

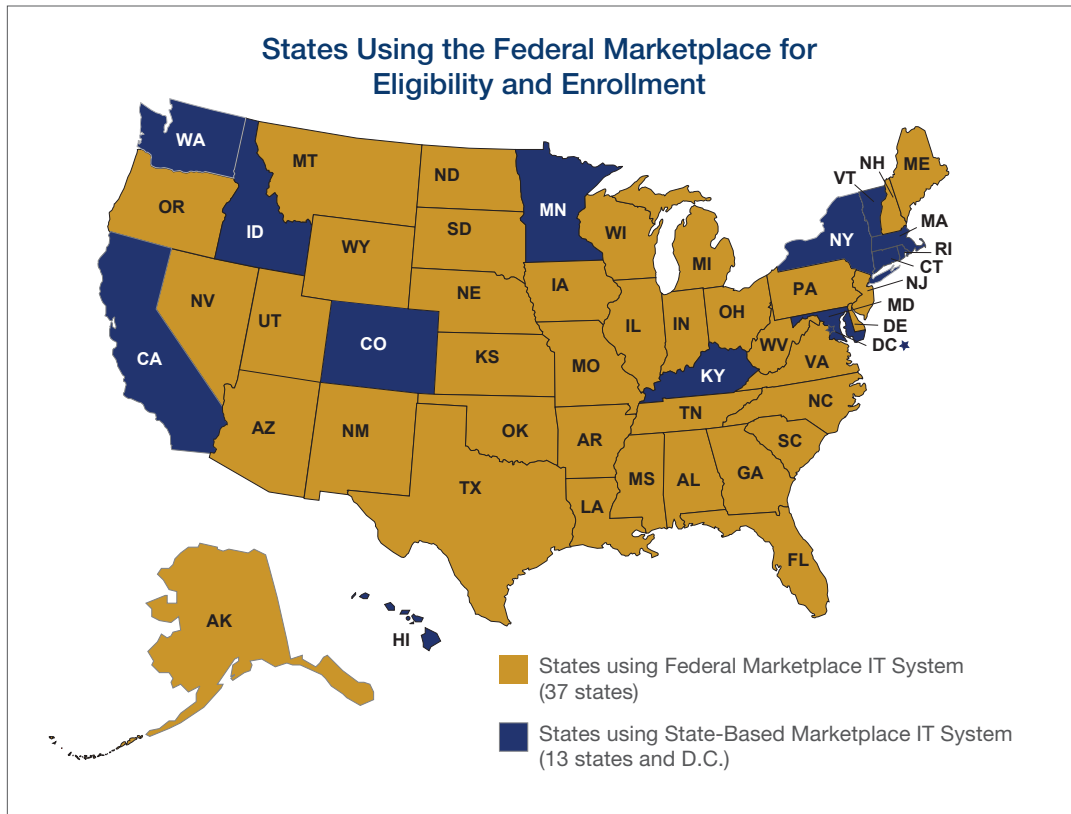


Renewing Coverage Through the Federal Marketplace

by Tricia Brooks

When the health insurance marketplaces reopen for enrollment on November 15, 2014, eight million current enrollees will have an opportunity to update their premium tax credit (PTC) eligibility and go shopping for a new qualified health plan (QHP). Keeping the majority of these enrollees covered is critical to meeting the overall enrollment projection of between 10 and 13 million people by the time the second enrollment period (OE2) ends on February 15, 2015.¹ In 37 states,² consumers

apply for and renew their coverage through the federal marketplace (FFM), which operates the online storefront (Healthcare.gov) and call center. While there is a path for automatic renewal for most enrollees, this strategy may not be in their best interests.³ However, past experience with Medicare Part D and private insurance has demonstrated that consumers often take the path of least resistance when automatic renewal is available, even when doing nothing impacts them financially.^{4, 5}





Enrollees should update their accounts to make sure they get the right amount of financial assistance for 2015.

When the FFM issued proposed guidance for the plan renewal process, including draft model insurer notices that emphasized “no action needed,” it received widespread pushback from consumer advocates and other stakeholders. Subsequently, the messaging shifted to encouraging all consumers to contact the marketplace so they do not “miss out on better deals and cost savings.”⁶ Whether these messages will move consumers to overcome their natural inertia in taking action remains to be seen.

