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Contents

Welcome 1

Tax Updates 2

Payment Notice Overview 3

Q&A..... 6

Avoiding Gaps in Coverage Complex Case Series 7

 Q&A..... 11

Conclusion..... 13

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Welcome

Good afternoon everyone. Welcome to today's assister webinar. My name is Melissa MacLean and I'm with the CMS Consumer Support Group. Before we begin today's presentation I want to go over some technical details. All lines have been muted so that everyone can have a good learning experience. If you are listening through your computer speakers and have any audio issues, or if your slides do not appear to be advancing, please try to refresh the webinar. The refresh icon that looks like two arrows near the volume bar. If you continue to have issues, try logging out and logging back in again. You're also always welcome to join us via telephone. Instructions for that are included in the alternate audio tab. If you would like to ask questions during the presentation please type them into the ask a question tab on your screen. Now I will turn our webinar over to Mrs. Deborah Bryant. Deborah, please go ahead.

Thank you so much Melissa, and good afternoon everyone. Thank you for joining today's call. My name is Deborah Bryant and I'm the Director of the Division of Consumer Advocacy and Assister Support for the Marketplace. I just want to remind everyone that today's call is intended as technical assistance and it is not intended for press purposes and is not on the record. If you are a member of the press please feel free to reach out to our press office at press@cms.hhs.gov. Please also note that the information

today is intended for informal technical assistance for assisters and is not intended as official CMS guidance.

Tax Updates

Now we know we have just a few more weeks before the tax filing deadline and I want to thank all the assisters out there for all the work you have done in helping consumers understand their 1095A's. For today's webinar we have more updates and reminders about tax season and we are joined by someone who will provide that update. We will also go over some new provisions in the recently released final 2017 Notice of Benefit and Payment Parameters rule that was released by CMS. Lastly will have a complex case scenario on avoiding gaps in coverage for consumers who are transitioning from a Marketplace plan to other types of health coverage. Again I want to thank you for all the work you have been doing in this post enrollment season and I encourage you to keep reaching out to consumers and reminding them about the April 18 tax deadline. I will turn it over to Annie Acs from our Marketplace Eligibility and Enrollment Group, who will provide us with some tax updates. Annie?

Thanks, Deborah. Good afternoon everyone. We are only a few weeks away from the tax filing deadline and we wanted to remind folks of a few helpful tax tips. By now, all Marketplace consumers should have received a statement in the mail from the Marketplace. It's called a form 1095-A. These statements include important information you need to complete and file a tax return. It's extremely important that those who received advance payments of premium tax credit reconcile these payments when they file their tax return using this form. Individuals who do not do so will generally see their refunds delayed and will not be eligible to receive advance payments of the premium tax credit in the future years.

Individuals with Marketplace or other types of health coverage may also have received additional forms called a form 1095-B or 1095-C from their employer, insurance company or a government program that provides their coverage like Medicare or Medicaid. Taxpayers do not need to attach this information to their return or wait to receive the form before filing their federal taxes but should keep it in a safe place with other tax records. When completing their form 8962 to file their taxes, consumers who transition from Marketplace coverage to Medicaid or CHIP may mistakenly think that they are not eligible for PTC during this transitional period and therefore are responsible for repaying APTC paid during the transitional period. Let consumers in this situation know that they may be eligible for the PTC and so may not be required to repay APTC during their Medicaid transition period. If the consumer has a form 1095-A and form 1095-B [indistinguishable] overlapping coverage years, consumers should use information on the form 1095-A and disregard the information on 1095-B for the month and complete their form 8962 for the overlapping coverage. Lastly just as a reminder, if consumers feel that they have a missing form 1095-A or their 1095-A contains incorrect information they should call the Marketplace call center to request an update to their form or to receive a copy of their form. Most consumers that have requested a correction have received an updated form or will receive it soon. However consumers who request a correction now may not receive an updated form in time for the April 18 filing deadline. These consumers should contact their tax preparer or visit [IRS.gov](https://www.irs.gov) to find out what to do next - which could include requesting an extension to file. However, please be aware that an extension to file your tax return does not give you more time to pay any taxes that may be due. Thank you.

