Centers for Medicare & Medicaid Services
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Contents

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Welcome

Good afternoon everyone. Welcome to today's assister webinar. My name is Everett Smith, with the Consumer Support Group. Before we start today's presentation, I'd like to go over a few technical details with you. 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 don't appear to be advancing, please try to refresh the webinar. Press the refresh icon that looks like two arrows. It's the third icon in the row near the volume bar. If you continue to have issues, try to log out and back in again. Sometimes that helps to reset things. You are also always welcome to join us via telephone. Instructions are included in the alternate audio tab. If you'd like to ask a question during the presentation please do so by typing them into the "Ask a Question" tab on your screen. I will turn it over to Miss Deborah Bryant. Deborah, please go ahead.

Thank you Everett and thank you for joining us today as Everett said my name is Deborah Bryant and I'm the director of the Division of Consumer Advocacy and Assistant Support for the Marketplace. As a reminder, this call is intended for technical assistance and not press purposes. It is not on the record. If you are a member of the press, please contact our press office at press@cms.hhs.gov. Also, as a

reminder, the information presented today is informal technical assistance for assisters and not intended as official CMS guidance.

Also, as a weekly reminder, webinars are recorded and posted online. So, if you would like to revisit the webinar or share with others, please visit Marketplace.cms.gov website to access past webinar materials, the written transcript, and a video of the slide presentation. We will update the list of materials as they become available.

Today we have two important presentations to share with you first we have presentation that provides an overview of special enrollment periods available through the Marketplace this presentation also describes the new streamlined category or special enrollment period and the timing for when consumers can choose the plan and gain coverage. This presentation also covers important updates in the requirements. For a second presentation we provide an overview of the health insurer rate review process for issuers inside and outside the Marketplace. This will include a discussion of how you will submit your premium rates to CMS for review and how assisters can be involved in the process. Before we start with the presentation I will turn it over to Michelle Koltov who will provide the Marketplace update. As a reminder if you have questions feel free to submit them through the webinar chat feature.

Marketplace Updates

Section 1557 Follow Up: OCS & CMS Partnership

Thank you Deborah. We are joined by Sarah Albrecht we will provide an overview of the recently finalized nondiscrimination rules implementing Section 1557 of the Affordable Care Act.

Thank you my name is Sarah Albrecht I am with the US Department of Health and Human Services office for civil rights joined by JA Carson and we appreciate the opportunity to give you a high level overview of the final rule implementing Section 1557 of the Affordable Care Act published in the Federal Register on May 18. This is the non- discrimination provision of the Affordable Care Act which prohibits discrimination based on race, color, national origin, sex, age or disability and certain health programs and activities. The rule released is intended to reduce health disparities in advanced health equity. OCR has been enforcing Section 1557 the statute since 2010, we have been accepting complaints of discrimination investigating them and enforcing the statute. The final rule clarifies the standards that HHS will apply so individuals can understand what their rights are and covered entities understand what their obligations are.

The most exciting aspect is that Section 1557 of the first civil rights law to prohibit sexual discrimination and health programs and activities. Under this the discrimination includes those based on individual sex, gender identity and stereotypes based on an individual sex, for example women must be treated equally with men in the healthcare they receive a provider can't turn away anyone who needs treatment for a broken arm because she's transgender. Another thing to note is Section 1557 prohibits marketing practices and benefit designs that help insurance another coverage this means they cannot use targeted marketing practices to discourage groups from participating however practices that encourage groups to participate are not discriminatory. Congress intended the ACA to help the uninsured and the underserved population to gain access to care. Marketing practices that are used to increase the underserved populations are generally permissible. With respect to the scope of the rule Section 1557 applies to health programs and activities receiving federal funds, the Marketplace and the issuers participating in Marketplace and health programs by HHS. One final thing to note is that Section 1557

requires effective communication for limited English proficiency and disabilities will talk more about that in the next two slides.

Section 1557 the final rule clarifies long-standing civil rights laws and applies them within the context of health programs and activities consistent with those existing laws the final rule requires that 90 days after the effective date of the final role each covered entity must post a notice of nondiscrimination as well as 15 taglines. These are short statements written in non-English languages that inform individuals with limited English proficiency of the availability of language assistant services. This notice must include information about communication assistance for not only individuals with limited English, but also individuals with limited disabilities as well as other important information such as how to file a complaint with OCR if an individual believes that he or she has been discriminated against.

Again consistent with our existing interpretation of laws, national origin discrimination applying within the context of 1557 the rule states failure to provide language assistant services such as oral interpretation or written translation to an individual with limited English may constitute discrimination and the provision of the rule that actually has this language requires covered entities to take reasonable steps to provide meaningful access to individuals who are limited English proficient in the covered entity's health program. Covered entities are encouraged to develop and implement a language access plan so they are prepared to meet this legal obligation.