This brief lays out the steps for renewing coverage in the federal marketplace and why enrollees should take action rather than allowing their enrollment to auto-renew. Consumers may need convincing to update their information to ensure they get the right amount of financial assistance, which could mean they get more help with paying for coverage through PTCs and cost-sharing reductions (CSR). Moreover, consumers may have new choices since 57 new insurers, a 30 percent increase over 2014, are offering plans in various states served by the federal marketplace.⁷ Navigators, certified application counselors, and other assisters will play a key role in educating consumers what actively renewing their coverage means. Renewal messages should also be included in the numerous outreach and public awareness campaigns promoting OE2 to encourage current enrollees to update their eligibility and shop for the best plan currently available.

What must consumers do to actively renew coverage in the federal marketplace?

To facilitate renewals, the FFM is largely replicating the initial enrollment process but will pre-populate a 2015 application with the enrollee’s current information. Consumers must complete two processes to renew their coverage: update their application for financial

assistance and select a QHP. Consumers must complete both steps, even if they do not intend to change plans. Additionally, enrollees must cancel their old plan, a critical action required of all enrollees who choose a new plan or get enrolled in Medicaid. These steps are described in more detail below.

How is the process different in Idaho, Nevada and Oregon, states that are switching their eligibility and enrollment systems?

Idaho has launched its own state-based marketplace eligibility and enrollment system. Current enrollees from Idaho will no longer use the federal marketplace to enroll or manage their coverage after December 31, 2014. On the other hand, Nevada and Oregon are switching to the federal marketplace. Consumers in those states will have to start from the beginning by setting up an account and applying as a new applicant for coverage. In Nevada, consumers who do not apply through the federal marketplace can keep their coverage but will lose their PTC and CSR. In Oregon, consumers will lose financial assistance and be dis-enrolled from their current plan on December 31, 2014 if they do not apply through the federal marketplace.

What happens if consumers do not actively renew coverage in the federal marketplace?

Almost all enrollees who take no action will continue to receive the same level of PTC and CSR they received in 2014. They will also stay enrolled in the same plan if available. If the current plan is not available, consumers can be automatically enrolled in a plan substituted by the insurer based on federal guidelines. Exceptions to maintaining financial assistance and being automatically renewed in a plan without having to take action are limited. Enrollees cannot have their financial assistance



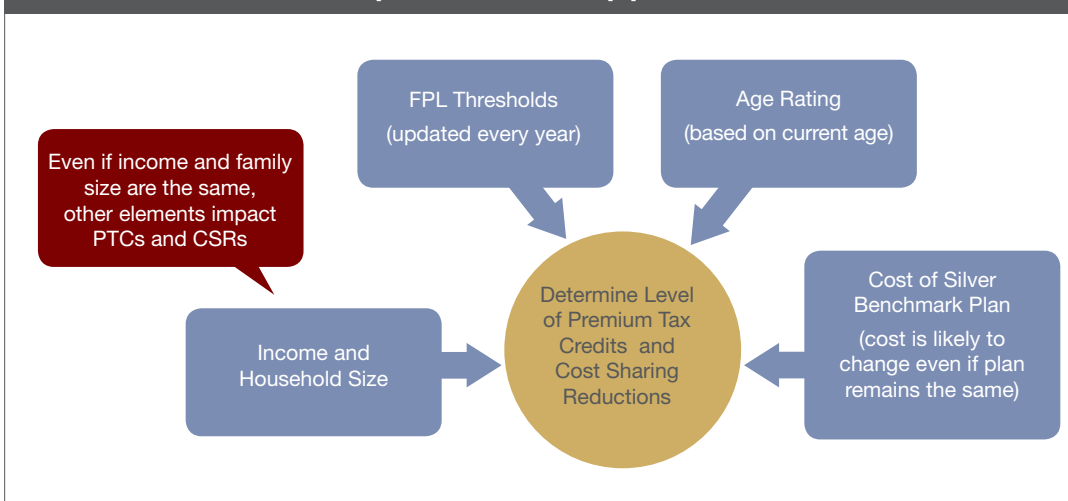
extended if 1) they did not authorize the federal marketplace to access their tax information when they applied for coverage, or 2) their latest tax information reflects income over 500 percent of the federal poverty level (FPL), well above the 400 percent income cutoff for premium tax credits. On the plan side, insurers who continue to offer marketplace plans are not required to provide ongoing coverage under certain circumstances, for example, if an individual stopped making premium payments or moved out of the plan's service area.

