

# Updates from HHS and CMS – Region 9



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*“Working to Achieve Health Equity”*

# Enrollment Data

- State-Level (11/1/17 – 12/23/17)

State Name	Total Number of Consumers Who Have Selected an Exchange Plan	New Consumers	Total Re-enrollees	Active Re-enrollees	Automatic Re-enrollees
Arizona	165,758	44,512	121,246	85,444	35,802

- Weekly Snapshot (11/1/17 – 12/23/17)

<u>CUMULATIVE PLAN SELECTIONS:</u>	<u>Nov 1-Nov 18</u>	<u>Nov 1-Nov 25</u>	<u>Nov 1-Dec 2</u>	<u>Nov 1-Dec 9</u>	<u>Nov 1-Dec 15</u>	<u>Nov 1-Dec 23</u>
Arizona	43,499	51,615	67,266	87,687	166,961	165,758

# Enrollment Data

- Effectuated Data (2/2018)

## Total Effectuated Enrollment and Enrollees Receiving APTC and CSR by State, February 2018

State	Total Enrollment	APTC Enrollment	Percentage of Enrollment with APTC	CSR Enrollment	Percentage of Enrollment with CSR
Nationwide	10,643,786	9,229,769	87%	5,612,435	53%
Arizona	154,435	131,078	85%	79,014	51%

# Qualified Health Plans (QHPs)

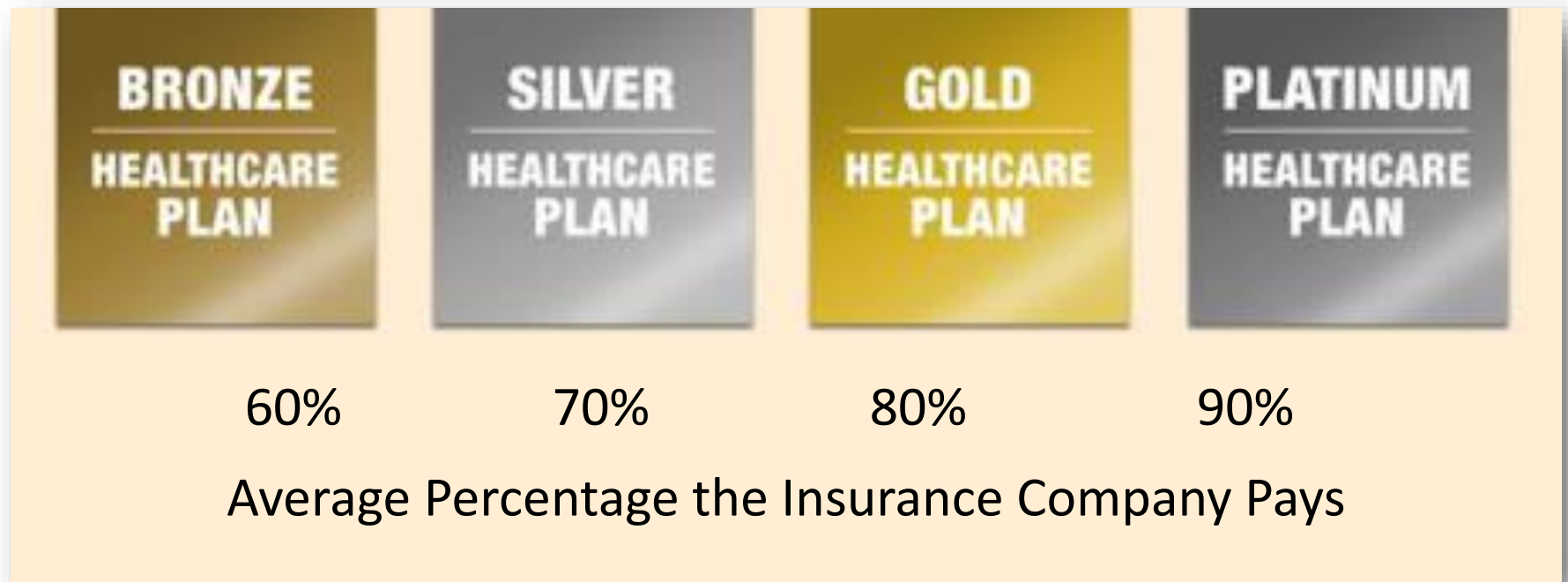
- A QHP
  - Is offered through the Marketplace by an issuer that's licensed by the state and in good standing
  - Covers essential health benefits
  - Is offered by an issuer that offers at least one plan at the “Silver” and one at the “Gold” plan category of actuarial value
  - Charges the same premium whether offered through a Marketplace or outside a Marketplace