I will highlight the four major disability requirements that the rule discusses, but I think it's important to note although this is the first time the requirements are gathered together the requirement should be familiar to covered entities because Section 1557 requirements regarding disability discrimination are consistent with the existing requirements under the Disability Act and Rehabilitation Act . The first requirement of the final rule in the requirement that covered entities insurer health program activities provided through electronic and information technology are accessible to disability individuals in doing so would not impose financial burden as a result of fundamental alteration in the health program activity. For example health insurance Marketplace creating a website must ensure that individuals with disabilities have an equal opportunity to benefit from the website tool that allows comparison of health insurance coverage? Determination of eligibility and timely access to health insurance coverage by making its website accessible to those with blindness or low vision. The second of the final rule is a requirement that covered entities make reasonable modifications of policies practices and procedures to provide individuals access to covered entity programs and activities. The third is a requirement that newly constructed and altered facilities are accessible to people with disabilities that incorporates standards for new construction and alteration covered under these can look to the ADA 2010 standards for accessible design for guidance.

Fourth and final rule requires appropriate auxiliary aids and services to persons with impaired sensory manual or speaking skills where necessary to afford persons an equal opportunity to benefit. In doing so covered entities give primary consideration to aid or service requested by the individual for example if a doctor has scheduled an appointment with a patient with a hearing impairment the doctor needs to provide an interpreter so patient and doctor can communicate during the appointment.

We give a very high level view of the final rule today there is much more information available on our website OCR is available to provide technical assistance as well. Our website is included on the last slide for a presentation HHS.gov/OCR and you can also email 1557@HHS.gov for any particular questions that you have. Thank you so much for the opportunity and to the extent that time allows we are happy to take any questions.

Great thank you so much Sarah and JA and we will provide more information about 1557. We want to remind everyone that June is lesbian gay bisexual and trendsgender (LGBT) pride month. This season is particular exciting as we celebrate the anniversary of marriage equality and new nondiscrimination protection under the ACA that Sarah and JA went over. We hope you join us in using the 2016 pride season to reach out to LG BT communities and encourage them to enroll in health coverage. We will also be collaborating on how to enroll on the next webinar which focuses on reaching and assisting LGBT consumers on June 10th from 2:00 PM to 3:30 PM a 90 minute webinar so mark your calendars for that.

Special Enrollment Period (SEP) Overview for Assisters

We will start with our next presentation. First we are joined by Carolyn Kraemer she will provide an overview of special enrollment periods. As a reminder if you have questions for the presentation feel free to send them through the chat feature. Carolyn?

Thank you Michelle. As Michelle mentioned today's special enrollment presentation will provide an overview of SEPs that are available to consumers and we will also talk about when coverage starts based on which SEP the consumer qualifies for and talk through a couple of examples that illustrate the start dates and the SEPs that apply and talk about a recent change to one of the SEPs available.

This slide covers periods of time when consumers can enroll in coverage through the Marketplace. As most of you already know, consumers can enroll any time during the annual open enrollment period which this year and next year goes from November 1 through January 31 to get coverage for that year. Consumers can also enroll during a special enrollment period during open enrollment, but they are often thought of as a pathway to coverage outside of open enrollment for consumers.

This next slide talks a little bit more about SEPs very generally. I think one important thing to note on this slide is most SEPs last for 60 days from the date of the event that qualified them for the special enrollment. So there are always exceptions, but it's a good rule of thumb to think in terms of the 60 days and the consumer needs to enroll during those 60 days to get coverage for a special enrollment period.

This slide covers regular coverage effective dates which is helpful for thinking about when coverage begins when someone enrolls through an SEP. These coverage dates generally apply to anybody who enrolls during open enrollment and they also apply to some special enrollments. Then we will talk more about that as we go through the presentation. A good way to think about this is that when your coverage starts it depends on when you enroll so usually if you enroll during the first half of the month up through the 15th your coverage starts the following month. If you enroll in the second half of the month on the 16th or later you're coverage begins not the next month, but the month after that. We'll go through more examples as we go through the presentation, but those regular coverage effective dates are helpful reference.

This next slide goes over the six main situations in which consumers can qualify for a special enrollment. And there are detailed circumstances within each of these categories and we will talk more about each of them during the presentation. All of these categories and more information about them can be found on the fact sheet that is linked on the slide, so this is also included in a previous newsletter, but I encourage you to click on it now as well and use it as a reference during the presentation, because it includes much of the material we will talk about.