Why is it important for consumers to update their information?

Consumers must update their applications in order to get the most accurate level of financial assistance for the upcoming year. Even if income and household size remain the same,

other factors can impact the level of premium tax credit an enrollee receives.⁸ Annual updates to the federal poverty levels generally mean that the same income translates into a slightly lower FPL and, therefore, lower premium because enrollees pay a sliding scale percentage of income based on the equivalent FPL level. Additionally, federal rating rules permit insurers to increase premiums as people age, but because enrollees' premium contributions are capped at a percentage of their income, their PTC should increase to cover the higher age-adjusted premium. Moreover, the cost of the silver benchmark plan (second lowest cost silver plan) is used to determine the level of PTC; if the cost goes up, the level of PTC also increases (and vice versa).

Why Is It Important for Consumers to Update Their Application?





How Does Updating Your Information Affect Your Financial Assistance?

In 2013, Jane applied for coverage through the federal marketplace. She reported projected income for 2014 of \$22,980 or 200% FPL. Based on her income, she was expected to pay a premium equal to 6.3% of her income, or \$121 per month, for the silver benchmark plan. The plan cost \$300 per month, so Jane qualified for a \$179 premium tax credit. Her plan is available in 2015 but the cost will increase to \$310.

Example 1 Jane does not update her information	Example 2 Jane updates her information but reports the same income and enrolls in the same plan	Example 3 Jane reports an increase in income and selects the same plan
Jane does not expect her income to change in 2015 and she likes her plan, so she does not contact the marketplace. Her 2014 PTC of \$179 is applied to the updated \$310 cost of her plan, so her new premium will be \$131.	Jane returns to the marketplace to update her application, even though her income has not changed. Based on the 2014 FPL, her income of \$22,980 now equals 197% FPL, so Jane is expected to pay 6.16% of income or a premium of \$118 and qualifies for a PTC of \$192. By updating her information, Jane receives a larger PTC and pays \$13 less per month to stay enrolled in her current plan. Jane also gets a higher value plan with larger cost-sharing reductions (87% vs. 73% coverage).	Jane returns to the marketplace and reports projected income of \$24,857, or 213% FPL. Based on the new projected income, Jane is expected to pay a premium of \$142, or 6.87% of her income. She enrolls in the same plan for \$310 and receives a PTC of \$168. If Jane had not contacted the marketplace, she would continue to receive a \$179 PTC and pay \$131. However, at tax time, Jane would need to repay \$108 in excess PTCs that she received.

How will consumers know what action they must take?

Consumers will receive separate notices from the federal marketplace and their insurance company. Both notices will encourage enrollees to update their account information but will also tell most consumers that they are not required to take any action to stay enrolled. Only enrollees who did not authorize the marketplace to check for updated tax information, or whose latest tax return reflects income over 500 percent FPL, will be informed that they must contact the marketplace or they will automatically lose their PTC. Even in those circumstances, most consumers can stay enrolled in their QHP, if available, without taking action and pay the full premium cost.

Will the federal marketplace automatically re-determine financial eligibility based on new tax data?

No, the federal marketplace will not automatically update eligibility for PTC and CSR, although it will use the most recent tax data to send specific messages to certain enrollees. Except for individuals whose tax data reflects income above 500 percent FPL and the small percentage of enrollees who did not authorize the marketplace to recheck their tax data, all enrollees will continue to receive their 2014 PTC and CSR if they take no action. However, it is critical to keep in mind that the data used to determine which notice a consumer receives is based on their 2013 tax return while their current level of financial assistance is based on the income they projected for 2014 when they applied. Importantly, the level of PTC that they receive in 2015 should be based on projected income for the upcoming calendar year.



