MARKETPLACE
ASSISTER TOOLKIT

Standard Operating Procedures Manual for Assisters in the Individual Federally-facilitated Marketplaces

SOP 14— Renew Health Coverage

Version 5.0 November 2016. This information is intended only for the use of entities and individuals that are certified to serve as Navigators, certified application counselors, or non Navigator assistance personnel in a Federally facilitated Marketplace. The terms "Federally facilitated Marketplace" and "FFM," as used in this document, include FFMs where the state performs plan management functions and State Partnership Marketplaces. Some information contained in this manual may also be of interest to individuals helping consumers in State based Marketplaces and Federally supported State based Marketplaces.

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SOP 14—Renew Health Coverage

A. Introduction

As an assister, you can help consumers renew their enrollment in Qualfied Health Plans (QHPs) through the Marketplace. The process for renewal of health coverage begins with the Marketplace's annual eligibility redetermination process for all consumers who were determined eligible for enrollment in a QHP in the previous year. Consumers are responsible for notifying the Marketplace within 30 days of any changes in their application information during the year. This helps ensure an accurate redetermination of eligibility. Any changes in coverage or eligibility as a result of the annual eligibility redetermination will be effective on January 1 of the next year.

If consumers requested help paying for health coverage, agreed to allow the Marketplace to re-check their tax return information on an annual basis, and have properly reconciled any advance payments of the premium tax credit received for the 2015 benefit year with the Internal Tax Revenue (IRS), the Marketplace will then check the consumer's income data from the IRS and use it to re-determine their eligibility for help paying for health coverage. For consumers covered by Medicaid or Children's Health Insurance Program (CHIP), their states' Medicaid or CHIP agencies will generally re-determine their eligibility for these programs on an annual basis.

The Marketplace will send consumers a Marketplace Open Enrollment Notice (MOEN) before open enrollment for the coming year. All consumers are encouraged to come back to the Marketplace and log into their HealthCare.gov account to update their application information, compare plan options, and enroll in coverage for the coming year. Consumers should also check to be sure they are receiving the correct amount of help paying for coverage and are still enrolled in the coverage for 2017 that works best for them.

If consumers do not agree to allow the Marketplace to re-check their tax return information on an annual basis when they filed an eligibility application, the Marketplace will still send consumers a notice. The notice will tell consumers that if they want to receive, or continue to receive, advance payments of the premium tax credit (APTC) or income-based cost-sharing reductions (CSRs) for 2017, consumers must contact the Marketplace or go to HealthCare.gov to update their information and select a QHP in time for a January 1 effective date. Otherwise, consumers' advance payments of the premium tax credit or income-based cost-sharing reductions will end on December 31, 2016. Similarly, if a tax filer receiving APTC or income-based CSR in 2014 or 2015, failed to file a 2014 or 2015 tax return (respectively), and did not return to the Marketplace to obtain an updated eligibility determination, enrollees in that tax filer's tax household will lose any help paying for coverage after December 31, 2016.

Most current Marketplace enrollees will be automatically enrolled in coverage for the next benefit year under the re-enrollment guidelines established for the Marketplaces, if they don't do anything. However, if consumers don't return to the Marketplace and select 2017 coverage by December 15, 2016, they could miss out on better deals and cost savings for coverage starting on January 1, 2017. That's why CMS is advising assisters to strongly encourage all consumers—even those who plan to re-enroll in their same plan—to come back to the Marketplace to review their plan options, as well as their application information.

In addition to the Marketplace Open Enrollment Notices, all consumers currently enrolled in a QHP will get a notice from their health insurance company before open enrollment. If the health insurance company does not

have information about the estimated APTC amount before it sends the notice, it will provide the information before or during open enrollment.

The plan's renewal letter notice will identify a plan that is the same as or similar to the enrollee's 2017 plan, if available. The plan notice will describe any changes to the enrollee's QHP. If the QHP will be discontinued or coverage in that QHP non-renewed, the issuer will send a notice to tell consumers which plan, if any, the consumers will be enrolled in for 2017 unless they return to the Marketplace and change plans. If the consumer will not have plans offered by their 2016 health insurance issuer available to them through the Federally-facilitated Marketplace (FFM) in 2017, the consumer may be automatically enrolled in a plan with a different health insurance issuer. However, the consumer should be encouraged to return to the Marketplace to make sure that the new plan with the new health insurance company will meet the consumer's needs—or see if there is another plan that would be a better fit.

The remainder of this Standard Operating Procedure (SOP) provides guidance on how to assist consumers with their annual eligibility redeterminations and completing the renewal process.