# Qualified Health Plans (QHPs) Cover Essential Health Benefits

- Essential health benefits include at least these 10 categories
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care (pediatric oral services may be provided by stand-alone plan)



# Health Plan Categories



# Eligibility and Enrollment in the Individual Market

- To be eligible for Marketplace coverage, you must
  - Be a resident of a state served by the Marketplace, and
  - Be a U.S. citizen, U.S. national, or a non-citizen who's lawfully present in the U.S. (and expected to be for the entire time coverage is sought), and
  - Not be incarcerated (other than incarceration pending disposition of charges)

# Ways to Use a Premium Tax Credit

## Choose to Get It Now:

### Advance Payments of the Premium Tax Credit (APTC)

- All or some of the APTC is paid directly to your plan on a monthly basis
- You pay the difference between the monthly premium and APTC
- You reconcile the APTC when you file a tax return for the coverage year

## Choose to Get It Later

- Don't request any advance payments
- You pay the entire monthly plan premium
- Claim the full amount on the tax return filed for the coverage year



# Guidance on Annual Eligibility Redetermination and Re-enrollment for Exchange Coverage for 2019 and Later Years

Guidance on Annual Eligibility Redetermination and Re-enrollment for Exchange Coverage for 2019 and Later Years:

<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-Enrollment-ARR-Guidance.pdf>

# Annual Redetermination Notices

- Marketplace Open Enrollment and Annual Redetermination Notices
  - Enrolled, but may be eligible for different financial assistance
  - Enrolled, but losing financial assistance
  - Enrolled, but not currently getting a tax credit or help with costs for their 2018 Marketplace coverage
  - Previously reenrolled automatically, but not currently eligible for automatic reenrollment with a tax credit or help with costs for 2019 coverage

Available at: <https://marketplace.cms.gov/applications-and-forms/notices.html>

# Hardship Exemptions

- Guidance on Hardship Exemptions from the Individual Shared Responsibility Provision for Persons Experiencing Limited Issuer Options or Other Circumstances:  
<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2018-Hardship-Exemption-Guidance.pdf>
- Guidance on Claiming a Hardship Exemption through the Internal Revenue Service (IRS):  
<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Authority-to-Grant-HS-Exemptions-2018-Final-91218.pdf>

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Center for Consumer Information and Insurance Oversight  
200 Independence Avenue SW  
Washington, DC 20201



**Date:** April 9, 2018

**From:** Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services (CMS)

**Subject:** Guidance on Hardship Exemptions from the Individual Shared Responsibility Provision for Persons Experiencing Limited Issuer Options or Other Circumstances

This guidance describes examples of circumstances that fall under the Federally-facilitated Exchange's (FFE's) hardship exemption policy that will address people facing limited issuer options or other circumstances preventing them from purchasing health insurance. Specifically, this guidance describes circumstances that will support a hardship exemption for people who:

- (1) Live in a county, borough, or parish in which no qualified health plan (QHP) is offered through the FFE;
- (2) Live in a county, borough, or parish in which there is only one issuer offering coverage through the FFE and can show that the resulting lack of choice has precluded them from

