Welcome to Open Enrollment X

Introductions

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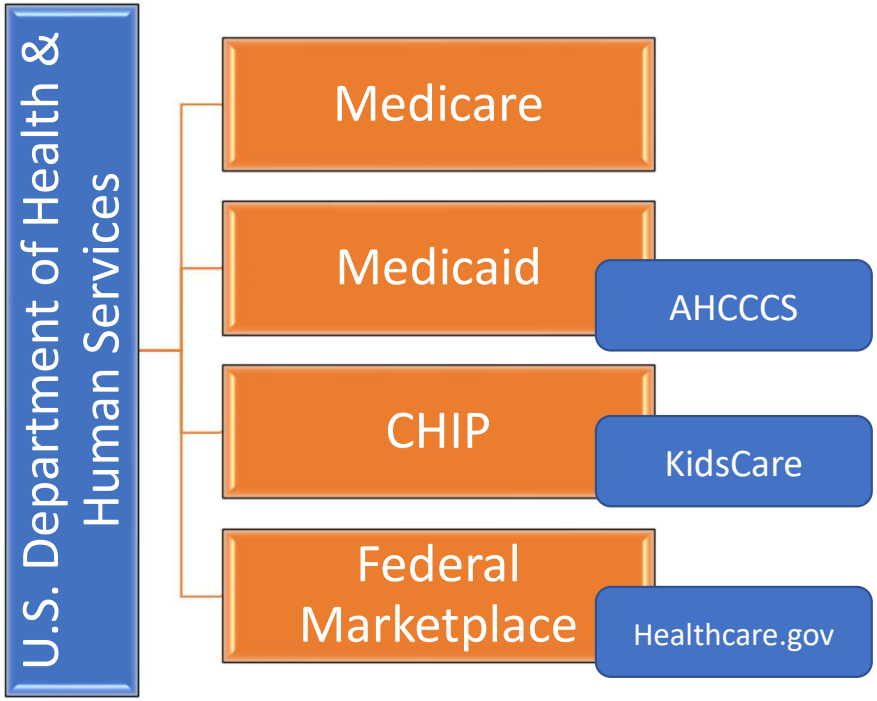
Presentation Overview

- What is the state of enrollment?
- Why should consumers care?
- What does CMS want you to know?
- How can we engage consumers?
- Where might we engage consumers?
- While you're thinking of us…

What is the state of enrollment?

A Brief Primer on Health Insurance

HHS & State Programs



Marketplace Enrollment Data

- Total Plan Selections Year-Over-Year

	OE1 Oct 1, 2013 – Mar 31, 2014	OE2 Nov 15, 2014- Feb 15, 2015	OE3 Nov 1, 2015- Jan 31, 2016	OE4 Nov 1, 2016 – Jan 31, 2017	OE5 Nov 1 – Dec 15, 2017	OE6 Nov 1 – Dec 15, 2018	OE7 Nov 1 – Dec 15, 2019	OE8 Nov 1 – Dec 15, 2020	OE9 Nov 1, 2021 – Jan 15, 2022
National	8 million	11.7 million	14.7 million	12.2 million	11.8 million	11.4 million	11.4 million	12 million	14.5 million
Arizona	**120,071**	**205,666**	**203,066**	**196,291**	**165,758**	**160,456**	**153,020**	**154,504**	**199,707**

- Average Total Premiums (Plan Year 2022)

	Average Raw Total Premium per Month	Average Actual Premium per Month
Nationwide for HC.gov	$594	$111
Arizona	$554	$180

Source: 2022 Public Use Files at https://www.cms.gov/research-statistics-data-systems/marketplace-products/2022-marketplace-open-enrollment-period-public-use-files

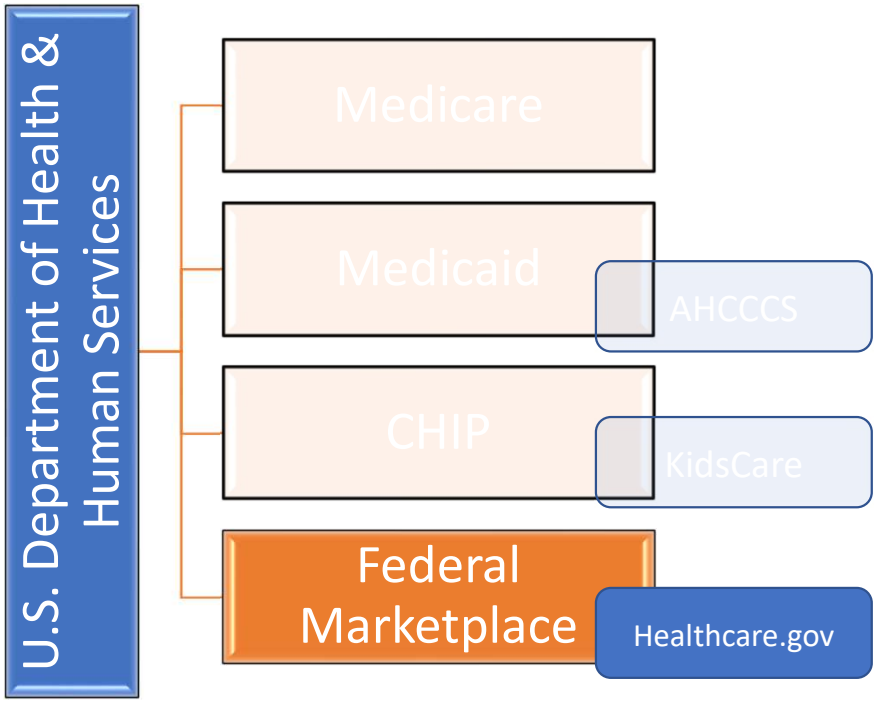
Why should consumers care?

Framework for Measuring the Impact of the Affordable Care Act

8

A Brief Primer on Health Insurance

HHS & State Programs



Access

Health Insurance companies must:

- Be licensed by the state and in good standing
- Offer at least one Silver plan and one Gold plan
- Charge the same premium whether offered through a Marketplace or outside a Marketplace

To be eligible for Marketplace coverage, consumers must:

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

Access

Public Charge Final Rule effective December 23, 2022

- On September 8, 2022, the U.S. Department of Homeland Security (DHS) issued a final rule applicable to noncitizens who receive or wish to apply for benefits provided by the U.S. Department of Health and Human Services (HHS) and States that support low-income families and adults.
- The rule, which details how DHS will interpret the "public charge" ground of inadmissibility, will help ensure that noncitizens can access health-related benefits and other supplemental government services to which they are entitled by law, without triggering harmful immigration consequences.
- The final rule applies to noncitizens requesting admission to the U.S. or applying for lawful permanent residence (a "green card") from within the U.S.
- When assessing whether a noncitizen is "likely to become primarily dependent on the government for subsistence," DHS will not penalize individuals who choose to access the vast majority of health-related benefits and other supplemental government services available to them, including most Medicaid benefits (except for long-term institutionalization – such as residing in nursing home – at government expense) and the Children's Health Insurance Program (CHIP).
- The final rule does not expand eligibility for Medicaid, CHIP, or other benefits to more people but clarifies DHS policy regarding recipients.