B. Procedures

1. All consumers who are currently enrolled in a QHP through the Marketplace for plan year 2016 will be sent a Marketplace Open Enrollment Notice before open enrollment that contains the following information:
    a. A note that the open enrollment period begins November 1, 2016 and ends January 31, 2017.
    b. A description of the annual eligibility redetermination and renewal process.
    c. The requirement to report changes affecting eligibility and the timeframe and channels to report changes.
    d. The key dates for ensuring coverage is effective on January 1, 2017.
    e. The reconciliation process for consumers receiving advance payments of the premium tax credit and/or cost-sharing reductions.
    f. Special instructions for those consumers receiving advance payments of the premium tax credit or cost-sharing reductions. For more information on these instructions, see Step 4.

Step 2. Assist consumers with reviewing their Marketplace Open Enrollment Notice.

Step 3. Explain to consumers that they should update their eligibility application with any new or changed information about themselves or their households. If there are no changes, consumers should still return to their account on HealthCare.gov to review the application and confirm the information is correct and review their financial assistance and plan options.

Step 4. Assist consumers with reporting any changes or new information (e.g., annual household income, household size) to the Marketplace. Keep in mind the guidance below is based on different consumer scenarios:

a. If consumers who applied for but were determined ineligible for advance payments of the premium tax credits or income-based cost-sharing reductions contact the Marketplace to report any changes or select a new QHP, they will also get an updated eligibility determination based on updated guidelines (e.g., federal poverty levels) for the new plan year.

b. If consumers who are not receiving advance payments of the premium tax credit or income-based cost-sharing reductions do not contact the Marketplace within the specified timeframe, generally, the Marketplace will automatically re-enroll them in the coverage for the next benefit year without advance payments of the premium tax credit or cost-sharing reductions.

c. Consumers who are receiving advance payments of the premium tax credit or income-based cost-sharing reductions and agreed to allow the Marketplace to re-check their tax return information on an annual basis and have filed a 2014 or 2015 tax return (if they received APTC in 2014 or 2015, as applicable) should be aware of the following key points about their annual eligibility redetermination and renewal process:

   i. If consumers have provided updated eligibility information to the Marketplace, the eligibility redetermination notice will be based on their most recent eligibility information on file.

   ii. If consumers have not provided updated eligibility information, the notice will encourage them to contact the Marketplace to get an updated eligibility determination by December 15, 2016.

   iii. If consumers do not update their information, the Marketplace generally will renew their QHP enrollment for the benefit year with the same level of help selected in the previous year. Income-based cost-sharing reductions and advance payments of the premium tax credit will be updated based on the consumer's most recent income and household size data reported to the Marketplace, updated FPL tables, and plan premiums.[1][2] However, if data sources show that the a consumer's household income is over 500% FPL, the consumer will get a notice that their APTC and CSR will be discontinued unless the the consumer takes action. The consumer may still be auto re-enrolled in a health plan on the FFM, but will lose APTC and CSR.

[1] The amount of premium tax credits consumers receive in the new plan year depends on their income and the premium cost for the second lowest cost Silver plan available on the Marketplace.
[2] Guidance on annual eligibility redetermination and re-enrollment for Marketplace coverage for 2017 can be found here: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ARR-2017-Guidance-051016-508.pdf.

d. Consumers who are receiving advance payments of the premium tax credit or income-based cost-sharing reductions and did not agree to allow the Marketplace to re-check their tax return information on an annual basis should be aware of the following key points about their annual eligibility redetermination and renewal process:
   i. The Marketplace Open Enrollment Notice will ask consumers to contact the Marketplace to get an updated eligibility determination.
   ii. In general, if consumers do not contact the Marketplace by December 15, their financial assistance (advance payments of premium tax credit or cost-sharing reductions) will end on December 31.
   iii. If consumers are still eligible for QHP coverage, the Marketplace generally will renew their coverage for the next benefit year but without financial assistance to help lower costs. Federal guidance explains how the Marketplace will decide which QHP the consumer will be automatically enrolled in for 2017 coverage.[3]

e. For consumers who are receiving advance payments of the premium tax credit or income-based cost-sharing reductions and did not file a tax return for the 2015 coverage year (and received APTC for 2015), advance payments of the premium tax credit and/or cost-sharing reductions will end on December 31, 2016. Here are key points about their annual eligibility redetermination and renewal process:
   i. The Marketplace Open Enrollment Notice will ask consumers to take action to ensure they file a 2015 tax return and then return to the Marketplace to update their application and attest to having filed a tax return. If consumers attest to having filed a tax return by December 15, the Marketplace generally will renew their coverage for the next benefit year.
   ii. In general, if consumers do not return to the Marketplace to attest to having filed a tax return or updated information from the IRS does not indicate that they have filed a 2015 tax return by December 15, their financial assistance will end on December 31, 2016.