Thank you so much, Annie. Right now I don't see any questions in the box about the tax season updates so we will follow up with Annie as any others come through. Stay tuned for the newsletter out on Wednesday that will have more important tips and reminders.

Payment Notice Overview

Next I'm going to turn it over to Emily Ames who will be providing an update on the 2017 Benefit Payment Notice. Emily?

Thank you. So you probably already know that we published some new requirements for our assisters in the 2017 Payment Notice a few weeks ago and we will talk through what those requirements are, when they will be effective and what we expect assisters to do to meet those requirements. I will be summarizing legal standards here but for complete information you should refer to the regulations themselves and we'll have some links to them at the end of the presentation. And these slides are also posted on Marketplace.cms.gov and we will send a link around in the next newsletter that we send out next week.

So first I'll be giving you an overview of the final rule and then I will talk through the new requirements for assisters and I will just touch on a couple other Marketplaces provisions that were finalized in this rule. The Notice of Benefit and Payment Parameters, or we call it the Payment Notice, is a set of regulations that's designed to promote healthy and stable markets for consumers and issuers. This year's payment notice sets standards for the 2017 plan year and beyond so it includes payment parameters for the 2017 benefit year, there are new standards to improve consumer's Marketplace experience, and just generally the rules are designed to promote continuity and stability in the marketplaces and help ensure that coverage is affordable and accessible. We will spend most of the time here on the provisions that directly impact assisters.

The first new assister provision has to do with post enrollment assistance. We know lots of you guys are already helping consumers with exemptions and we want to make sure that this help was available to more consumers. In the Federally-facilitated Marketplace, starting with Navigator grants awarded in 2018, Navigators will be required to help consumers with five specific post enrollment topics and we will go over what these are in a minute. In the meantime between now and 2018 Navigators are permitted to provide this assistance but they are not required to. And in State-based Marketplaces they have the option of requiring or permitting their Navigators to provide assistance. So if you're if an SBM, check with your Marketplace about whether you are required to provide it. And there are corresponding training topics related to these requirements, so in the FFM we will include training on things like exemptions and appeals in our 2018 Navigator training and in the meantime we will keep sharing information with you guys in webinars, newsletters, and through other technical assistance.

These are the post enrollment topics that Navigators will be helping with starting in 2018 and again you can provide this assistance now and start building your organization's expertise in these areas and especially now that open enrollment is over, these are great things to be focusing on. The first thing is helping consumers understand the process of filing exchange eligibility appeals. This would include helping consumers understand that they have 90 days to appeal an exchange eligibility determination including determinations related to APTC, Medicaid or CHIP, and also SEP determinations, exemptions determinations, and SHOP determinations. This would also include helping consumers understand the process of how to appeal, what steps to take, how to access appeals forms, and letting consumers know about free or low cost legal help in your area. One thing to keep in mind here is that you should not provide legal advice in your capacity as a Navigator, so this assistance is more about helping consumers understand their rights and what steps to take, but not advising them to take any specific actions. It's kind of like when consumers pick a plan you give them all the information but you do not tell them which plan to pick. The next post-enrollment topic is helping consumers understand and apply for exemptions that are granted through the Marketplace. This is also letting consumers know about the

availability of exemptions through the tax filing process but because you can't provide tax assistance, in your capacity as Navigators, you don't want to be helping consumers fill out tax forms. For Marketplace exemptions, definitely helping consumers fill out those applications and submit them and for exemptions that are claimed through consumer's taxes, just helping consumers understand the availability of those exemptions, how they can claim them and the availability of IRS resources on this topic - but not actually helping them for example to fill out IRS form 8965. The third post-enrollment topic is helping consumers with the exchange related component of the premium tax credit reconciliation process. This would include helping consumers access their forms 1095A and understand what to do with them, helping them report errors on their 1095A's, helping them use the Marketplace tool to find their second lowest cost silver plan and helping them access IRS resources on this process including form 8962 and the instructions for that form. But again Navigators should not be providing tax advice in their capacity as Navigators. So the line here is really unless you are a tax professional, you should not be helping consumers fill out form 8962 – it's really just the Marketplace side of things, helping them find their 1095A's, making sure they are accurate and understanding what to do with that information. The fourth post-enrollment topic is helping consumers understand basic concepts and rights related to their health coverage and how to use it. For example helping consumers understand terms like deductible and co-insurance, the differences between going to an emergency room and going to a primary care provider, how to identify in network providers and how to make and prepare for an appointment with a provider, how to make a follow-up appointment and fill prescriptions and then certain rights like the right to coverage of preventive health services, about cost-sharing, nondiscrimination protections and prohibitions on pre-existing conditions and exclusions. The last post-enrollment topic is referrals to licensed tax advisors and tax preparers and other resources for tax preparation and tax advice. If consumers have questions about things like exemptions and reconciliations that are beyond what you're able to help with as a Navigator, you can connect them with appropriate tax assistance. So for example a good place to refer folks might be a local volunteer income tax assistance program or tax counseling for the elderly program. These referrals have to be made in a fair, accurate, and impartial manner and we'll be releasing more guidance and tips soon for making referrals and guidance like this.