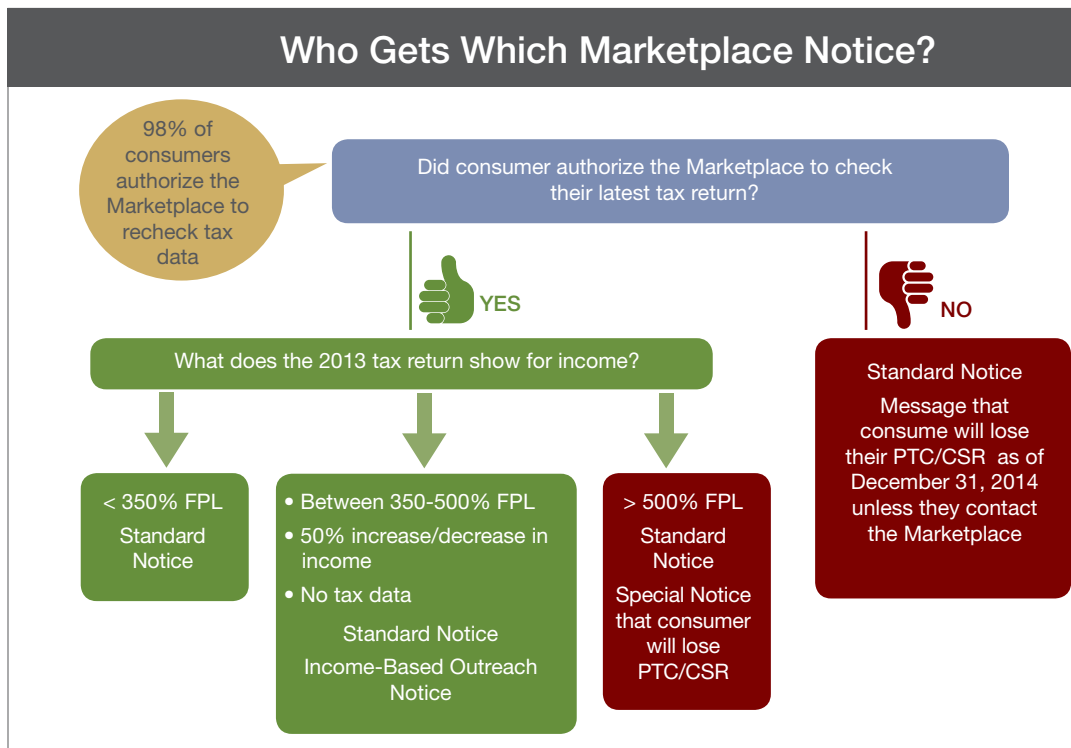
What will the federal marketplace notices tell consumers?

Enrollees, as well as individuals who applied but did not enroll, will receive a standard notice of open enrollment with key deadlines. The notice will encourage consumers to contact the marketplace to update their account information to ensure they are receiving the right amount of financial assistance. It will give information about the premium tax credit reconciliation process and alert those who did not authorize the marketplace to check their tax data that they must contact the marketplace or lose their PTC and CSR.

The standard notice to enrollees who meet certain income-based criteria will include a special outreach message. Enrollees with incomes between 350 and 500 percent FPL and those with a 50 percent increase or decrease in income will be warned that

their tax information indicates they may have had a change in circumstances that could significantly affect the amount of help they receive for paying premiums and other out-of-pocket costs. Consumers whose tax information reflects income above 500 percent FPL will receive a special notice embedded in the standard notice indicating that they must contact the marketplace to see if they continue to qualify for PTC and CSR past December 31, 2014.

Notices will be sent in the format the consumer elected to receive them, either by mail or electronically, and in Spanish or English with taglines for how to get help in other languages. Copies of the marketplace notices can be downloaded in English and Spanish at <http://marketplace.cms.gov/technical-assistance-resources/training-materials/training.html>.