Step 5. If consumers are unsure if they agreed to allow the Marketplace to re-check their tax return information on an annual basis, tell consumers that they can return to the Marketplace to give this authorization when they update their 2017 eligibility and plan selection.

Step 6. Enrollment.

Changes submitted on a 2017 application generally don't take effect unless consumers complete the process by continuing to enrollment and selecting a plan. If returning consumers want to keep their

[3] 17 See 45 C.F.R. § 155.335(a)(2).

Marketplace plan for next and it remains available, , they should select the plan labeled "YOUR CURRENT PLAN" at the top of the plan results in Plan Compare.

Even if consumers are satisfied with their 2016 plan, it is still a good idea for consumers to compare plans to see what's covered; and whether desired providers, services, and prescription drugs are still covered by the plan; and to compare costs.

C. Next Steps

1. If consumers receive updated eligibility notices, proceed to SOP-6 Review Eligibility Results.
2. If consumers would like to file an appeals request, proceed to SOP-10 Request an Eligibility Appeal.
3. If consumers would like to complete an exemption application, proceed to SOP-11 Exemptions.
4. For more help answering consumers' specific questions, see the Frequently Asked Questions (FAQs) related to SOP-14 Renew Health Coverage.

Appendix A: Frequently Asked Questions (FAQs)

The FAQs below are designed to help Assisters answer consumers' specific questions on renewing their health coverage through the Individual Marketplace. For more information on this topic, see SOP-14 Renew Health Coverage.

FAQ 1. How will I know if my current coverage is available for renewal?

- Answer: Consumers will get a notice from two different sources before open enrollment begins: the Marketplace and their health insurance company. The Marketplace will send an annual eligibility redetermination notice and the health insurance company notice will either tell consumers that they can renew their coverage for 2017 (known as a renewal notice) or that their QHP is being discontinued (known as a discontinuance notice). The health insurance company generally must send a discontinuation notice at least 90 days before the date the coverage will be discontinued.

FAQ 2. What happens if my current coverage is being discontinued for the upcoming benefit year?

- Answer: For the 2017 coverage year, if your QHP is being discontinued and if state law allows, you will be enrolled automatically into a different QHP, possibly with a different insurance company. The new QHP would be chosen based on a set of established rules. You can also return to the Marketplace and select a new QHP.

FAQ 3. Why was I re-determined ineligible for coverage through the Marketplace?

- Answer: There are several reasons why consumers who were previously eligible for QHP enrollment may no longer be eligible when the Marketplace re-determines their eligibility, including incarceration or moving outside the service area of the Marketplace.

Appendix B: Acronyms & Definitions

The proceeding sections describe the commonly used acronyms and terms that appear throughout the Manual.

Frequently Used Acronyms

Exhibit 1—Frequently Used Acronyms

Acronyms	Descriptions
APTC	Advance payments of the premium tax credit
CAP	Consumer Assistance Program
CCIIO	Center for Consumer Information & Insurance Oversight
COBRA	Consolidated Omnibus Budget Reconciliation Act
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CSR	Cost-sharing Reduction
DHS	Department of Homeland Security
DMI	Data-matching Issue
EHB	Essential Health Benefits
FAQ	Frequently Asked Questions
FFM	Federally-facilitated Marketplace
FPL	Federal Poverty Level
HDHP	High Deductible Health Plan
HHS	Department of Health & Human Services
HMO	Health Maintenance Organization
HSA	Health Savings Account
ID	Identification
IHS	Indian Health Service
IRS	Internal Revenue Service
MAGI	Modified Adjusted Gross Income
MEC	Minimum Essential Coverage
PII	Personally Identifiable Information
QHP	Qualified Health Plan
SBC	Summary of Benefits and Coverage
SEP	Special Enrollment Period
SHIP	State Health Insurance Assistance Program

Acronyms	Descriptions
SHOP	Small Business Health Options Program
SOP	Standard Operating Procedure
SSI	Supplemental Security Income
SSN	Social Security Number
VA	Veterans Affairs
VHA	Veterans Health Administration

Definitions

The following is a list of terms from HealthCare.gov, CCIIO, and the Affordable Care Act explained in plain language that you may reference to assist consumers.