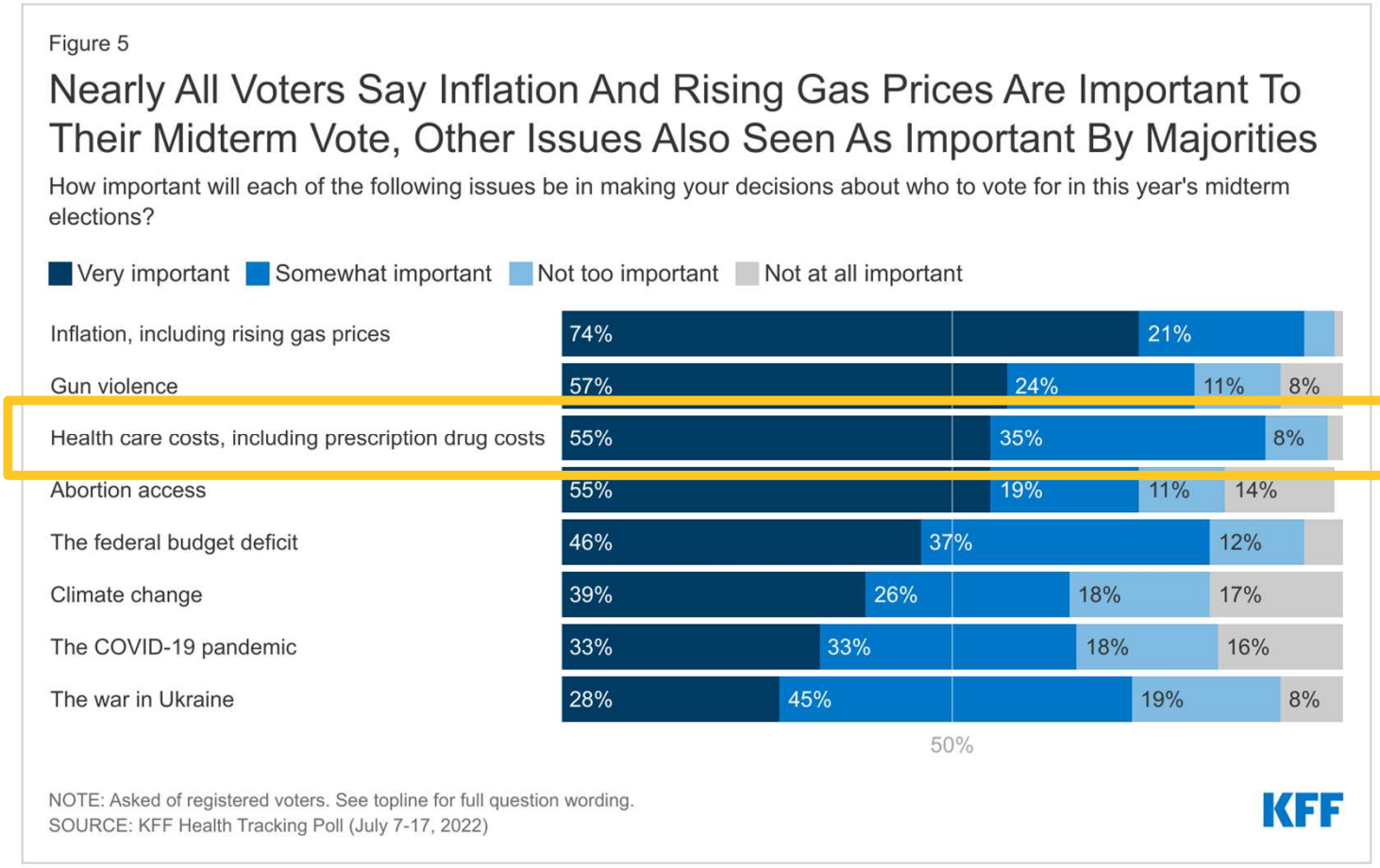
Quality

- No pre-existing condition exclusions
- No lifetime or annual limits
- Up to age 26 on parent's coverage
- Free preventive services
- No gender discrimination
- Essential health benefits

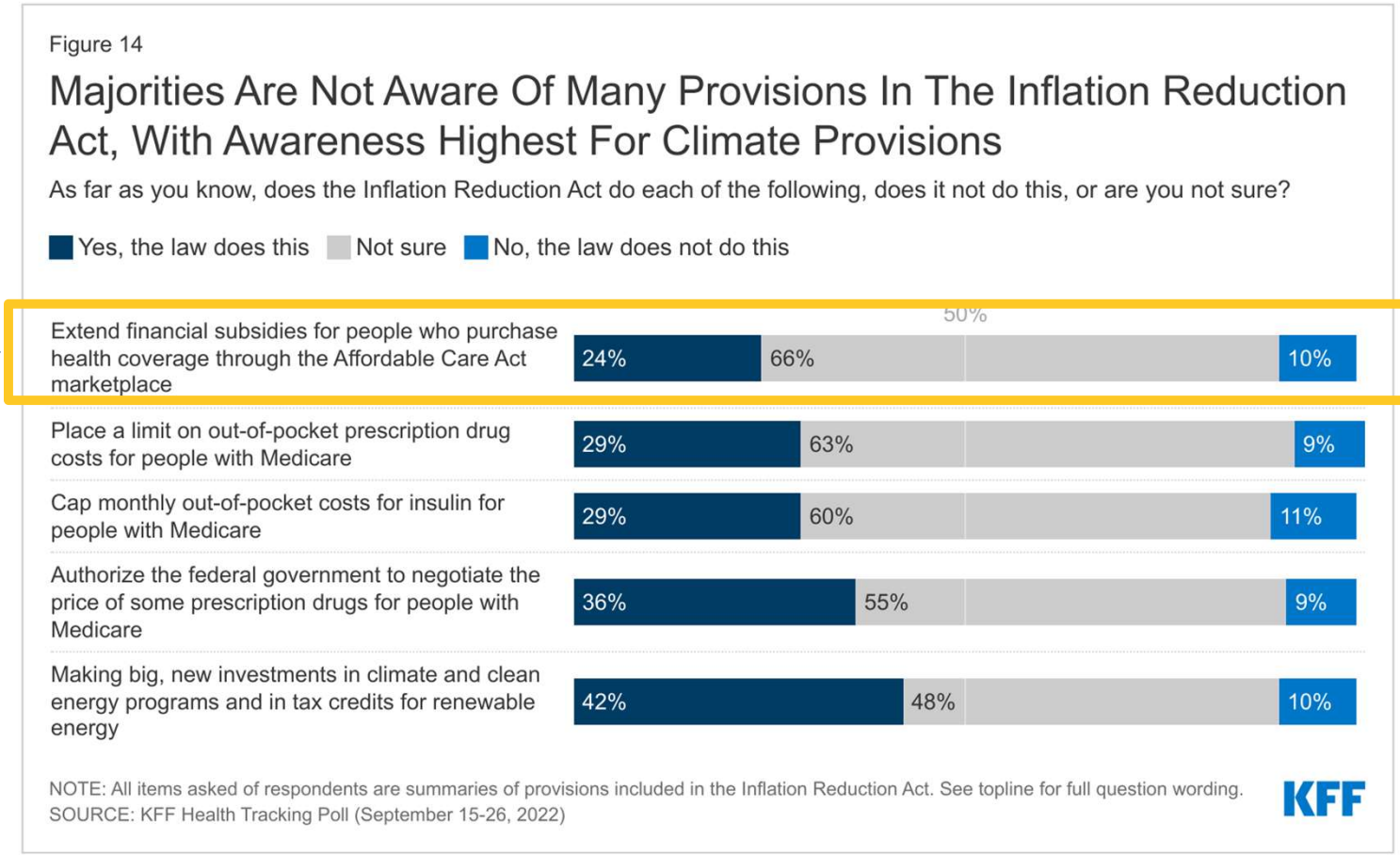
Quality

- All plans offered in the Marketplace cover these 10 essential health benefits:
  - Ambulatory patient services (outpatient care you get without being admitted to a hospital)
  - Emergency services
  - Hospitalization (like surgery and overnight stays)
  - Pregnancy, maternity, and newborn care (both before and after birth)
  - Mental health and substance use disorder services, including behavioral health treatment (e.g. counseling & psychotherapy)
  - Prescription drugs
  - Rehabilitative and habilitative services & devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
  - Laboratory services
  - Preventive and wellness services & chronic disease management
  - Pediatric services, including oral and vision care (note: adult dental and vision coverage are not essential health benefits)