Another new requirement and this applies to all of our assisters, so Navigators, certified application counselors, and non-navigator assistance personnel, before providing assistance you have to let consumers know that you're not acting as a tax advisor or attorney when you're providing assistance as an assister and that you cannot provide tax or legal advice within your assister capacity. And this should be part of the information you give consumers about your functions and responsibilities and you can add this information to the consent form you use with consumers and we will also update our model authorization forms to reflect this. Just as a side note we know that there are Navigators who are also trained as tax professionals. You can definitely help with things like the tax filing components of the reconciliation process or claiming exemptions through a tax return but you should keep these separate and not perform any tax assistance within your capacity as a Navigator or using Navigator grant funds and you would still need to provide this disclaimer before providing any Navigator assistance.

The next new requirement we finalized is that Navigators will have to provide targeted assistance to underserved or vulnerable populations in FFM states -this will begin with Navigator grants awarded in 2018 and in SBM states, 60 days after the publication of the final rule so that's May 9th. Marketplaces will have flexibility to define and identify the underserved or vulnerable populations in their service area, so in FFM states we'll be identifying these populations in our Navigator FOA and grant applicants will also be able to propose additional communities to target during the process. The primary criteria we'll use that we'll be looking for you to target communities that are disproportionately without access

to coverage or care or are at greater risk for poor health outcomes. And of course Navigators still have to help any consumer seeking assistance. You're not going to be serving these populations exclusively, we just want to be sure that part of your work includes targeting folks who have the least access to affordable coverage.

Next we made a small tweak to the regulations to ensure that Navigators and non-navigator assistance personnel have completed their training prior to providing any assistance. Not just application enrollment assistance but also before providing outreach and education. And this doesn't prevent folks who are not trained just generally conducting outreach and education about the Marketplace or from providing application enrollment assistance just as long as they're not filling themselves out as exchange Navigators or exchange certified Navigators or non-navigator assistance personnel.

We also finalized the provision requiring CAC designated organizations to provide the Marketplace in their state metrics about the number [Indiscernible] about the organization CAC's. So this will help the Marketplaces oversee their CAC programs and improve our understanding of the scope of consumer assistance that is being provided across FFM's. And SBM's aren't required to collect this data from their CAC's but they can if they want to – if you're a CAC in an SBM state you should check with your Marketplace about whether they will require you to provide this information. In the FFM we will start collecting reports beginning with the third quarter of 2017, so that's July 1 through September 30 of next year - that will be the first reporting period.

This slide shows the fields we will be collecting, it will be the number of individuals who have been certified by the organization, the total number of consumers who received application and enrollment assistance from the organization, and of that number the number of consumers who received assistance applying for and selecting a QHP, enrolling in a QHP or applying for Medicaid or CHIP. And for CAC's who are also HRSA grantees or Navigator grantees we try to align these reporting requirements with the requirements under those grants so that you won't have to collect separate data, this will just be data that you are already collecting.