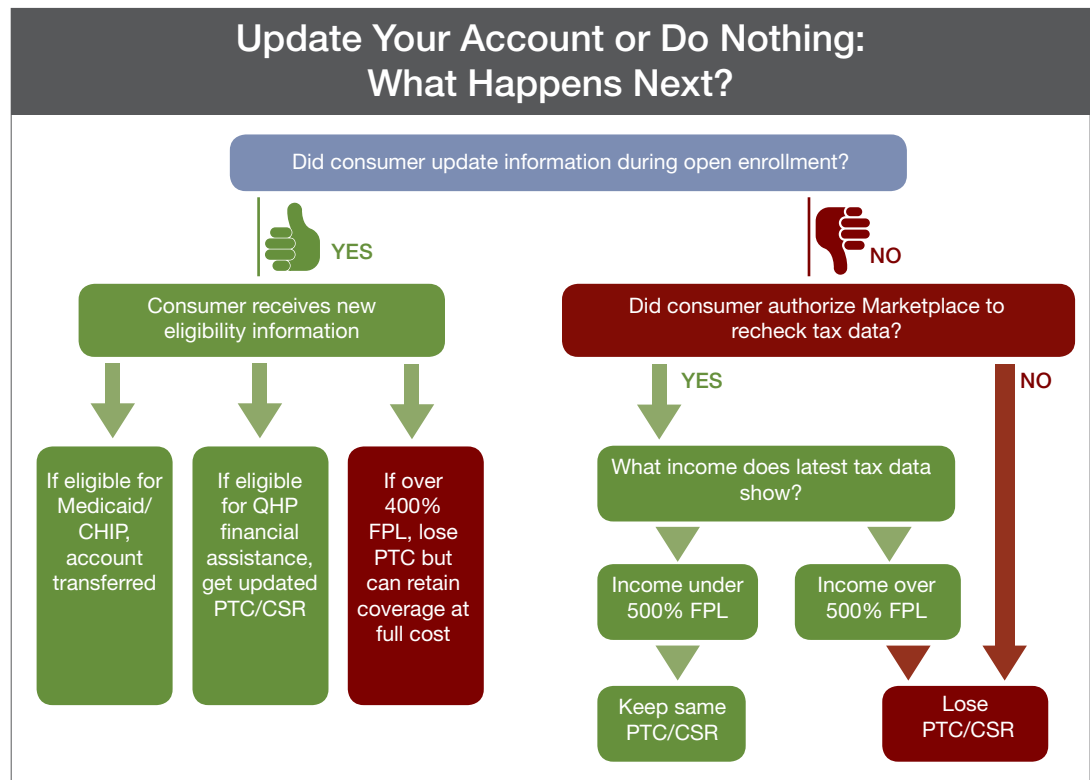


What must consumers do to update their account information and what happens next?

Consumers should log into their account and follow the “Enroll To Do List.” The federal marketplace will pre-populate a 2015 application for enrollees with the information it has on file. Enrollees should review the information and update it based on any changes in household members and who needs coverage. They should also make sure the income reflects what they estimate it will be in 2015. When they submit the updated application, a new eligibility determination will be made based on the updated income

and household size. It will also take into consideration the updated FPL thresholds and any changes to the silver benchmark plan along with cost adjustments based on age.

After updating and submitting their application, consumers will receive a new eligibility determination. They must then complete the enrollment steps to select a plan, even if they want to keep their current plan. *If consumers do not make an active plan selection, their level of financial assistance will revert to the 2014 PTC and CSR levels, and they will be auto-enrolled in the same plan, or if not available, the plan their insurer substituted.*





What is the process for QHP renewal?

Under “guaranteed issue” rules, insurers cannot deny coverage to new applicants, and they must renew coverage for current enrollees except in certain circumstances such as nonpayment of premiums or when a young adult enrolled on their parent’s plan turns 26. If the same plan remains available in the marketplace, the insurer must renew coverage in that plan, although there may be changes to various aspects of the plan. If the same plan is not available, federal regulations establish a hierarchy for enrolling individuals first in the same product line (i.e., HMO, PPO) or a different product line if the enrollee’s product line has been discontinued. Insurers that have stopped offering any marketplace products in a given area may also auto-renew someone in a plan outside the marketplace, where PTC and CSR are not available. It is important to note that some insurers may continue to offer plans on the marketplace but withdraw from certain geographic area. Enrollees and consumer assisters will want to pay close attention to the insurer notice to make sure the insurer is not automatically enrolling someone in a plan outside the marketplace where financial assistance is not available.

Insurers must send a notice that includes content specified in federal guidance. Copies of the model notices are available at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Renewal-Notices-9-3-14-FINAL.PDF>. The different notices include similar information. Each features a box at the top highlighting whether the plan is continuing (and if there are changes) or if the insurer is substituting a different plan. It cautions consumers if the plan is not a silver plan,

Hierarchy of Plan Auto Renewal



which is the only metal level that offers cost sharing reductions. The notice must include the new premium, stating that it assumes the 2014 level of PTC, and what the consumer’s estimated savings are. It encourages the consumer to return to the marketplace and provides marketplace contact information along with the deadline for January 1, 2015 enrollment. Notices will include tag lines for languages spoken by 10 percent or more of the population in a county. Insurers must provide interpreter services at no charge upon request.



Allow Your Plan to Auto-Renew or Go Shopping?



Why should consumers shop for a new plan?