Affordability



Affordability



Affordability

The Inflation Reduction Act extended the expanded financial assistance from the American Rescue Plan (ARP)

- Meaningfully reduced premiums for people across the income spectrum by 50% on average.
  - $67 per consumer per month
- Under the ARP, middle-income people and families over 400% of the federal poverty level (FPL) gained access to ACA premium tax credits for the first time.
  - ~$52,000 for a single person and $106,000 for a family of four
- Expanded premium tax credits to all Marketplace consumers for whom sticker price premiums exceed 8.5% of income, the maximum contribution under the ARP.

Affordability

- Average Total Premium & Average APTC in Arizona

	Average Raw Total Premium per Month	Average Actual Premium per Month
PY 2021	$581	$219
PY 2022	$554	$180

- Average Premium Paid by Those Receiving APTC

	Average Premium after APTC
PY 2021	$130
PY 2022	$120

More than 4/5 of Arizonans

Affordability

Most Arizonans qualify for financial assistance

- **83.9%** of enrollees received Advanced Premium Tax Credits (APTC) and/or Cost Sharing Reductions (CSRs)
- Average premium for enrollees receiving APTC was **$120**
- **15.6%** of enrollees in Arizona paid less than $10 for premiums per month

- **Over one-third of re-enrollments were automatic in OE9, and those consumers may have missed out on additional savings**


CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Disclaimer

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Welcome to OE10

- Primer on the Health Insurance Marketplace
- Marketplace Updates
  - Inflation Reduction Act/ American Rescue Plan Impacts
  - Standardized Plan Options
  - Open Enrollment Notices
  - Continued Pause of Failure to File and Reconcile
  - Special Enrollment Periods
  - Family Glitch
- Notable Events Impacting 2023
  - No Surprises Act
  - Public Health Emergency Unwinding
  - Future Learning Opportunities

Understanding Metal Levels

60% 70% 80% 90%

Average Percentage the Insurance Company Pays

Saving on your Monthly Insurance Bill

Premium Tax Credits

- When you apply for coverage in the Health Insurance Marketplace, you'll find out if you qualify for a "premium tax credit" that lowers your premium — the amount you pay each month to your insurance plan.
- The amount of your premium tax credit depends on the estimated household income for 2023 that you put on your Marketplace application.
- You can apply some or all of this tax credit to your monthly insurance premium payment. The Marketplace will send your tax credit directly to your insurance company, so you'll pay less each month. This is called taking an "advance payment of the premium tax credit," or APTC.

Saving on your Monthly Insurance Bill

Cost-Sharing Reductions

If you qualify for savings on out-of-pocket costs and enroll in a Silver plan:

- **You'll have a lower deductible**. This means the insurance plan starts to pay its share of your medical costs sooner. For example, if a particular Silver plan has a $750 deductible, you have to pay the first $750 of medical care yourself before the insurance company pays anything (other than for free preventive services). But if you qualify for cost-sharing reductions (CSR), your deductible for a Silver plan could be $300 or $500, depending on your income.
- **You'll have lower copayments or coinsurance**. These are the payments you make each time you get care — like $30 for a doctor visit. For example: If a Silver plan's copayment is $30 for a doctor's visit, if you enroll in the plan and qualify for extra savings, you may pay $20 or $15 instead.
- **You'll have a lower "out-of-pocket maximum."** This means the total amount you'd have to pay in a year if you used a lot of care, like if you got seriously sick or had an accident, would be lower. For example: Instead of $5,000 for a given plan, your out-of-pocket maximum for a particular Silver plan could be $3,000 due to your CSR.

More info: https://www.healthcare.gov/lower-costs/save-on-out-of-pocket-costs/

Reminder: Silver vs. Bronze Plans

- While assisting consumers during Open Enrollment, it is important to help them consider **total health care costs** and **not just the monthly premium** for the plans they are exploring.
- Bronze Plans:
  - These plans can have low monthly premiums, but very high deductibles and pay less of a consumer's costs when they need care.
- Silver Plans:
  - If a consumer qualifies for CSRs, assisters should explain the benefits of enrolling in a Silver plan. If the consumer qualifies for and enrolls in a Silver plan with CSRs, their **deductible will be lower** and **they'll pay less each time they receive care**.
  - Consumers with incomes between 100-200% of the FPL may be eligible for high-CSR variant Silver plans, which may offer the lowest overall costs for them even if Bronze plans offer lower or $0 premiums after APTC.
- If a consumer does not qualify for CSRs and expects a lot of doctor visits or needs regular prescriptions, a Gold or Platinum plan may be a good option for them. Use the See Plans and Prices tool (https://www.healthcare.gov/see-plans/#/) to compare plans and prices.
  - For more information, visit https://www.healthcare.gov/choose-a-plan/plans-categories/

Source: Plan Year 2023 Marketplace Policy & Operations Updates (October 6, 2022) Plan Year 2023 Marketplace Policy Operations & Updates

Reduction in Annual Maximum Limitation on Cost Sharing for PY 2023

» The Marketplace calculates CSRs for each consumer whom it determines is eligible for income-based CSRs.

Eligibility Category	Reduced Maximum Annual Limitation on Cost Sharing for Self-only Coverage for PY 2023	Reduced Maximum Annual Limitation on Cost Sharing for Other than Self-only Coverage for PY 2023
Individuals eligible for CSRs under § 155.305(g)(2)(i) (household income greater than or equal to 100 and less than or equal to 150 percent of FPL)	$3,000	$6,000
Individuals eligible for CSRs under § 155.305(g)(2)(ii) (household income greater than 150 and less than or equal to 200 percent of FPL)	$3,000	$6,000
Individuals eligible for CSRs under § 155.305(g)(2)(iii) (household income greater than 200 and less than or equal to 250 percent of FPL)	$7,250	$14,500

Source: Plan Year 2023 Marketplace Policy & Operations Updates (October 6, 2022) Plan Year 2023 Marketplace Policy Operations & Updates

From Coverage to Care

- C2C Home Page: go.cms.gov/c2c
- Customer resources are available free of charge 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

Marketplace Updates

- Inflation Reduction Act/ American Rescue Plan Impacts
- Standardized Plan Options
- Marketplace Open Enrollment & Annual Redetermination Notices (MOEN)
- Continued Pause on File & Failure to Reconcile
- Special Enrollment Periods
- Family Glitch

American Rescue Plan (ARP) & Inflation Reduction Act (IRA)

- During Plan Years 2021 & 2022, **the ARP expanded eligibility for APTC to include consumers with an annual household income greater than 400% of the Federal Poverty Level (FPL)**. This change allowed more consumers to enroll in affordable health insurance coverage.
- **The IRA includes a three-year extension of the expanded APTC provisions of the ARP so that consumers have access to expanded APTC until January 1, 2026**. These provisions will ensure greater consumer access to expanded cost savings and affordable health insurance coverage.
- **The IRA also extends the 150% FPL Special Enrollment Period**, ensuring that consumers below 150% of the FPL have increased access to health insurance and plan flexibility.