With that overview we will jump straight to the first situation in which consumers may qualify for an SEP and that is loss of qualifying health coverage. A couple things important to keep in mind about this SEP is that consumers can qualify if they lose health coverage that constitutes minimal essential coverage, that's what the term qualifying refers to. You can learn more about minimal essential coverage by searching for that term on HealthCare.gov, but you can think about it as coverage that is affordable according to Marketplace standards and meet certain quality requirements. This slide and the next goes through specific loss of coverage denials that are helpful when thinking about the SEP. So a good basic one is losing coverage through a job, most employers coverage qualifies as a loss of coverage through a job loss applies if someone is enrolled in employer-sponsored coverage and that coverage becomes unaffordable according to Marketplace standards, because it changes so it no longer meets certain qualifying standards.

Here are a couple other examples of coverage that is considered qualifying so this looks familiar to many of you, Medicare, Medicaid, and CHIP individual coverage though those are a couple of other examples of qualifying coverage. This slide covers scenarios in which some consumers would not qualify for this SEP and this is helpful. This addresses points of confusion that have come up so this is a good one to be aware of. If a consumer voluntary ends coverage or if coverage ends because someone did not pay premiums that does not qualify as a loss of coverage. This applies, as I mentioned before, if the coverage is not qualifying and not essential coverage or if the consumer lost coverage more than 60 days ago and that is a general reference for that 60 day SEP window.

This covers the dates when coverage takes effect for the SEP, so when coverage begins. One thing to keep in mind about this SEP, is consumers can report future loss of coverage in addition to losing coverage in the past so this slide addresses both of those situations. And as you can see in contrast with regular effective dates, your coverage start depends on when you sign-up. Consumers can sign up to enroll in coverage any time during the month and that coverage is effective the following month even if they sign-up during the second half of the month for this particular SEP.

This next slide provides a short example of somebody who loses coverage, because she decides to leave her job and start her own business. In this example, and so scenario one and scenario two, illustrates different times when coverage would begin based on when she decides to enroll within that 60 day window. Then the slide also illustrates it's important to keep in mind about this SEP, which is while it does not apply if you voluntarily drop your coverage, if the consumer leaves his or her job voluntarily and as a result loses coverage than that does qualify as a loss of coverage. So that's something to keep in mind. I won't walk through this in detail because we are limited in time, but the slides are available in the newsletter in the future you can go through them in more detail then.

The second scenario remembering back to the slide when we talked about six scenarios this is the second is the change in household size, so the coverage you can get by getting married or having a baby adopting a child or losing a child or having a child due to foster care placement or becoming dependent through a court order. Coverage effective dates for this type of SEP as you see in this slide are actually retroactive back to the day of the event. So for example, if a child is born on May 5 and the new parent comes in and reports that were on May 25 that parent and family can get coverage that begins May 5 which is the day the child was born. If you are helping someone who has a SEP like this is that her birth adoption or foster care placement at the consumer prefers to have coverage begin based on regular coverage effective date to the following month instead of retroactive to the date of the event they can call the Marketplace call center and request that. That is something to be aware of and in the case of gaining an independent through court order. Consumers can call the Marketplace and request regular

coverage effective date if they prefer not to have coverage retroactive to the day of the event so something to be aware of in case some prefer it. Then marriage, so you see in the first row takes effect the first day of the following month after plan selection so like when somebody loses coverage and can have coverage take effect the first of the following month no matter when during the month they select the plan this applies to the marriage SEP as well.

Here is a scenario illustrating a couple of consumers who have gotten married, one has already enrolled in coverage and they both get a SEP and enroll in coverage together so I won't go through that too much detail.

The third scenario is a change of primary place of living. So generally, we can think of this as applying when a consumer moves and when the consumer gains access to new Marketplace plans, because of that move and so below are a couple details about what a move might look like .So somebody moves to a new home in a new country or County or if somebody moves to the US from a foreign country etc. There are a couple other examples if someone is moving to or from a shelter or other transitional housing and situations like that.

Here we have an example of somebody who changes his primary place of living and gets coverage. I am going to switch this so you can see when coverage takes effect that follows regular coverage effective dates like we talked about at the beginning. So this could be an easy one to remember, because coverage begins based on when the consumer enrolls in the plan.

We will talk briefly today about a change to the SEP that begins in July 2016. This will take effect on July 11, 2016 and at that point folks who qualify for the move SEP due to a change in their primary place of living, will be required to have had at least one day of coverage in the 60 days prior to their move in order to qualify for this SEP. So this is an important thing to be aware of you will see more about this in the future newsletter, but something to be aware of now that this will begin in July. An important exception is that this will not affect eligibility for coverage through the permanent move SEP for folks moving outside of the US or for folks who are moving, because they are leaving incarceration. This new rule carved out exceptions for those individuals, because they by definition will not have prior coverage.