And lastly we tried to simplify the rules around providing gifts and promotional items. This is another one that applies to Navigators, non-navigator assistance personnel, and CAC's. So we didn't touch the rules that assisters can't use Marketplace funds to purchase gifts or promotional items but we wanted to streamline the rest of the rule. So now the rule is that assisters can provide gifts and promotional items as long as they are not purchased with Marketplace funds, as long as they are not used to induce consumers to enroll in coverage, and as long as they don't exceed a 15 dollar value. So we're hoping that that is simpler for folks to follow than the previous rule. So for example assisters can provide things like pens, magnets, or key chains, things that are worth 15 dollars less each, you might want to provide these at outreach events for example, as long as you aren't using Marketplace funds to purchase them and as long as they aren't being used to induce enrollment. What we mean by that is you can't require consumers to enroll in coverage in order to actually get the item but you can use these items to encourage consumers to learn more about the Marketplace or to get help applying for coverage or other assistance. And as before, these prohibitions don't apply to the reimbursement of legitimate expenses, that a consumer might incur in an effort to receive exchange application assistance. For example travel or postage expenses.

That's it for the assister provisions. I will touch on a couple of other provisions that we thought would be helpful for you to know about from the payment notice.

We established the Marketplace open enrollment period for the individual market for benefit years 2017 and 2018, it will be the same as the one we just had so November 1st through January 31st and then for benefit year 2019 and later it will begin on November 1st and run through December 15th. We also codified a Marketplace model for SBMs using the federal platform. So these are SBMs that rely on HealthCare.gov for their eligibility and enrollment functions – for individual marketplace they are called SBMs-FPs. These Marketplaces will retain primary responsibility for plan management functions, consumer assistance, and for ensuring that all Marketplace requirements are met but they will rely on the federal platform for eligibility determinations and enrollment processing activities. If you're interested definitely check out the final rules for other provisions. There are some provisions that we finalized to help consumers with the price out-of-network costs at in-network facilities. We finalized the provisions to give consumers notification when a provider network changes, and to give insurance companies the option to offer plans for standardized cost-sharing structures and to provide a rating on HealthCare.gov about the breadth of each QHP's network [indistinguishable]. We have links to the final rule here on the last slide, if you want to read more and there is a link to the press release and a fact sheet about the rule. Definitely submit your questions to the chat feature and we will get to them if we have time at the end. I'll turn it back over to Deborah.

Q&A

Thanks so much, Emily. We have a few questions on taxes and the payment notice. Annie, I'm going to ask a couple of the tax questions first if that's OK. For the first question - if someone receives their 1095-A and their address has changed and now they are trying to file their taxes and the original 1095-A address doesn't match their current address, will they have issues in filing their taxes?

As long as they received a copy of their 1095-A they will not have issues filing. If they would like to change their address on their 1095-A, they can call the Marketplace center to make that address change and they should definitely go back into their account so that their address is changed going forward but if they have a copy of their 1095-A, they don't have to get the address changed on it, they can use the coverage information included in the various parts of the 1095-A to reconcile.

Great and that kind of answers another question but if you don't mind just emphasizing the point – folks are asking how do you report changes or errors on your 1095-A?

If a consumer has a missing 1095-A or thinks that there's incorrect information on their 1095-A, they should call the Marketplace call center. There is an exception to that - if they have a zero populated under second lowest cost silver plan or they think that their second lowest cost silver plan value is incorrect, we encourage consumers to use the tax tools on HealthCare.gov to obtain that value instead of requesting a corrected form -- since they can just pull that value from the tax tool and use it to report on their 8962.

Next question - if someone requested a change on their 1095-A, should they call the Marketplace to know when that's ready or will they receive an email when the form is updated?

We do perform consumer outreach if someone has requested a corrected 1095-A, so they will receive both the corrected form in the mail and in their online account if they have a Marketplace account and then they will also receive a phone call letting them know whether we agree with their request and a form is either on its way or has been denied.

Last question, if a consumer has requested a change in their 1095A and it does not come before the tax filing deadline, what should they do?

Great, thanks. So most consumers that have requested a correction have received an updated form or will receive it soon. However consumers who request a correction now, through the end of tax filing season, may not receive an updated form in time for the deadline on April 18. Those consumers should contact their tax preparer or visit IRS.gov to find out what to do next which could include requesting an extension to file. That extension to file does not give a consumer more time to pay any taxes that may be due.