Source: Plan Year 2023 Marketplace Policy & Operations Updates (October 6, 2022) Plan Year 2023 Marketplace Policy Operations & Updates

2023 Payment Notice

Advancing Standardized Plan Options

» In accordance with the Administration's Executive Order 14036 on Promoting Competition in the American Economy, the rule helps simplify the consumer shopping experience by establishing standardized plan options for issuers offering qualified health plans (QHPs) on HealthCare.gov.

Implementing New Network Adequacy Requirements

» The rule requires QHPs on the FFM to ensure that certain classes of providers are available within required time and distance parameters.

Increasing Value of Coverage for Consumers

» Under the rule, CMS is updating the allowable range in metal coverage levels for non-grandfathered individual and small group market plans. This change will likely require some plans to increase the generosity of their coverage, making it more comprehensive and lowering costs for many consumers.

For more information, view the full Executive Order and press release:

https://www.federalregister.gov/documents/2021/07/14/2021-15069/promoting-competition-in-the-american-economy

https://www.cms.gov/newsroom/press-releases/hhs-announces-new-policy-make-coverage-more-accessible-and-affordable-millions-americans-2023

Source: Plan Year 2023 Marketplace Policy & Operations Updates (October 6, 2022) Plan Year 2023 Marketplace Policy Operations & Updates

Standardized Plan Offerings

- The 2023 Notice of Benefits and Payment Parameters Final Rule helps simplify the consumer shopping experience by establishing standardized plan options for issuers offering Qualified Health Plans (QHPs) on HealthCare.gov.
- With **standardized maximum out-of-pocket limitations, deductibles, and cost-sharing features**, consumers will be able to more directly compare other important plan attributes, such as premiums, provider networks, prescription drug coverage, and quality ratings when choosing a plan.
- These standardized plan options expand the availability of coverage for services before consumers meet their deductibles, which will make it easier to access important services. They also include **simpler cost-sharing structures** that will allow consumers to more easily understand their coverage.
- Issuers offering QHPs on HealthCare.gov will be required to offer standardized plan options at every network type, at every metal level (Bronze, Silver, Gold, and Platinum), and throughout every service area where non-standardized options are offered starting in 2023. **These plans will be differentially displayed on HealthCare.gov to help consumers make more informed choices about their coverage.**
- Learn more: https://www.cms.gov/newsroom/press-releases/hhs-announces-new-policy-make-coverage-more-accessible-and-affordable-millions-americans-2023

Source: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, https://www.federalregister.gov/documents/2022/05/06/2022-09438/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023

2023 Payment Notice (Continued)

Expanding Access to Essential Community Providers

» Under the rule, for PY 2023 and beyond, CMS is increasing the Essential Community Provider (ECP) threshold from 20% to 35% of available ECPs in each plan's service area to participate in the plan's provider network.

Further Streamlining HealthCare.gov Operations

» The rule sets the FFM and SBM-FP user fees for 2023 at the same level as 2022.

Increasing Access for Consumers and Removing Barriers to Coverage

» The rule aims to protect consumers from discriminatory practices related to the coverage of the essential health benefits (EHB) by expanding the CMS nondiscrimination policy. CMS currently is working to finalize a proposed rule under which CMS proposes to explicitly identify and recognize discrimination on the basis of sexual orientation and gender identity as prohibited forms of discrimination based on sex.

For more information, view the press release: https://www.cms.gov/newsroom/press-releases/hhs-announces-new-policy-make-coverage-more-accessible-and-affordable-millions-americans-2023

Source: Plan Year 2023 Marketplace Policy & Operations Updates (October 6, 2022) Plan Year 2023 Marketplace Policy Operations & Updates

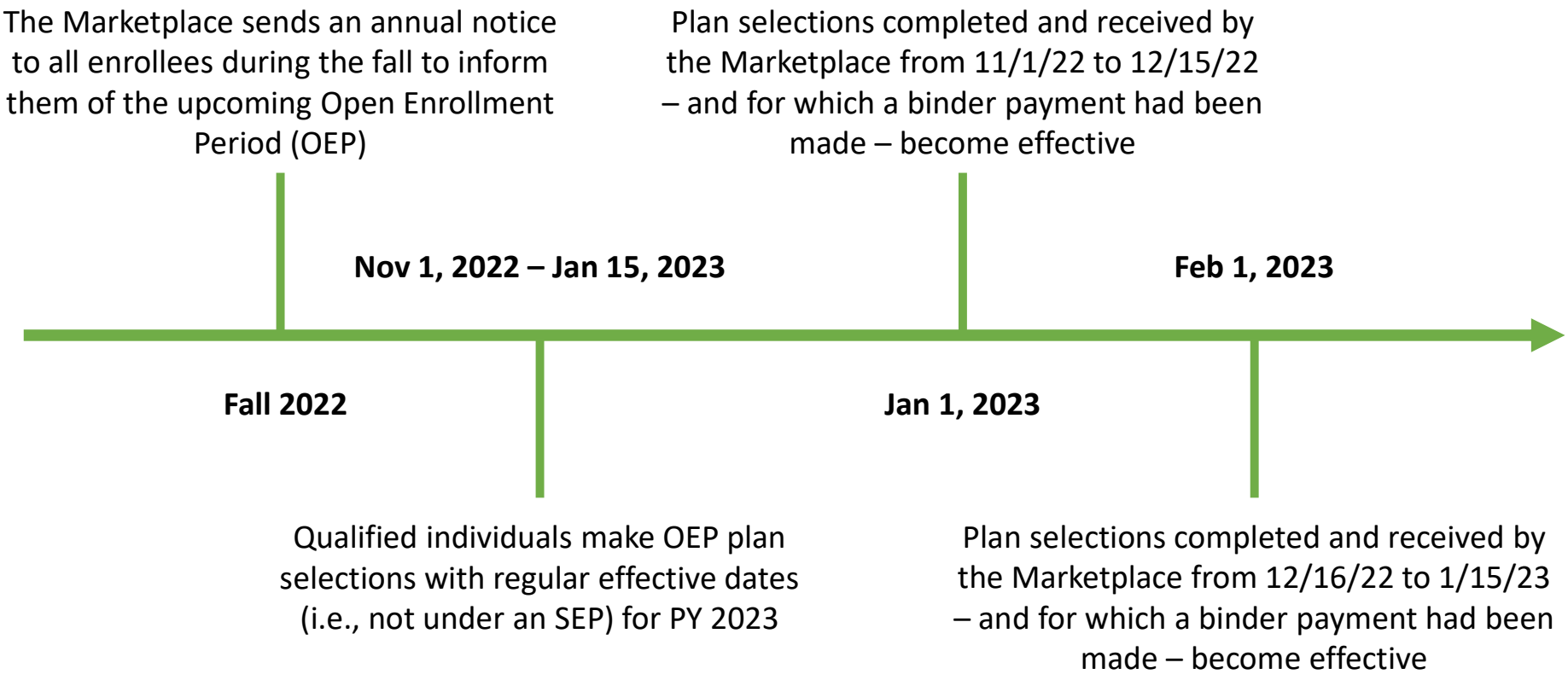
2023 Payment Notice (Continued)

Key Points for Assisters

- CMS will differentially display standardized options on HealthCare.gov and will resume enforcement of the existing standardized plan option differential display requirements for web-brokers and QHP issuers utilizing a Classic DE or EDE pathway.
- CMS finalized changes to require web-broker websites to display a prominent and clear explanation of the rationale for explicit QHP recommendations and the methodology for default display of QHPs on their websites.
- CMS finalized changes that will prohibit QHP advertising, or otherwise providing favored or "preferred placement," in the display of QHPs, on web-broker websites based on compensation an agent, broker, or web-broker receives from QHP issuers.
- CMS codified standards of conduct that provide additional details regarding the requirement that agents, brokers, and web-brokers provide information to FFEs and SBE-FPs that a consumer has attested to as being correct. More specifically, CMS codified standards of conduct capturing specific examples of what it means to provide correct information to the FFEs and SBE-FPs for the consumer's email address, mailing address, telephone number, and household income projection.