# Short-Term, Limited Duration Insurance (STLDI)

- Under the new rule, the limit is up to 364 days
  - Originally under the ACA, STLDI plans were limited to 3 months
- Insurers are allowed, but not required, to extend policies
  - The maximum duration, including any extensions, would be 36 months in total
- Issuers must display prominently in consumer materials one of two versions of a consumer notice explaining the policy that they are purchasing

# Same-Day Voluntary Terminations

## **First Open Enrollment Period (OEP) with Same-day Voluntary Terminations Available to Enrollees**

- A change in the 2019 Payment Notice provides Exchanges the option to allow enrollees to elect same-day policy terminations, replacing the 14-day “reasonable notice” period
- The FFEs have elected to begin offering same-day policy terminations as of July 27, 2018
  - In ‘My Account’, when terminating coverage for all enrollees on an application, there will no longer be 14 days “grayed out” and unable to be changed on the date picker. Rather, enrollees will be able to select the present date or another date in the future as their termination date.

# Same-Day Voluntary Terminations

## First Open Enrollment Period (OEP) with Same-day Voluntary Terminations Available to Enrollees

- The FFEs have elected to begin offering same-day policy terminations as of July 27, 2018
  - Functionality for policies where coverage is ending for some but not all enrollees has always permitted coverage to end the day the enrollee requests the change (sometimes with a HICS case to move the termination date); the new policy and functionality permits same-day terminations for entire policies
  - The correct termination date of the entire policy, whether it is same day or in the future, at the enrollee's option, will be identified on the 834 transaction (termination for some enrollees on a policy, but not the entire policy, may still require HICS to move the termination date)
- Review presentation on Options to Terminate Plans and Report Changes: <https://marketplace.cms.gov/technical-assistance-resources/consumer-options-to-terminate-plans.pdf>

# Medicare and the Marketplace

- Medicare isn't part of the Health Insurance Marketplace
- Generally, there's no coordination of benefits between Marketplace Qualified Health Plans (QHPs) and Medicare
- QHPs aren't secondary insurance to Medicare
- If you have Medicare, it's illegal for someone to knowingly sell you a Marketplace plan

# Medicare and the Marketplace

- You may have a Qualified Health Plan (QHP) through the Marketplace and Medicare at the same time only if you signed up for the QHP before you had Medicare
- If you have Marketplace and Medicare coverage, you may need to end any Marketplace cost savings being paid on your behalf
- If you have premium-free Medicare Part A, you're considered covered
  - Need to terminate Marketplace coverage
- If you have to pay a premium for Medicare Part A
  - Can drop Medicare and enroll in Marketplace QHP (with subsidies if you're otherwise eligible)



# Consumers with Medicare and Marketplace

- Assistance with Medicare:
  - AZ SHIP Hotline: (800) 432-4040 (Leave a message for a callback)
  - Eight Regional SHIP offices
    - <https://des.az.gov/services/aging-and-adult/state-health-insurance/ship-offices>

# Medicare PDM: Notifying Dually-Enrolled Consumers

- Notify consumers who are identified as enrolled in MEC Medicare and a Marketplace plan
  - Request that they return to their Marketplace application and end coverage.
- If consumers do not cancel coverage
  - may have to pay back all or some of the APTC paid on their behalf for months they had both Marketplace coverage with APTC and MEC Medicare, when they file their Federal income tax return.

# Non-renewal of Coverage for Marketplace Consumers with Medicare

- Issuers will non-renewing 2018 coverage for Plan Year 2019 for enrollees who have been identified to have Medicare coverage.
- Issuers will end coverage for enrollees with Medicare and everyone on the policy, including the enrollees who were not enrolled in Medicare.
- Issuers will send a termination notice noting that coverage cannot be renewed because a member is also enrolled in Medicare.

# Non-renewal of Coverage for Marketplace Consumers with Medicare

- This means that Marketplace enrollees who are **Not** enrolled in Medicare, but who are enrolled in coverage on the same policy with an enrollee who has Medicare coverage, will also have their coverage non-renewed.
- Encourage enrollees whose coverage was not renewed for Plan Year 2019 and who are **Not** covered by Medicare to return to the Marketplace and enroll in coverage during Open Enrollment.
- If they don't enroll in 2019 coverage by December 15, these enrollees are also eligible for a Special Enrollment Period (SEP) through March 1, 2019, to enroll in coverage with a retroactive coverage effective date back to January 1, 2019, to avoid any gaps in coverage.