Every year, insurance companies can change their premiums, cost-sharing, benefits, drug formularies, and provider networks within federal parameters. Equally important, new insurers are entering the marketplace in many areas so consumers may have new coverage options. Moreover, an individual or family may have different circumstances and health care needs going forward. For these reasons, it is smart to go shopping to compare plans. Even consumers who are not interested in comparing plans should confirm that their doctors and other preferred health care providers are still in the network, that any prescription drugs they use are covered, and that other key coverage elements, including benefits and cost-sharing, continue to meet their needs.

How do consumers shop for a new plan?

Consumers can browse and compare plans on Healthcare.gov without being logged into their account. The “Enroll To Do List” that they see when they login will provide instructions on the steps to select a new plan. As noted above, while the application will be pre-populated with the account information on file, the consumer’s previous plan choice will not be pre-populated. The notice from insurers will include a plan identification number, which will make it easier for consumers to locate and select their current plan if they want to keep it. Otherwise, consumers can compare plans and select a new plan that best fits their needs.



Update Date	New Plan Effective Date
On or before December 15, 2014	January 1, 2015
Between December 16, 2014 and January 15, 2015	February 1, 2015 (2014 QHP and PTC/CSR remain in effect in January)
Between January 16 and February 15, 2015	March 1, 2015 (2014 QHP and PTC/CSR remain in effect in January and February)

When will updated financial assistance and new plan selection go into effect?

The deadlines for enrolling or updating information remain the same. Any action taken by the 15th of the month becomes effective on the first of the upcoming month. Changes made after the 15th become effective on the first of the second upcoming month.

Will consumers be able to switch plans if they change their mind?

New for this second open enrollment period, consumers will be able to switch plans at any time before open enrollment ends on February 15, 2015. Any change will become effective based on the same deadlines for updating financial eligibility and making an initial plan selection.

Are consumers required to take action to cancel their old plan when they are enrolled in Medicaid?

Yes, this little known fact recently emerged when consumer advocates and insurers became aware that the federal marketplace does not cancel the current plan when it receives confirmation of Medicaid enrollment. The lack of enrollment coordination and the potential financial liability this represents

to consumers is alarming. Consumers may logically assume that the FFM would automatically cancel their old plan enrollment when they get enrolled in Medicaid. While a longer-term solution needs to be identified, it is critical that stakeholders and consumer assisters make sure that consumers understand the importance of this final step. The FFM is expected to release guidance and step-by-step instructions on what action consumers in these circumstances must take to cancel coverage for some or all members of the family.

How can navigators, certified application counselors, and other assisters get ready for open enrollment?

Get familiar with the various notices that consumers will receive from the marketplace and insurers. Look to see what new insurers and plans may be available in the area. It will be particularly helpful to determine the cost of the silver benchmark plan, because premium tax credits are based on this cost. If consumers select a higher cost plan, they will pay the difference between the silver benchmark plan and the plan they choose, but this should not be the only factor that determines a consumer's choice of plans.



A successful second open enrollment period, is critical to maintaining and furthering our country's gains in increasing the number of people with health coverage.

How can assisters help consumers?

Encourage consumers to update their accounts in order to get the most accurate level of PTC and CSR and to go shopping to compare plans. Ask key questions such as whether the consumer was happy with their 2014 plan choice and if there have been any changes in their health care needs or personal circumstances. Help enrollees confirm key coverage elements, including whether the consumer's preferred health care providers are in the network, if needed prescription drugs are covered, and what cost-sharing the consumer is expected to pay for various services, particularly those that the consumer anticipates using. Make sure that consumers who get enrolled in Medicaid cancel their old plan according to the instructions that the FFM is expected to release soon. Also, remind consumers to report any change in income or household size during the year and to double check their projected income for 2015 after they file their 2014 taxes.

Looking forward, how can we improve the renewal process in future years?

As long as the most recent verifiable income information available to the marketplace is two-year old tax data, it is not in the best interest of the consumers to use this data to automatically re-determine financial assistance. However, the marketplace should build the technology to provide a quick and easy way for consumers to review and update only the information that is needed to re-determine eligibility for financial assistance (i.e., members of the household and projected income) for the upcoming year.

Individuals who are enrolled in Medicaid are no longer eligible for premium tax credits to purchase a QHP, however, there may be a temporary overlap of coverage while the Medicaid is being processed. Although consumers can continue their QHP coverage at full cost, it is improbable that individuals with income just over the poverty line would do so. Once the federal marketplace receives confirmation from the state that an individual has been enrolled in Medicaid, it should send an additional notice to the consumer alerting them that their PTC and QHP enrollment will stop at the end of the month, along with instructions for the few who may wish to stay enrolled at full cost. Taking this action is a better way to coordinate coverage and streamline the backend administrative functions while protecting consumers from financial liability for unpaid premiums when they are unaware that they must take additional steps to dis-enroll.