Source: Plan Year 2023 Marketplace Policy & Operations Updates (October 6, 2022) Plan Year 2023 Marketplace Policy Operations & Updates

Timeline for Plan Year 2023



Source: Preparing for Plan Year 2023 Open Enrollment (September 22, 2022) https://regtap.cms.gov/uploads/library/AB-Slides-Preparing-092222-5CR-092222.pdf

Marketplace Open Enrollment & Annual Redetermination Notices

Health Insurance Marketplace

DEPARTMENT OF HEALTH & HUMAN SERVICES
465 INDUSTRIAL BOULEVARD
LONDON, KENTUCKY 40750-0001

William Johnson
1201 N East Ave
Wilmington, DE 19805

Sep 09, 2022

2022 Application ID: ########

Open Enrollment starts November 1:
Confirm your coverage & financial help for 2023

Review your Health Insurance Marketplace® coverage and costs for next year. The following people are currently enrolled in coverage with financial help through the Marketplace:

- William Johnson

The Marketplace Open Enrollment Period is November 1, 2022 – January 15, 2023. During this time, you can shop for new Marketplace coverage or choose to stay in the same type of plan, if it's still right for you. You're currently getting financial help with the cost of health coverage each month. It's important to update your household income and other information to make sure you're getting the right amount of help.

Update your Marketplace application for 2023 coverage. You must enroll by December 15, 2022 for your plan's coverage to start on January 1, 2023. Visit HealthCare.gov to update your Marketplace application during Open Enrollment. If you don't update your Marketplace application with your current household income and other information by December 15, 2022, we'll review your eligibility for coverage and financial help in 2023 based on information from the most recent income data sources we have for your household. Even if your situation hasn't changed, we might not have all of your up-to-date information. **This could mean**

Source: Marketplace Open Enrollment and Annual Redetermination Notices (September 2022) https://marketplace.cms.gov/applications-and-forms/notices

Updated Eligibility Notices

Every consumer applying for Marketplace coverage must download their Eligibility Notice before choosing a plan.

Consumers who choose “print preference” also get an Eligibility Notice in the mail.

The Eligibility Notice lets consumers know:

- Their eligibility for Marketplace health plans, advance payments of the premium tax credit (APTC), cost-sharing reductions (CSRs), Special Enrollment Periods (SEPs), and Medicaid/CHIP.
- Deadlines to enroll and submit documents and coverage effective dates.
- If they have a data matching issue (DMI) or an SEP verification issue (SVI) requiring them to provide additional documentation to confirm information on their application.
- Information about their right to appeal.

Consumers also get an Eligibility Notice anytime the Marketplace re-processes their application during the year (e.g., after a DMI expires) or during annual redeterminations/re-enrollment for the next coverage year

Source: Redesigned Marketplace Eligibility Notice (March 16, 2022) https://marketplace.cms.gov/technical-assistance-resources/redesigned-marketplace-eligibility-notice-training.pdf

Key Improvements to the Redesigned Eligibility Notice

- Puts focus on info that's most important to consumers: what they're eligible for and what to do next.
- Uses clear, person-centered design that delivers results, deadlines, and calls to action on a single page.
- Removes the need for consumers to self-select whether information applies to them.
- Introduces a clear distinction between household-level and person-level messages.
- Eliminates significant language redundancy in the current notice.
- Creates a comprehensive "Eligibility Guide" that allows for more comprehensive program and operational detail than the current notice.

Source: Redesigned Marketplace Eligibility Notice (March 16, 2022) https://marketplace.cms.gov/technical-assistance-resources/redesigned-marketplace-eligibility-notice-training.pdf

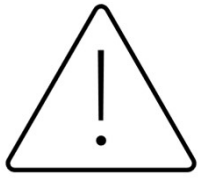
Race and Ethnicity Questions in the Marketplace Application

- CMS routinely analyzes data on who is signing up for coverage and how Marketplace applicants move through the online workflows in order to measure Marketplace effectiveness. One of the barriers to making informed decisions is that consumers, or individuals filling out applications on consumers' behalf, often do not provide attestations to the optional race and ethnicity questions in the FFM application. In the Marketplace, non-reporters of race and ethnicity data are disproportionately Black and Latino, leading to an undercount of these populations.
- We encourage all agents and brokers to take the time to ask consumers to respond to these questions. This information will **help CMS reduce health disparities, prevent discrimination, promote equity for all communities and FFM consumers**, and better follow its mission to improve health care coverage. CMS asks this question in order to ensure outreach is reaching all communities and that the application process does not create barriers for individuals or groups.
- CMS will use this data to identify possible application, enrollment, or coverage barriers and disparities for all communities seeking coverage through the FFM. In addition, the question about language preference will help CMS assess language needs of the populations being served and help CMS and insurers have language services ready.
- For more information, view this video on race and ethnicity questions in the Marketplace application and this tip sheet on addressing consumer concerns about these questions.

Sources:: Plan Year 2023 Marketplace Policy & Operations Updates (October 6, 2022) Plan Year 2023 Marketplace Policy Operations & Updates
Tips for Addressing Consumer Concerns about the Marketplace Application Race and Ethnicity Questions: https://www.cms.gov/files/document/addressing-consumer-concerns-about-marketplace-application-race-and-ethnicity-questions.pdf

Failure to File and Reconcile Operations Flexibilities for PY 2023

- For PY 2023, CMS will continue to not act on data from the Internal Revenue Service (IRS) indicating that a consumer failed to file a tax return and reconcile a previous year's APTC with the PTC allowed for the year.
  - In PYs 2021 and 2022, CMS did not act on such data from the IRS due to the impact of the COVID-19 PHE.
  - This does not change the general requirement for taxpayers for whom APTC was paid in 2021 to file their taxes and reconcile the APTC with the PTC allowed for the year.
- For more information, please refer to last year's Failure to File and Reconcile (FTR) Operations Flexibility for PYs 2021 and 2022 – Frequently Asked Questions.