# AHCCCS Complete Care and Medicare

- AHCCCS Complete Care
  - new AHCCCS managed care plan service areas
- Medicare Advantage Dual Special Needs Plans (SNP)
  - non-renewal dual SNPs for 2019
    - Medicare plan will not be available in 2019
    - Join new plan
      - October 15, 2018 to February 28, 2019
    - Join new plan by 12/31/2018
      - effective date of 1/1/2019

# Consumers with Medicare and Marketplace

- Assistance with Medicare:
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# Where to Seek Help for Common Issues

- Issues divided into two categories:
  - Pre-enrollment: contact Marketplace call center
    - questions about the HC.gov application process
      - financial assistance
  - Post enrollment: contact Issuer and/or AZ DOI
    - questions about plan benefits, premiums, cost-share

# Where to Seek Help for Common Issues (Marketplace Call Center)

- Account and Eligibility Matters
  - Difficulty completing a Marketplace application
  - Password resets
  - Unlocking HealthCare.gov accounts
- Data Match Issues
  - Checking on the status of sent materials
  - Exemptions
  - Needing an exemption certificate number (ECN)
  - Checking on the status of an exemption request



# Where to Seek Help for Common Issues (Marketplace Call Center)

- Special Enrollment Periods/Changes in Circumstance Examples
  - Gaining/losing minimum essential coverage (MEC)
  - Birth/adoption of child
  - Changes in annual income
  - Requesting plan termination
- Plan Compare
  - Assistance reviewing available plans/costs
  - Identifying local assister resources in the community

# Where to Seek Help for Common Issues (Marketplace Call Center)

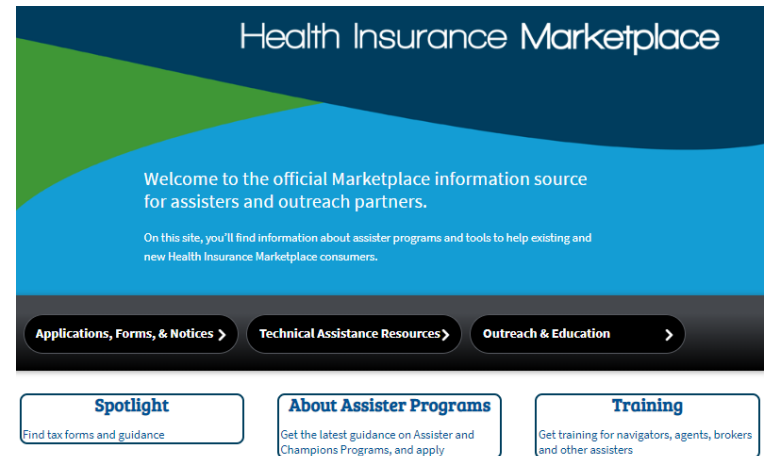
- 1095-A Tax Forms
  - Requests for reprints or non-receipt of forms
    - Consumers are encouraged to first check their HealthCare.gov My Account to retrieve copies of their forms
  - Mailing address corrections
    - Request will be forwarded to a CMS contractor for review and handling
  - Disagreement with coverage period or other information on the form
    - Consumers should first check with their issuer and see what enrollment periods/APTC their issuer has on file

# Where to Seek Help for Common Issues (Marketplace Issuers)

- Enrollment Issues
  - Delayed enrollment processing
  - Requests for earlier termination dates than the Marketplace has awarded
  - Incorrect application of APTC and/or CSR
- Benefit Coverage
  - Questions about coverage and formularies
  - Difficulty finding a network provider
  - Excessive cost-sharing being charged
  - Claims processing
  - Internal claims appeals and external review

# Resources

- CMS's official source for materials: <https://marketplace.cms.gov/>
- Outreach and Education Materials: <https://marketplace.cms.gov/outreach-and-education/outreach-and-education.html>
- Product ordering home: <https://productordering.cms.hhs.gov/>
  - Select “Request an Account.”
  - Fill out the form with your contact and shipping information.
  - In the "Why I need access?" field, type the name of your organization and its purpose. (Example: ABC Partnership Group, an advocacy group for people with diabetes).
  - You will receive an approval notice by email within 3 days. Once approved, you can order resources.