Thank you so much. Our next question is on the payment notice. This question is coming from a CAC who'd like to know if a CAC or assister is also certified as a VITA volunteer, can they give tax advice to the consumer?

The same rule applies as for Navigators, if you're a CAC and also a tax professional like a VITA volunteer, you can definitely help with things like the reconciliation process or claiming exemptions through a tax return, but again you have to keep these duties separate from your CAC functions and not perform any tax assistance within your capacity as a CAC. You could have separate people performing these functions, have some CAC's perform the application and enrollment assistance and have other folks who are certified as VITA volunteers providing that assistance. Or you can just divide it up and explain to the consumer now I am helping you as a CAC, I'm helping you as a VITA volunteer, just making sure those things are separate.

Great. Someone asks if we can repeat the open enrollment period. Can we put the slide up there for folks to see? The slides will be made available with the assister webinar so we'll let you know when they are available.

Again, for open enrollment for the benefit year 2017 and 2018 it will be November 1 through January 31, just like the one we just had, and for benefit year 2019 and later, it will be November 1 through December 15.

I see a lot of other questions coming through on the 1095-A form. We will address these questions in our upcoming assister newsletter. We need to move on to our next and final presentation. Thank you Emily and thank you Annie.

Avoiding Gaps in Coverage Complex Case Series

Next presentation we are joined by Ijeamaka Okoye from our Consumer Support Group here at CCIIO and she's going to provide an updated presentation. It's a complex case scenario on avoiding gaps in coverage. As a reminder if you have questions you can submit them through the webinar chat feature. JJ?

Good afternoon everyone. Today's presentation we want to go over transitioning from a Marketplace plan to other health coverage. When helping consumers with eligibility and enrollment activities, assisters may encounter some complex situations. This week we will present a complex scenario about helping consumers avoid gaps in their health care coverage when they transition from a Marketplace plan to another type of health coverage.

On today's agenda I'll provide a high level overview of the types of coverage options to which consumers who are currently enrolled in a Marketplace plan may potentially transition to. For example employer-sponsored coverage, Medicaid or CHIP coverage, or Medicare coverage. Then I will provide some summaries and key takeaways.

In today's scenario we have Jocelyn who enrolled in a Marketplace plan last year but she recently received an offer of employer-sponsored coverage. So let's meet her. She's a 27-year-old and she's also single, she purchased coverage in a Marketplace plan that began on January 1, 2016. When she purchased this plan she was working part time and was making around \$36,000 a year and had no offer of employer-sponsored coverage through her job. Because of this she was determined eligible to receive financial assistance through the Marketplace to lower her monthly insurance costs. On March 1, 2016, Jocelyn was laid off from her job and was able to find a new one the following week. This job, at a local department store, offered her employer-sponsored coverage and she estimates that she will make approximately \$15,300 in 2016.

Jocelyn's employer pays 100% of the cost of their employee's premiums and the plan she has chosen from meets the minimum value standards therefore her offer of employment sponsored coverage is considered affordable because she would contribute no portion of her income to her monthly premiums. Jocelyn does have to wait 45 days before her employer-sponsored coverage kicks, her employer has a waiting period. Not all employers have this. Since Jocelyn's first day of work began on March 9, her coverage under her employer's group would take effect on May 23rd, which is the 45 days – after the 45 day wait period. Additionally her job has given her 30 days from her first day at work to decide whether or not she wants to enroll in this plan offered through her employer. She is not sure if she wants to accept her offer of employer-sponsored coverage or see what other coverage options she may have. In order to avoid a coverage gap, how should she transition from the Marketplace plan to employer sponsored coverage or to another health coverage option such as Medicaid, if it's offered to her? She has a few coverage options to consider. We're going to review her options and how she should transition from her Marketplace plan to a new coverage option in order to avoid a coverage gap.