Sources:: Plan Year 2023 Marketplace Policy & Operations Updates (October 6, 2022) Plan Year 2023 Marketplace Policy Operations & Updates
Failure to File and Reconcile (FTR) Operations Flexibilities for Plan Years 2021 and 2022 – Frequently Asked Questions (FAQ) , https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/FTR-flexibilities-2021-and-2022.pdf

Pre-enrollment Special Enrollment Period Verification Process

- CMS has finalized a policy change that scales back the Special Enrollment Period pre-enrollment verification (SEPV) process. Under these new guidelines, pre-enrollment verification is only required for consumers who qualify for the loss of qualifying health coverage Special Enrollment Period (SEP).
- New applicants (i.e., those who are not already enrolled in Marketplace coverage)* who are eligible for this SEP generally must submit documents that confirm their SEP eligibility before the Marketplace finalizes their plan selection, before they make their first premium payment, and before they start using their Marketplace coverage. If the consumer lost qualifying health coverage (or "minimum essential coverage"), the consumer may report a loss of qualifying health coverage up to 60 days before or after the loss of coverage.

*Existing Marketplace enrollees who attest to SEP qualifying events are not subject to SEPV

Sources:: Plan Year 2023 Marketplace Policy & Operations Updates (October 6, 2022) Plan Year 2023 Marketplace Policy Operations & Updates

SEP Effective Coverage Dates

- Due to a new regulatory change beginning in 2022 in Marketplaces using the federal platform, the following SEPs will all have an effective coverage date of the first day of the month following plan selection (or the first day of the month following the triggering event if it is a future event) regardless of what day of the month plan selection occurs:
  - Past loss of qualifying health coverage (up to 60 days in the past)
  - Future loss of qualifying health coverage (up to 60 days in the future)
  - Change in primary place of living
  - Change in eligibility for Marketplace coverage or help paying for coverage

Sources:: Plan Year 2023 Marketplace Policy & Operations Updates (October 6, 2022) Plan Year 2023 Marketplace Policy Operations & Updates

SEP Effective Coverage Dates (Continued)

- The change in household size SEP may follow standard effective date guidelines or retroactive effective date guidelines. If the enrollee is gaining a dependent through marriage, the SEP will have an effective coverage date of the first day of the month following plan selection regardless of what day of the month plan selection occurs.
- If the enrollee is gaining or becoming a dependent due to birth, adoption, placement for adoption or foster care, or child support or other court order, the SEP will have a **retroactive effective date**.
  - A retroactive effective date means the coverage effective date will be retroactive to the day the child was born, adopted, or placed for adoption or foster care, or date that the court order took effect.
  - Consumers may call the Marketplace Call Center to request that coverage start on the first of the month following plan selection.

Sources:: Plan Year 2023 Marketplace Policy & Operations Updates (October 6, 2022) Plan Year 2023 Marketplace Policy Operations & Updates

The “Family Glitch” and IRS Final Rule for Affordability of Employer Sponsored Coverage for Family Members of Employees

- What is the “family glitch”?
  - The current affordability calculation for offers of employer sponsored coverage (ESC) only accounts for a consumer's self-only premium, as opposed to the family premium, even if the coverage is offered to more than one person.
  - Because of this, an offer of ESC may be considered affordable for an employee and their dependents even if the cost of covering everyone offered coverage would exceed the affordability threshold. This is called the “family glitch.”
- IRS ~~Proposed~~ Final Rule
  - The IRS released a proposed rule that would amend existing regulations regarding eligibility for PTCs and update the calculation used to assess the affordability of an offer of ESC so that the cost of the **family premium** is used to determine whether an employee’s household members have an offer of affordable ESC, rather than the cost of the individual premium.
  - See the final rule, released October 13

Sources:: Plan Year 2023 Marketplace Policy & Operations Updates (October 6, 2022) Plan Year 2023 Marketplace Policy Operations & Updates
Helping Consumers Resolve Data Matching Issues (DMIs), https://www.cms.gov/files/document/helping-consumers-resolve-data-matching-issues.pdf

Notable Events Impacting 2023

No Surprises Act

Unwinding the Public Health Emergency

Future Learning Opportunities

No Surprises Act

- The No Surprises Act and implementing regulations provide important new protections for health care consumers, including:
  - Prohibiting surprise medical bills in certain situations.
  - Taking consumers out of the dispute process between plans/issuers and out-of-network providers/facilities for covered services furnished by out-of-network providers.
  - Requiring good faith estimates of expected charges and providing a process for uninsured and self-pay consumers to dispute charges that are significantly higher than the estimate.
  - Expanding rights to the external review process.
  - Requiring certain information be included on insurance ID cards.
  - Requiring provider directories be kept up to date and providing help to consumers who rely on incorrect information.
- Consumers can get help from the No Surprises Help Desk:
  - 1-800-985-3059, 8 a.m. to 8 p.m. EST, seven days a week.
  - No Surprises Complaint Form: CMS.gov/nosurprises/consumers/complaints-about-medical-billing.

Sources:: Plan Year 2023 Marketplace Policy & Operations Updates (October 6, 2022) Plan Year 2023 Marketplace Policy Operations & Updates

Consumers in Need of Marketplace Coverage When Public Health Emergency Ends

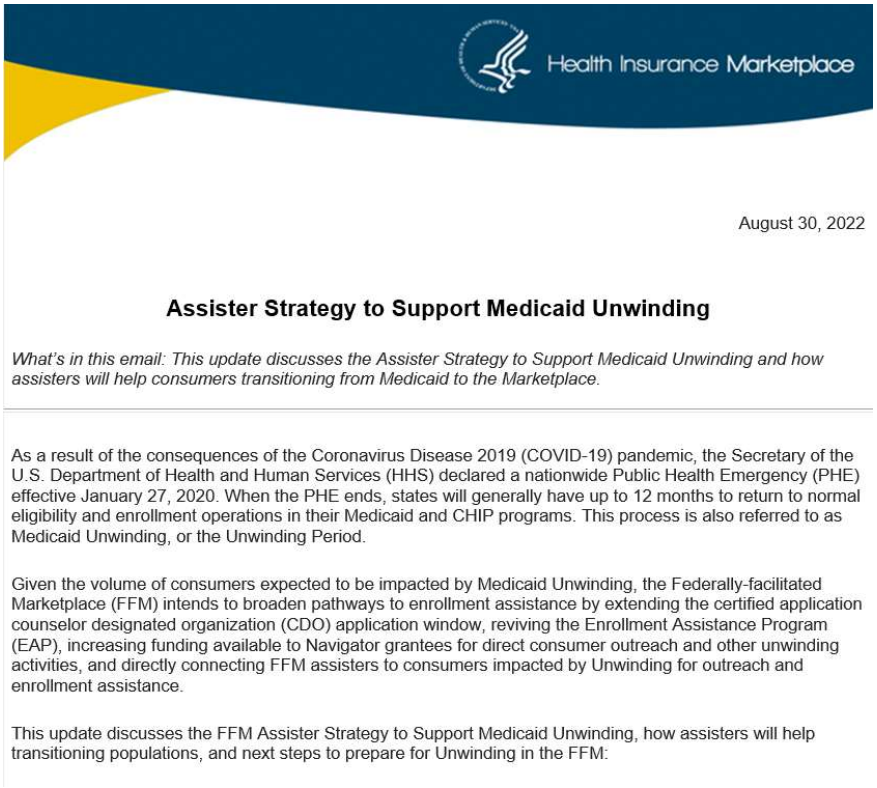
- In March 2020, CMS temporarily waived certain Medicaid and Children's Health Insurance Program (CHIP) requirements and conditions as part of the response to the COVID-19 Public Health Emergency (PHE). The easing of these rules helped prevent people with Medicaid and CHIP—in all 50 states, the District of Columbia, and the five U.S. territories—from losing their health coverage during the pandemic. **However, state Medicaid agencies will soon be required to restart Medicaid and CHIP eligibility reviews.**

- In an effort to minimize the number of people who will lose Medicaid or CHIP coverage when the PHE ends, CMS is working with states and other stakeholders to inform people about renewing their coverage and exploring other available health insurance options, such as Marketplace coverage, if they no longer qualify for Medicaid or CHIP.

