and the Children's Health Insurance Program (CHIP). This is because many families have members who are eligible for different types of insurance.

For example, in a low-income family, a father may be eligible for marketplace coverage, but his child may be eligible for CHIP because of the specific eligibility rules in his state.

There are also households with family members who have different citizenship or immigration statuses. For these families, some members may be eligible for new coverage, but others may not be.

In these cases, assisters who are helping consumers apply for, enroll in, and retain health coverage have a special role to play: Families with members who are eligible for different types of health insurance may be confused by the rules for the different types of coverage and must have the information they need to navigate the health coverage system.

- Give these appointment cards or magnets to consumers as part of the enrollment process.
- Develop culturally appropriate and easy-to-read materials that highlight the key aspects of the renewal process and that explain the procedure(s) consumers must follow to report changes in income or life circumstances. For example, an organization could design a bookmark with this information that it could give to consumers.
- **Tips specifically for providers:**
  - Add a “tickler” or alert to each patient’s medical record that staff can see when patients come in for appointments. Staff can then remind patients about how to report changes and renew their health insurance. Providers should be prepared to give patients additional information on how the renewal process works.
  - Call patients and remind them to follow the necessary steps to keep their coverage.
  - Offer application assistance to patients, or refer patients to organizations that can provide such assistance.

 **TIP**

Assisters should always make sure that they get consumers to sign the appropriate consent forms. Voice broadcast, emails, and text messages are very cost-effective in-reach tools, but they require the consumer’s permission before they can be used.

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## Endnotes

**The federal regulations guiding the content of this document are listed in the endnotes below.**

<sup>1</sup> The Urban Institute, *Administrative Renewal, Accuracy of Redetermination Outcomes, and Administrative Costs* (Washington: The Urban Institute, October 2013), available online at <http://www.urban.org/UploadedPDF/412921-Administrative-Renewal.pdf>.

<sup>2</sup> 26 CFR § 1.36B-4

<sup>3</sup> Plans must give individuals reasonable notice before cancelling their health plan (45 CFR § 156.270(b)(1)).

<sup>4</sup> 45 CFR § 155.430(b)(2)(ii)

<sup>5</sup> 45 CFR § 156.270(d)

<sup>6</sup> 45 CFR § 156.270(g)

<sup>7</sup> 45 CFR § 156.270(d)(3)

<sup>8</sup> 45 CFR § 156.1240

<sup>9</sup> Jackson Hewitt, *Uninsured + Unbanked=Unenrolled* (Jackson Hewitt, May 2013), available online at <http://jacksonhewittaca.com/wp-content/uploads/2013/05/ACA-Banking-and-Premium-Report.pdf#page=1&zoom=auto,0,800>.

<sup>10</sup> Ibid.

<sup>11</sup> If a person does not choose to find out if he or she is eligible for financial assistance, the marketplace may not require that person to report changes that would affect eligibility for financial assistance, such as a change in income (45 CFR § 155.330(b)(2)).

<sup>12</sup> 45 CFR § 155.330(b)

<sup>13</sup> 45 CFR § 155.330(b)(1)

<sup>14</sup> 45 CFR § 155.420(d)(b)

<sup>15</sup> 45 CFR § 155.420(c)

<sup>16</sup> 45 CFR § 155.420(b)

<sup>17</sup> 45 CFR § 156.260(b)

<sup>18</sup> 45 CFR § 155.420(d)(6)

<sup>19</sup> 45 CFR § 155.330(d)(1)(ii)

<sup>20</sup> 45 CFR § 155.330(e)

<sup>21</sup> 45 CFR § 155.335

<sup>22</sup> 45 CFR § 155.335(c)

<sup>23</sup> 45 CFR § 155.335(c)(3)

<sup>24</sup> After 2017, marketplaces may send separate notices about redeterminations of coverage and open enrollment. (45 CFR § 155.335(d)(2)).

<sup>25</sup> 45 CFR § 155.335(g), 45 CFR § 155.335(h)

<sup>26</sup> 45 CFR § 155.335(g)(2)

<sup>27</sup> 45 CFR § 155.335 (h)

<sup>28</sup> 45 CFR § 156.290 (b)

<sup>29</sup> If the qualified health plan is decertified by the marketplace, the plan will not be cancelled until the consumer has an opportunity to enroll in new coverage (45 CFR § 156.290(c)(2)).

<sup>30</sup> 45 CFR § 156.265(e)

<sup>31</sup> 42 CFR § 447.55

<sup>32</sup> CMS, *Premiums, Copayments, and Other Cost Sharing* (Baltimore: CMS), available online at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Cost-Sharing/Cost-Sharing.html>, accessed in January 2014.

<sup>33</sup> 42 CFR § 447.55(b)(2)

<sup>34</sup> 42 CFR § 435.919

<sup>35</sup> 42 U.S.C. § 1397CC(e)(3)(c)

<sup>36</sup> 42 CFR § 457.570(c)(1)

<sup>37</sup> 42 CFR § 447.570(c)(3)

<sup>38</sup> 42 CFR § 457.570(b)

<sup>39</sup> 42 CFR § 435.916(c)

<sup>40</sup> 42 CFR § 435.916(c), 42 CFR § 435.907(a)

<sup>41</sup> 42 CFR § 435.916(f)(2)

<sup>42</sup> The Affordable Care Act requires all states to use the same method to count annual household income when determining eligibility for Medicaid, CHIP, and financial assistance for coverage in the health insurance marketplaces. This method of counting is called MAGI and is defined in the U.S. tax code. For certain populations, such as people with disabilities, states will not use MAGI and will continue to use traditional methods to count income to determine eligibility for Medicaid. For more information on MAGI, see Families USA, *A Closer Look: Simplifying Enrollment and Eligibility with Modified Adjusted Gross Income (MAGI)* (Washington: Families USA, October 2011), available online at <http://familiesusa2.org/assets/pdfs/health-reform/MAGI-Simplifying-Enrollment.pdf>.

<sup>43</sup> People who are eligible for traditional Medicaid, that is, those who were eligible for Medicaid prior to the Medicaid expansion that is part of the Affordable Care Act, may have their eligibility reviewed more frequently than on an annual basis. State policies in this case will vary, but states must adopt the same administrative renewal processes described in this section when possible. Make sure to review the requirements in your state. (42 CFR § 435.916(b)).

<sup>44</sup> 42 CFR § 435.916(a)(2)

<sup>45</sup> 42 CFR § 435.916(a)(2)

<sup>46</sup> 42 CFR § 435.916(a)(2)(ii)

<sup>47</sup> 42 CFR § 435.916(a)(2)(ii)

<sup>48</sup> 42 CFR § 435.916(f) (2)

<sup>49</sup> 42 CFR § 435.916 (a) (3)

<sup>50</sup> 42 CFR § 435.916 (a) (3) (i) (B)

<sup>51</sup> 42 CFR § 435.916 (f) (2)

<sup>52</sup> 42 CFR § 435.916 (f) (2)

<sup>53</sup> 42 CFR § 435.916

<sup>54</sup> 42 CFR § 435.916 (a) (3) (i) (C) (iii)

<sup>55</sup> 42 CFR § 435.916(a)(3)(i)(C)(iv)