On this slide you will see the three options that we're going to go over is her current Marketplace plan, employer-sponsored coverage that she has been offered, and Medicaid coverage. The first option is transitioning from a Marketplace plan to employer sponsored coverage and consumers will get a new job and receive an offer of employer-sponsored coverage. Consumers who get a new job like Jocelyn may receive an offer of employer-sponsored coverage. If current Marketplace enrollees are transitioning to employer-sponsored coverage they should consider the following: if a consumer's offer of employer-sponsored coverage is considered to be affordable and meets the minimum value standard under the regulations, then the consumer is not eligible to receive financial assistance to the Marketplace. In order for a self-only plan to be affordable, it cannot be more than 9.66% of the consumer's annual income for the 2016 plan year. This percentage does change or may change year-to-year, and last year it was slightly lower. To meet the minimum value standard the health plan must among other things pay at least 60% of the total cost of medical services for a standard population. Also, consumers who have an offer of employer-sponsored coverage that is affordable and hits the minimum value standards can reject it and remain in their plan, they will not be eligible for financial assistance if they do decide to keep their plan. They will have to pay the full cost of the premium. Consumers must report that they have an offer of employer sponsored coverage on their Marketplace application by reporting a life change and I will go over how to do that in the next few slides. Because Jocelyn's plan is considered affordable she will most likely lose her eligibility to receive financial assistance. Consumers who have an offer of employer-sponsored coverage but are still in their waiting period, in the employer's waiting

period, they may still be eligible to receive financial assistance through the Marketplace during the waiting period. For example, in Jocelyn's situation since she has a waiting period of 45 days between March 9th and May 23rd, she may still be eligible to receive financial assistance through the Marketplace until her plan kicks in at her job.

In this situation she can do – or she should do two things. She should go to the Marketplace and report the life change twice. The first time that she reports a life change she will first go into change her income, and to also notify the Marketplace that she has a new offer of employer-sponsored coverage, when she changes or transitions into her new job, then she's going to come back again when her waiting period ends, and she becomes eligible for employer sponsored coverage.

Consumers should make sure that the offer for employer-sponsored coverage meets their healthcare needs and budget and so they should ensure that the offer of employer-sponsored coverage is affordable for them and the consumer is able to pay it month-to-month and in Jocelyn's situation her employer-sponsored coverage may also offer different benefits or a different network of providers so she should call her provider that she currently have to make sure that they are accepting the plan that her employer is offering. She should also check the drug formularies to make sure that any medications that she is taking will be covered under this plan through her employer. She should also look at different premiums and cost sharing between the plans, comparing costs like deductibles, copayments and coinsurance from this plan.

I'm going to go over how to terminate a Marketplace plan once someone begins employer-sponsored coverage. To prevent a gap in health coverage consumers should be mindful of the termination date that they set. The Marketplace termination generally can take effect as soon as 14 days from the day the consumer takes action. Consumers may request an earlier termination date directly from the issuer and consumers can somebody more than 14 days in the future based on the start date of their new coverage. Consumers should also set the last day of their Marketplace coverage to the day before their employer-sponsored coverage will begin. Consumers can terminate their Marketplace plan by calling the Marketplace call center or following the steps on the next slide. Please note that if the consumer is ending encourage for everyone on their application the consumer's cancellation can take effect as soon as 14 days from the day he or she canceled that plan and if the consumer is ending coverage for just some people but not all enrollees on the plan, in most cases their coverage will end immediately.

Here is some instructions on this slide on how to terminate plans. The first one is how to terminate plans for all enrollees and the second one is for some enrollees. So if the consumer wants to terminate coverage for all enrollees he or she will need to log into their account on HealthCare.gov, they'll select the current application that needs to be cancelled and towards the bottom of the screen there is a red button that cannot be missed that says end all coverage or terminate coverage and after they select that option they will confirm the termination. The second option is consumers want to terminate coverage for some enrollees but not all enrollees, the instructions are a bit different. So they would need to log into their account as well, select the current plan that they would like to terminate, and they are going to report a life change. They would need to click report a life change twice and then they would attest and continue and then they will be brought to a page that says who needs coverage, and on this page there is going to be a list of the household members that are on the application and what the consumer needs to do is they need to decide who wants to keep the Marketplace coverage, and they will remove the people who no longer need Marketplace coverage and when they actually select individuals who no longer need coverage, they will confirm the removals and then enter the following questions after that. After they do that they will view their eligibility results and continue through enrollment. Also note that

when some people on the application are removed, the premium tax credit or other savings may change. Consumers need to make sure that they review their new eligibility results after they remove some members from the application.