- CMS plans to share additional information and resources with agents and brokers in the coming months so they can prepare to assist consumers in need of assistance with Marketplace coverage if they are no longer eligible for Medicaid.

Sources:: Plan Year 2023 Marketplace Policy & Operations Updates (October 6, 2022) Plan Year 2023 Marketplace Policy Operations & Updates
Welcome to the Marketplace: A Guide for New Agents and Brokers, https://regtap.cms.gov/uploads/library/AB-Slides-NewABs-5CR-090822.pdf

Public Health Emergency Unwinding



Health Insurance Marketplace

August 30, 2022

Assister Strategy to Support Medicaid Unwinding

What's in this email: This update discusses the Assister Strategy to Support Medicaid Unwinding and how assisters will help consumers transitioning from Medicaid to the Marketplace.

As a result of the consequences of the Coronavirus Disease 2019 (COVID-19) pandemic, the Secretary of the U.S. Department of Health and Human Services (HHS) declared a nationwide Public Health Emergency (PHE) effective January 27, 2020. When the PHE ends, states will generally have up to 12 months to return to normal eligibility and enrollment operations in their Medicaid and CHIP programs. This process is also referred to as Medicaid Unwinding, or the Unwinding Period.

Given the volume of consumers expected to be impacted by Medicaid Unwinding, the Federally-facilitated Marketplace (FFM) intends to broaden pathways to enrollment assistance by extending the certified application counselor designated organization (CDO) application window, reviving the Enrollment Assistance Program (EAP), increasing funding available to Navigator grantees for direct consumer outreach and other unwinding activities, and directly connecting FFM assisters to consumers impacted by Unwinding for outreach and enrollment assistance.

This update discusses the FFM Assister Strategy to Support Medicaid Unwinding, how assisters will help transitioning populations, and next steps to prepare for Unwinding in the FFM:

https://marketplace.cms.gov/

Source: Renew Your Medicaid or CHIP Coverage https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/renew-your-medicaid-or-chip-coverage/index.html

Public Health Emergency Unwinding

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Renew Your Medicaid or CHIP Coverage

As COVID-19 becomes less of a threat, states will restart yearly Medicaid and Children's Health Insurance Program (CHIP) eligibility reviews. This means your state will use the information they have to decide if you or your family member(s) still qualify for Medicaid or CHIP coverage. If your state needs more information from you to make a coverage decision, they'll send you a renewal letter in the mail. Most children can still be covered through the Children's Health Insurance Program. For details, check your Medicaid notice or contact your state Medicaid office at the links below.

Get ready to renew now

Here are some things you can do to prepare for the renewal process:

1. **Update your contact information -** Make sure your state has your current mailing address, phone number, email, or other contact information. This way, they'll be able to contact you about your Medicaid or CHIP coverage.
2. **Check your mail -** Your state will mail you a letter about your coverage. This letter will let you know if you need to complete a renewal form to see if you still qualify for Medicaid or CHIP.
3. **Complete your renewal form (if you get one) -** Fill out the form and return it to your state right away to help avoid a gap in your coverage.

If you no longer qualify for Medicaid or CHIP

You may be able to buy a health plan through the Health Insurance Marketplace®, and get help paying for it. Marketplace plans are:

- 4 out of 5 enrollees can find plans that cost less than $10 a month.
- Plans cover things like prescription drugs, doctor visits, urgent care, hospital visits, and more.

https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/renew-your-medicaid-or-chip-coverage/index.html

Future Learning Opportunities

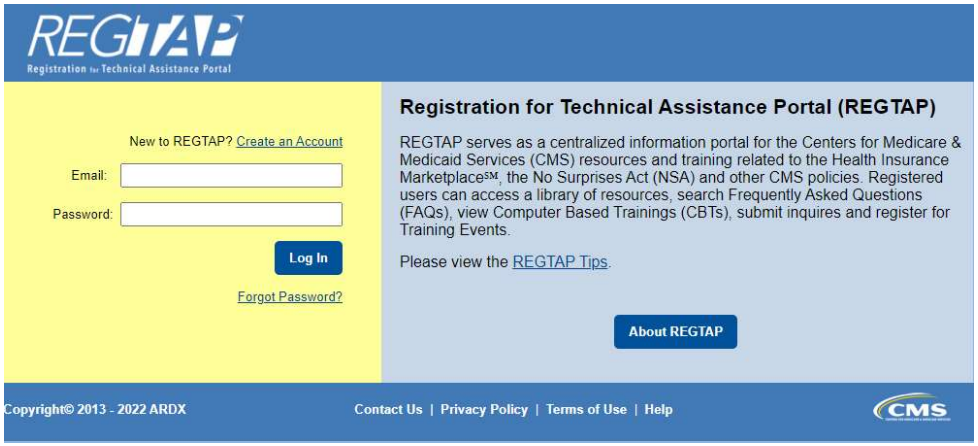
2023 Open Enrollment Webinars for Champions for Coverage, Navigators, CACs, Assisters, Agents & Brokers, Partners, and other Stakeholders

1st Webinar: Thursday, October 20, 2022, 10:00 AM – 11:00 AM AZT

Future webinars will take place on November 2, December 13, January 10, and January 24.

Please send all questions to PARTNERSHIP@cms.hhs.gov

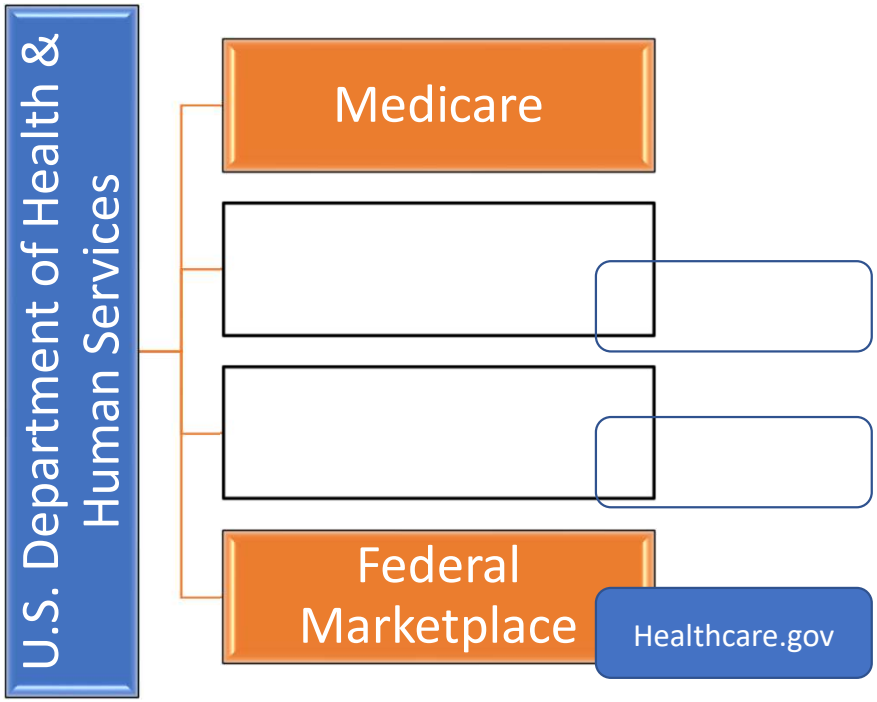
More resources on REGTAP.info




CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

How can we engage consumers?