# From Coverage to Care

C2C Home Page: [go.cms.gov/c2c](https://www.cms.gov/c2c)

- Customer resources available, free of charge and in multiple languages
  - 5 Ways to Make the Most of Your Health Coverage
  - A Roadmap to Better Care and a Healthier You
  - A Roadmap to Behavioral Health
  - How to Maximize Your Health Coverage
- <https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/c2c/consumer-resources.html>

# My Health Coverage at a Glance









## Mi Cobertura de Salud en Resumen

### Información sobre el plan

Nombre del plan ▼	Número de grupo ▼	Número de identificación del miembro ▼
<input type="text"/>	<input type="text"/>	<input type="text"/>
Síto web ▼	Número de teléfono ▼	Otro ▼
<input type="text"/>	<input type="text"/>	<input type="text"/>

### Conozca lo que paga por el cuidado de su salud

 <b>Prima</b> El pago que realiza a una compañía de seguro médico o plan de salud por su cobertura. Por lo general se paga mensualmente para mantener la cobertura.	Costo ▼ <input type="text"/> \$ o n/d por mes/año/otro:								
 <b>Deducible</b> El monto que paga por los servicios de atención médica antes de que su plan de salud comience a pagar.	Costo ▼ <input type="text"/> \$ o n/d								
 <b>Copago</b> El monto fijo que paga por un servicio o suministro médico. Los costos pueden ser diferentes según se trate de una visita médica, una visita hospitalaria como paciente ambulatorio o una receta.	<table> <tr> <td>Copago de proveedor de atención primaria ▼</td> <td>Copago de especialista ▼</td> </tr> <tr> <td><input type="text"/> \$ o n/d</td> <td><input type="text"/> \$ o n/d</td> </tr> <tr> <td>Receta ▼</td> <td>Copago hospitalario ▼</td> </tr> <tr> <td><input type="text"/> \$ o n/d</td> <td><input type="text"/> \$ o n/d</td> </tr> </table>	Copago de proveedor de atención primaria ▼	Copago de especialista ▼	<input type="text"/> \$ o n/d	<input type="text"/> \$ o n/d	Receta ▼	Copago hospitalario ▼	<input type="text"/> \$ o n/d	<input type="text"/> \$ o n/d
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<input type="text"/> \$ o n/d	<input type="text"/> \$ o n/d								
 <b>Coseguro</b> La porción que usted paga al compartir el costo de los servicios después de haber pagado cualquier deducible.	<table> <tr> <td>Coseguro de proveedor de atención primaria ▼</td> <td>Coseguro de especialista ▼</td> </tr> <tr> <td><input type="text"/> \$ o n/d</td> <td><input type="text"/> \$ o n/d</td> </tr> <tr> <td>Coseguro de recetas ▼</td> <td>Coseguro hospitalario ▼</td> </tr> <tr> <td><input type="text"/> \$ o n/d</td> <td><input type="text"/> \$ o n/d</td> </tr> </table>	Coseguro de proveedor de atención primaria ▼	Coseguro de especialista ▼	<input type="text"/> \$ o n/d	<input type="text"/> \$ o n/d	Coseguro de recetas ▼	Coseguro hospitalario ▼	<input type="text"/> \$ o n/d	<input type="text"/> \$ o n/d
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Coseguro de recetas ▼	Coseguro hospitalario ▼								
<input type="text"/> \$ o n/d	<input type="text"/> \$ o n/d								
 <b>Gasto límite de su bolsillo</b> La cantidad máxima que usted paga antes de que su plan comience a pagar el 100 % de los servicios cubiertos en un año del plan.	Gasto límite de bolsillo ▼ <input type="text"/> \$ o n/d Ingrese el gasto límite actual y anote si incluye los deducibles u otros costos.								
 <b>Servicios preventivos</b> Pruebas de detección de salud de rutina, chequeos y vacunas. Por ejemplo, la vacuna antigripal, la prueba de detección de depresión y de presión arterial.	Costo ▼ <input type="text"/> \$ o n/d \$0 (para la mayoría de los planes, ajustar si es necesario)								