In option two we are going to go over how someone transitions to Medicaid from a Marketplace plan. In this situation, Jocelyn in the state that she lives in, she's eligible to enroll in Medicaid.

Some considerations on transitioning to Medicaid coverage. Medicaid has a year-round open enrollment so unlike the Marketplace open enrollment period that's only a set amount of months, Medicaid is open year round so consumers can apply 12 months out of the year. If they are determined eligible for Medicaid their coverage will be effective back to the date they actually applied sometimes it can take effect up to three months earlier in some states. Eligibility for Medicaid is determined by household size, income, residency, citizenship, and other factors as well as the state specific eligibility criteria. There's a link on the screen for more information about Medicaid eligibility and it's by states so if you are interested in learning more about your state, or other states, please click on that link on Medicaid.gov. Also consumers should not experience a gap in coverage as they move from Marketplace plans to Medicaid coverage. Jocelyn should tell the Marketplace about her change in income, as I said earlier her income went from 36,000 to 15,000, so she should tell them about her drop in income by reporting a life change in her Marketplace application.

Additionally consumers who have been determined eligible for CHIP should terminate their Marketplace coverage with financial assistance as soon as they receive a notice that they have been determined eligible for Medicaid or CHIP. Once Jocelyn has been determined eligible for Medicaid, she should terminate her Marketplace plan with financial assistance. Her coverage will be effective retroactive to at least the date of her application.

In this last scenario we're going to imagine that she is no longer 27 but is almost 65, and she wants to enroll in Medicare but she's not sure how to do this but she does want to avoid a gap in coverage. In order for a consumer to transition from a Marketplace plan to Medicare, they need to make sure that they are eligible for Medicare and their eligibility should not and will not prevent them from keeping their Marketplace plan. However, they will not be eligible for financial assistance through the Marketplace if they are eligible for Medicare. Consumers generally cannot enroll in an individual Marketplace plan after they are already enrolled in Medicare and it is illegal for issuers to sell a Marketplace plan to consumers who are eligible for Medicare benefits. In this scenario she is eligible for free Medicare part A and can keep her Marketplace plan when she enrolls in Medicare but like I said before she will no longer be eligible for financial assistance through the Marketplace. Jocelyn will have to pay full price for her Marketplace plan's premium once she is enrolled in Medicare part A and she should return to the Marketplace to update the information as soon as she is enrolled in Medicare Part A. Anytime there is a change you should go back and report life change to the Marketplace application. She must report this change and it will end her financial assistance and it will prevent her from having to pay APTC's that she received while she was also enrolled in Medicare part A when she files her federal taxes.

To avoid a coverage gap consumers should not terminate their Marketplace plan before their Medicare coverage begins. Once their Medicare coverage starts that's when consumers can terminate their Marketplace plan. If Jocelyn decides to enroll in Medicare she may be able to enroll in Medicare Advantage or a Medicare gap policy which may be appropriate if she thinks that Medicare part A or B is not adequate for her and on this slide there is currently a link for more information about Medicare

coverage. If consumers decide to stay enrolled in an individual Marketplace plan and do not sign up for Medicare, when they are first eligible, they may have to pay a late enrollment payment every month if they later decide to enroll in Medicare.

Some key takeaways, before ending today's presentation were going to review coverage options that are available to consumers like Jocelyn who are transitioning from a Marketplace plan to other coverage options. The first key takeaways is if consumers receive an offer for employer-sponsored coverage they generally will have until their employer's deadline to enroll in the job based plan. And if it's affordable and meets the minimum value standard they are no longer eligible to receive financial assistance through the Marketplace. Consumers who have an offer of employer-sponsored coverage but are still in the waiting period like Jocelyn was, she had the 45 day waiting period, she may still be able to receive financial assistance until her employer-sponsored coverage kicks in through the Marketplace. Consumers who have been determined eligible for Medicaid or CHIP are not eligible for financial assistance through the Marketplace. As consumers receive their Medicaid or CHIP determination, consumers should terminate their Marketplace plan with financial assistance. Consumers must terminate the Marketplace plan by either calling the Marketplace call center or going online. I will say that calling the call center may be easier if you want to terminate some enrollees and not all. Consumers should be careful when they are setting their termination date to avoid a coverage gap. They generally have 14 days that they need to set a termination date at least 14 days in the future and it is also illegal for issuers to sell a Marketplace plan to consumers who are already enrolled in Medicare, if they know the Marketplace plan will duplicate the consumer's Medicare benefits. If consumers decide to stay enrolled in an individual market Marketplace plan and do not sign up for Medicare when they are first eligible they may have to pay a late enrollment fee every month until they enroll in Medicare. That concludes the presentation. Are there any questions?