Engaging on Medicare and the Marketplace



How Do the Programs Interact?

Medicare and The Marketplace

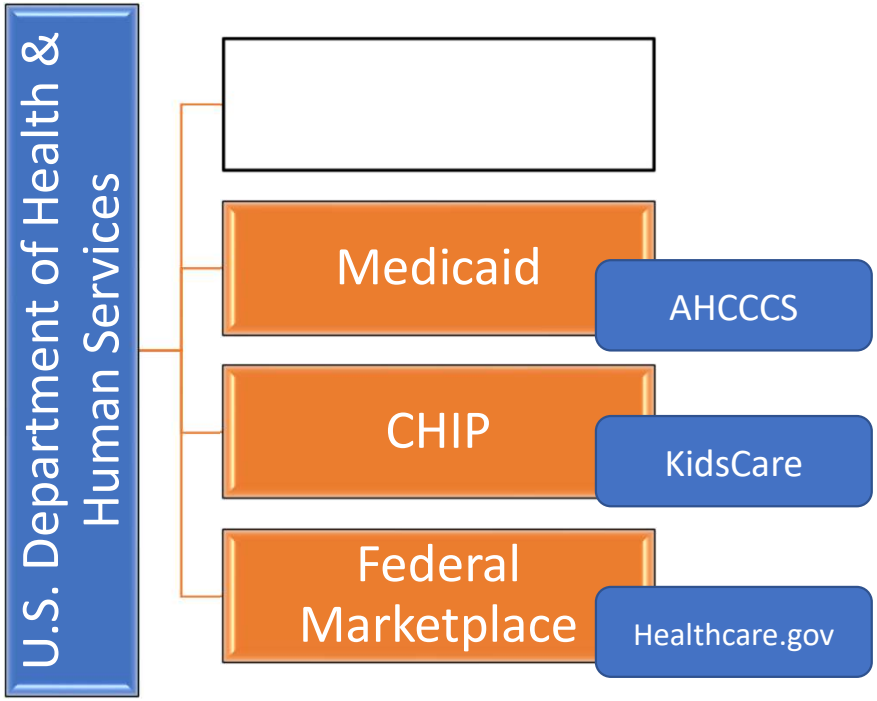
- **TAKE-HOME: If a consumer is Medicare-eligible, don't take financial assistance. If they're about to be Medicare-eligible, connect them to a SHIP.**

- Generally, there's no coordination of benefits between Marketplace Qualified Health Plans (QHPs) and Medicare

- QHPs aren't secondary insurance to Medicare

- Consumers are not eligible to receive advance payments of the premium tax credit (APTC) or cost-sharing reductions (CSRs) if enrolled in both MEC Medicaid or SCHIP and an Exchange QHP
  - Consumers may be inadvertently paying for duplicate coverage if they are enrolled in both programs.

Engaging on AHCCCS and KidsCare



A Lot Of Arizonans May Lose Coverage Soon

Public Health Emergency (PHE) Unwinding, Redetermination, Medicaid Pause

	February 2020	September 2022	Difference
AHCCCS	1,606,523	2,119,931	**513,408**
KidsCare	35,749	66,400	**30,651**

	July 2012	July 2017	Difference
AHCCCS	1,212,693	1,671,275	**458,582**
KidsCare	15,330	21,626	**6,296**

Engaging on AHCCCS and KidsCare

Public Health Emergency (PHE) Unwinding, Redetermination, Medicaid Pause

- **TAKE-HOME: The most important thing consumers can do is update their contact information so they can be notified to take action when it is necessary. If they are not eligible, that is where you come in.**

- A consumer will not be moved directly from AHCCCS or KidsCare into a Marketplace plan. They will need to take action and apply during their Special Enrollment Period.

- Notifications will go out from AHCCCS when the consumer is up for redetermination some time during the 12 months following the end of the PHE.

- If a consumer is applying for AHCCCS/KidsCare right now and deemed eligible, they should be fine until they go to apply again next year.

Engaging on AHCCCS and KidsCare

Public Charge Final Rule

- **Public Charge Final Rule effective December 23, 2022**

- On September 8, 2022, the U.S. Department of Homeland Security (DHS) issued a final rule applicable to noncitizens who receive or wish to apply for benefits provided by the U.S. Department of Health and Human Services (HHS) and States that support low-income families and adults.
- The rule, which details how DHS will interpret the "public charge" ground of inadmissibility, will help ensure that noncitizens can access health-related benefits and other supplemental government services to which they are entitled by law, without triggering harmful immigration consequences.
- The final rule applies to noncitizens requesting admission to the U.S. or applying for lawful permanent residence (a "green card") from within the U.S.
- When assessing whether a noncitizen is "likely to become primarily dependent on the government for subsistence," DHS will not penalize individuals who choose to access the vast majority of health-related benefits and other supplemental government services available to them, including most Medicaid benefits (except for long-term institutionalization – such as residing in nursing home – at government expense) and the Children's Health Insurance Program (CHIP).
- The final rule does not expand eligibility for Medicaid, CHIP, or other benefits to more people but clarifies DHS policy regarding recipients.

Where might we engage consumers?

Putting the “Messenger” in “Trusted Messenger”

- **TAKE-HOME: Bring the information to the community clearly, early and often**

- Use basic language as much as possible
- Remove as many of the barriers to entry throughout the process
- Leave with a call to action
- Organizing versus Mobilizing: *are you building assets and leadership in the community, or just trying to build numbers?*

Some Community Hubs Are Classic

- **TAKE-HOME: Think about where is there a captive audience that may already be thinking of their health**

- Schools
- Health centers
- Pharmacies
- Farmers Markets/Grocery Stores
- County Offices

Some Community Hubs Are New and Novel

- **TAKE-HOME: Think about where is there a captive audience that may already be thinking of their health**

- COVID-19 Vaccine Sites
- (Early) Polling Locations
  - Locations can be found on your county's website
  - Many counties have an interactive map to help visualize locations

While you are thinking of us…

Request for Information
Make Your Voice Heard

Seeking Public Comment by November 4, 2022

CMS is committed to engaging with partners, communities, and individuals across the health system to understand their experiences with CMS payment policies and quality programs, particularly how existing and proposed CMS payment policies and quality programs impact the experience of healthcare.

Through this RFI, CMS is seeking public input on accessing healthcare and related challenges, understanding provider experiences, advancing health equity, and assessing the impact of waivers and flexibilities provided in response to the COVID-19 Public Health Emergency (PHE).

Make Your Voice Heard: https://www.cms.gov/request-information-make-your-voice-heard

Other Ways to Keep Your Community Healthy

- **Updated COVID-19 Vaccines** are available and free for everyone 5 years old and up
  - Visit WeCanDoThis.hhs.gov for resources from the Public Education Campaign
  - Find local vaccines in your area by type
    - Visiting Vaccines.gov
    - Text your zip code to 438829
    - Call 1-800-232-0233 toll-free
- **Flu season is here**, so get a free flu vaccine as well
- If someone qualifies for AHCCCS or another government program, they can **get reduced-cost or free internet** at WhiteHouse.gov/GetInternet

Contact Us

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