Advance Payments of the Premium Tax Credit: (APTC) The Affordable Care Act provides a new tax credit to help consumers afford health coverage purchased through a Marketplace. Consumers can use advance payments of the premium tax credit to lower their monthly premium costs. If consumers qualify, they may choose how much in advance payments of the premium tax credit to apply to their premiums each month, up to a maximum amount. If the amount of advance payments of the premium tax credit consumers get for the year is less than the premium tax credit they're due based on their annual household income, they'll get the difference as a refundable credit when they file their federal income tax return. If their advance payments of the premium tax credit for the year are more than the amount of the premium tax credit for which they are eligible, they may be required to repay the excess advance payments with their tax return. (Reference: HealthCare.gov/glossary/advanced-premium-tax-credit)

Benefit Year: A calendar year for which a health plan provides coverage for health benefits. The benefit year for non-grandfathered individual market plans bought inside or outside the Marketplace generally begins January 1 of each year and ends December 31 of the same year. Unless terminated earlier, a consumer's individual market coverage ends December 31 even if the coverage started after January 1. Any changes to benefits or rates of an individual market health insurance plan are generally made at the beginning of the calendar year. (Reference: HealthCare.gov/glossary/benefit-year)

Centers for Medicare & Medicaid Services (CMS): The federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs, as well as the Federally-facilitated Marketplaces. For more information, visit CMS.gov. (Reference: HealthCare.gov/glossary/centers-for-medicare-and-medicaid-services)

Cost-sharing Reduction: A discount that lowers the amount consumers have to pay out-of-pocket for deductibles, coinsurance, and copayments. Consumers also have a lower out-of-pocket maximum. Consumers are eligible for cost-sharing reductions if they get health insurance through a Marketplace, they meet household income requirements, and if they enroll in a health plan from the Silver plan category (See Health Plan Categories). Consumers may qualify for additional cost-sharing benefits if they are a member of a federally recognized tribe. (Reference: HealthCare.gov/glossary/cost-sharing-reduction)

Enrollee: In an individual Marketplace, a qualified individual enrolled in a QHP through the Marketplace. (Reference: 45 CFR §155.20)

Health Coverage: Consumers' legal entitlement to payment or reimbursement for their health care costs for covered services or items generally under a contract with a health insurance company, a group health plan offered in connection with employment, or a government program like Medicare, Medicaid, or CHIP. (Reference: HealthCare.gov/glossary/health-coverage)

Health Insurance: A contract that requires a consumer's health insurer to pay some or all of the consumer's health care costs in exchange for a premium. (Reference: HealthCare.gov/glossary/health-insurance)

Health Insurance Issuer (Issuer): An insurance company, insurance service, or insurance organization that must have a license to engage in the business of insurance in a state and that is subject to state laws that regulate insurance. (Reference: 45 CFR §144.103)

Marketplace: A marketplace for health insurance, also known as an "Exchange," operated by a governmental agency or non-profit entity that meets applicable government standards. A Marketplace makes QHPs available to qualified individuals and/or qualified employers. Generally, in CMS documents, this term is often used to refer both to Marketplaces serving the individual market for qualified individuals and to Small Business Health Options Program (SHOP) Marketplaces serving the small group market for qualified employers, and is often used regardless of whether a Marketplace is established and operated by a State or by HHS. However, in this document, the term Marketplace generally is used to refer only to the Federally-facilitated Marketplaces (FFMs), and frequently is used to refer only to the FFMs for the individual market. (Reference: 45 CFR §155.20)

Medicaid: A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their programs, in which Medicaid can vary state by state and may have a different name in your state. (Reference: HealthCare.gov/glossary/medicaid)

Plan Year: A consecutive twelve-month period during which a health plan provides coverage for health benefits. A plan year may be a calendar year. (Reference: 45 CFR §155.20)

Premium: The amount that consumers or employers pay for a health insurance or job-based coverage. Premiums are paid by the consumer or employers on a monthly, quarterly, or yearly basis. (Reference: HealthCare.gov/glossary/premium)

Service Area: A geographic area where a health insurance plan accepts members limited to a specific area if it limits membership based on where people live, work, or reside. For plans that limit which doctors and hospitals consumers may use, it is also generally the area where consumers can get routine (non-emergency) services. The plan may disenroll consumers if they move out of the plan's service area, and out of network costs may apply for services received outside a plan's network (Reference: HealthCare.gov/glossary/service-area)

Appendix C: Support Resources

If consumers require assistance that is outside of assister activities, refer consumers to other organizations and resources as appropriate. Exhibit 2 provides a list of external resources.

Exhibit 2—External Resources

Resource	Contact Information	What does this resource do?	How should consumers use this resource?
HealthCare.gov	http://www.HealthCare.gov	This website allows consumers to access information about the Affordable Care Act and to enroll in health coverage through an FFM.	To find out about health coverage options available through an FFM. To apply for health coverage online. To get real-time answers to questions using the online chat function.
Medicaid	http://www.Medicaid XE "Medicaid" .gov	This state-administered health insurance program is for low-income families and children, pregnant women, the elderly, people with disabilities, and in many states, other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their program, so Medicaid varies state-by-state and may have a different name in your state.	To find answers to questions about health coverage through Medicaid or CHIP. To get further information about their state's Medicaid program and agency contact information.