Q&A

Yes, we have a few. The first question – the assister wants to know will a consumer qualify for an SEP if they end their Marketplace plan before they get a final Medicaid or CHIP determination and are later found ineligible for Medicaid or CHIP?

No. Consumers will not qualify for a special enrollment for this particular reason and they cannot reenroll in the Marketplace plan unless they qualified for another SEP for another reason. Otherwise they will have to wait for the next open enrollment and they have a gap in coverage so it's very important that consumers are found eligible and Medicaid actually tell them that they are eligible for Medicaid before the cancel their Marketplace plan.

Ok. Another assister wants to know if a family is trying to cancel coverage for just one family member, but they want to make sure that their other family member stay enrolled on the Marketplace plan, what should they do?

As I said the easiest thing to do is to call the Marketplace call center, so if an applicant or the subscriber, the person who actually created the account on HealthCare.gov, wants to cancel the plan for themselves and not for a spouse or dependent, they need to do this by phone. If it is done online, it will be canceled for the subscriber and all the dependents on the plan of the consumer should contact the call center so that the dependents can stay on the plan. That's only if the applicant wants to cancel but keep others on. But if the applicant wants to stay on and remove other people on the application, they can do that online.

If someone wants to terminate only some enrollees on a plan can you repeat again when the termination will be effective?

If they want to terminate some enrollees, it will be effective 14 days in the future from the date that the plan will start. Does that make sense?

If they want to terminate some of the folks on the plan, it takes up to 14 days for the termination to take effect?

Correct.

Sorry, just scrolling through some of the other questions. If someone's medication is not covered on their employer sponsored plan, the consumer still won't be eligible for APTC's if they refuse the employer-sponsored plan, correct?

Yes, unfortunately. If their employee sponsored coverage is considered affordable, and meets the minimum value standard, unfortunately they will not be eligible for financial assistance so they may need to contact their issuer through the employer-sponsored coverage to figure out what other options they have for their medication.

Sorry just scrolling through the questions.

These slides will be posted online, they are already on Marketplace.cms.gov but it's a little bit outdated, so we will be updating the slide deck soon and we will put the new link in the newsletter when it's posted and goes live.

Here's another question. What happens if the consumer has rejected the employer-sponsored coverage because they felt it was too expensive but are no longer eligible for employer-sponsored coverage because the employer has closed the open enrollment period?

So the consumer rejected the employer-sponsored coverage because they thought it was too expensive for them and is no longer open enrollment for their employer-sponsored coverage.

If the employer-sponsored coverage was too expensive for them but it was considered affordable through the Marketplace then they would have to wait until the open enrollment period for their employer again so the following year or whenever it's open for that employer.

I think we can take one more question. This one, again I think folks are confused about the termination. Can you explain under which circumstances a consumer can terminate coverage immediately when they cancel?

Let me find the slide for everyone to see. Here goes – So consumers if they want -- if you're ending coverage, if consumers are ending coverage for everyone on their application – So they want everyone on the application to no longer have coverage, it will take place 14 days from the day they cancel but if they want to end coverage for just some people on the application, then the individual who wants to end their coverage, their coverage will end immediately, in most cases.

Conclusion

Thank you so much, IJ. Again, these slides will be available on Marketplace.gov as well as a recording of this webinar that you can go back and listen to or share with other assisters. I just want to give a special thank you to Annie, Emily, and IJ for joining us today. Our next webinar will be in two weeks, on Friday, Friday, April 1, at 2 PM. If you like to sign up for the CMS weekly assister newsletter listserv, and our webinar invitations, please send us a request via the assister listserv box and you can reach that at assisterlistserv@cms.hhs.gov. Thank you again and have a wonderful weekend.