### Sepa a dónde ir si necesita atención

Consejo sobre costos: Por lo general, los servicios cuestan menos si usa los proveedores dentro de la red, es decir, los centros, profesionales y proveedores con los que su plan ha acordado trabajar para brindar servicios. Para averiguar quién está dentro de su red, revise el directorio del plan y pregunte en el consultorio de su proveedor.

 <b>Proveedor de Atención Médica Primaria</b> El proveedor principal (generalmente un médico) al que consulta por la mayoría de los problemas de salud. Puede ser un consultorio privado, una clínica comunitaria u otro centro. Acuda a este proveedor para obtener servicios preventivos, recetas o si tiene otras preguntas sobre su salud.	El nombre de mi proveedor ▼ <input type="text"/> El número de teléfono de mi proveedor ▼ <input type="text"/>
 <b>Especialistas</b> Un médico que se enfoca en un área específica de la medicina o en un grupo de pacientes para el diagnóstico, la prevención y el tratamiento de determinados tipos de enfermedades o trastornos. Un especialista que no es un médico es un proveedor que tiene más capacitación en un área específica.	El nombre de mi especialista ▼ <input type="text"/> El número de teléfono de mi especialista ▼ <input type="text"/>
 <b>Farmacia</b> Tienda en donde se tramitan las recetas y se venden medicamentos. Para tramitar recetas, busque una farmacia dentro de su red. De esta modo, no pagará tanto. Revise el directorio del plan o consulte con su farmacia local.	La dirección de mi farmacia ▼ <input type="text"/> El número de teléfono de mi farmacia ▼ <input type="text"/>
 <b>Departamento de Emergencias (ED o ER)</b> El ED del hospital de su zona es donde usted recibiría servicios para una enfermedad, una lesión, un síntoma o un trastorno de gravedad por el que una persona razonable buscaría atención y tratamiento de inmediato para evitar que el problema empeore.	La dirección del hospital de mi zona ▼ <input type="text"/> El número de teléfono del hospital de mi zona ▼ <input type="text"/>

### Fechas que debo recordar y otras notas

Revise su plan todos los años antes del periodo de inscripción y contacte a su plan para informar sobre cualquier cambio en su vida (por ejemplo, si se casa o tiene un bebé) o sobre los cambios en su información de contacto. Para obtener más información sobre cómo comenzar visite <http://bit.ly/1ManerasCSC> y lea las [5 maneras de aprovechar su cobertura médica](#).

Fecha de vencimiento de la prima ▼ <input type="text"/> Pagar la prima el 10/15/2018	Fecha de renovación ▼ <input type="text"/> Renovar el plan el 08/15/2018
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Otra información ▼

Información de contacto, alergias, listas de medicamentos, enlaces al resumen de beneficios y cobertura, ayuda para recordar la contraseña, información de contacto fiscal, etc.

### Información adicional

Para obtener más información y un glosario de términos, visite <http://bit.ly/1GuiaParaUnMejorCuidado> y lea la [Guía para un mejor cuidado y una vida más saludable](#).

Pág. 4 de 4 | Departamento de Salud y Servicios Humanos de los EE. UU.



gov.cms.gov/nc  
 1281010, en Febrero 2018  
 Septiembre de 2018

# Contact Us

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