For enrollees who remain eligible for QHP enrollment, the system should remind them of their current plan selection, rather than requiring them to locate it by browsing or refer to the insurer's renewal notice for the plan identification number. Making it easy to keep your same plan, however, has a downside in that it does not encourage consumers to review key coverage aspects of their plan or take a look at what new options are available. To address this, the marketplace could provide consumer-friendly messages that alert consumers to the availability of new plans, as well as build a sophisticated plan selection tool that allows consumers to easily compare plans and key elements of coverage. Importantly,



insurers should receive dis-enrollment transactions when consumers are enrolled in Medicaid or select a new plan. These backend functions are critical for administrative efficiency and to ensure that consumers are not double billed, or worse, have duplicate charges or automatic premium payments. Expecting insurers to compare old and active rosters is both inefficient and prone to errors that can create financial hassles for consumers and insurers alike.

Last, but not least, consumer assistance can play a key role in supporting retention in the same way it has proven instrumental in boosting enrollment,⁹ but additional resources are needed. Importantly, the rules and guidance related to assisting enrollees with renewal should be clarified so that assisters are clear that they can proactively reach out to help clients with whom they have existing relationships and written authorization to provide help.

CONCLUSION

All eyes will be on the federal and state marketplace online systems and call centers starting November 15, 2014 to see if they hold up under the volume of enrollment and re-enrollment that will occur in a much-shortened time frame during OE2. A successful second open enrollment period, including renewing coverage for the eight million current enrollees, is critical to maintaining and furthering our country's gains in increasing the number of people with health coverage. Marketplaces should continue to work on improving the consumer experience in enrolling in and retaining coverage through enhanced technology and greater access to consumer assistance at both the marketplace and community level.

ENDNOTES

1. The Congressional Budget Office projected 13 million enrollees for 2015 when it updated its estimates in February 2014. Recently the Department of Health and Human Services released their projections that between 10.3 and 11.2 million will select a plan by the end of the second enrollment period, but that only 9 to 9.9 million people will be enrolled at the end of 2015.
2. Nevada and Oregon, both state-based marketplace states, are switching to using Healthcare.gov and the federal marketplace for eligibility and enrollment. Consumers in these states will need to complete a new application and select a plan by December 15, 2014, to stay covered with financial assistance. In Nevada, consumers can stay enrolled in their current plan if they do not update their eligibility. However, in Oregon, consumers must re-apply and select a plan or will lose both their financial assistance and coverage as of December 31, 2014.
3. T. Brooks, "All Enrollees Should Contact the Marketplace at Renewal," Georgetown University Center for Children and Families Blog, July 2014.
4. Jack Hoadley, et al., "To Switch or Not to Switch: Are Medicare Beneficiaries Switching Drug Plans To Save Money?," Kaiser Family Foundation, October 2013.
5. Peter J. Cunningham, "Few Americans Switch Employer Health Plans for Better Quality, Lower Costs," NIHCR, January 2013.
6. "5 Steps to Staying Covered Through the Marketplace," Health Insurance Marketplace, October 2014.
7. M. Gunja and E. Gee, "Health Insurance Issuer Participation and New Entrants in the Health Insurance Marketplace in 2015," US Department of Health and Human Services, ASPE Office of Health Policy, September 2014.
8. "Premium Tax Credits: Answers to Frequently Asked Questions," Center on Budget and Policy Priorities, July 2013.
9. R. Grob, et al., "Taking Stock and Taking Steps: A Report from the Field after the First Year of Marketplace Consumer Assistance under the ACA," Kaiser Family Foundation, October 2014.



Tricia Brooks is the Senior Fellow at the Georgetown University Center for Children and Families. The author would like to thank her colleagues at Georgetown University Health Policy Institute, Sean Miskell, Sabrina Corlette, Sophia Duong and Sarah Koslov for their helpful review of this brief. Design and layout assistance provided by Nancy Magill.

The Center for Children and Families (CCF) is an independent, nonpartisan policy and research center whose mission is to expand and improve health coverage for America's children and families. CCF is based at Georgetown University's Health Policy Institute.

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