I won’t go over this in too much detail, but it's a helpful reference for thinking through and how it takes effect in keeping in mind it will not keep folks from getting coverage who did not have prior coverage, because they moved from outside the country or because they were released from incarceration or in cases where somebody moved from a non-Medicaid expansion state to a Medicaid expansion state. Good to keep in mind and you can use that graphic as a reference.

Moving on to the fourth category of situations when consumers might qualify for a SEP is a change in eligibility for coverage or for help paying for coverage. So there are a couple different scenarios that fall into this category and I think it is helpful to think of them. They are included in the slides of this is the first slide. For some of these, the consumer will need to have already been enrolled in coverage so that is the first bullet point here, someone is already enrolled in coverage and then his or her eligibility for help paying for coverage changes or they become ineligible for help paying for coverage or their eligibility changes for out-of-pocket cost. In those situations, the consumer would need to have been enrolled in a Marketplace plan. A couple other scenarios we talked about before of being newly released from incarceration or applies to somebody who is an American Indian or Alaska Native. These folks can actually enroll in plans once a month so they have a consistent SEP. These next two involved folks that become newly eligible for Marketplace coverage, because they gain lawfully presents status and

become a US citizen so their eligibility to enroll in coverage through the Marketplace. This last point covers what is referred to as coming out of the Medicaid gap so this situation applies if somebody was previously not eligible for assistance paying for coverage, because they were not eligible for Medicaid because they lived in a non-expansion state and they have an income change that makes them eligible for APTC. This slide addresses the dates when coverage starts based on plan selection. You can see these SEPs follow regular coverage effective dates so it's good those are simple, because there are a lot of scenarios. And then the note on the bottom is a reminder that folks who are American Indian or Alaska Native can sign up or change plans once per month throughout the year.

Moving on to our fifth scenario. This is a situation in which consumers can qualify for special enrollment because they experience an enrollment or plan error and there are a couple different types of this as well. So the first one covers situations where a consumer was not enrolled in a plan or was enrolled in a wrong plan, because of misinformation or misrepresentation and so forth by the Marketplace entity or someone affiliated with the Marketplace like a certified assister or H&R broker insurance company representative or Marketplace call center representative and so on and then this is category includes technical errors or when incorrect data is displayed. It's important to keep in mind this SEP does not apply to consumers who experience a change in benefit. So for example, if somebody has drug formulary changes or their primary care changes during the year that does not qualify as wrong plan data.

This slide illustrates when coverage takes effect or these SEP usually these follow regular coverage effective dates, but in some cases folks that qualify for them can actually get coverage that goes back to the date when they would've had coverage of the error had not occurred so that might vary based on the situation.

Finally we will move on to our sixth category, other qualifying changes and so this includes a couple of different situations. The last one on the slide is one that we often think about under the category the exceptional circumstance situation and this is the consumer experiences an exceptional circumstance like the incapacitated or victim of a natural disaster and that circumstance keeps the consumer from enrolling in coverage in a timely manner so that one that folks often think about. Another is the first point on the slide which is when a consumer applies for Medicaid or CHIP during open enrollment but then after open enrollment ends the agency determines that the consumer was not eligible for Medicaid and open enrollment has passed and those folks can get in SEP to enroll in coverage and there is a question that applies to that on the application. This category includes folks who were survivors of the domestic abuse or some abandonment as well service members beginning or ending their service. Coverage effective dates for this type will vary based on the situation so it will depend on which particular scenario the consumer you are working with experiences.

The second to the last slide illustrates a couple of different situations that do not trigger SEP and these are based on commonly asked questions we have had. So you can see a couple examples include voluntarily dropping coverage, you would not qualify for loss of qualifying coverage SEP in that situation. Another one we talked about that I think is helpful is if someone changes from one legally present status to another and their eligibility for Marketplace coverage does not change. For example, if someone goes from being lawfully present in the US and was eligible for Marketplace coverage if that person becomes a citizen they don't necessarily qualify for a SEP, because the eligibility for Marketplace coverage has not changed. Another one is permanent folks who are moving solely for medical treatment or on vacation would not qualify for the permanent move SEP. And a good one to keep in mind is that divorce or death

of a family member does not necessarily qualified them for a SEP unless it is associated with the loss of coverage.

With that we will finish up on our final slide is a review of those six situations. As well as a link to that fact sheet that will help you review and remember some of the things we talked about today.

The Issuer Rate Review Process

Thank you Carolyn, I know there are a lot of questions you guys have been submitting so please continue to submit. We will hold our questions until the end. Our next presentation we are joined by Lisa Cuozzo from the rate review division of the oversight group here at CCIIO for an overview and update of issue rate review processes and pleas keep submitting questions.

Good afternoon everyone thank you. I'm Lisa I am with the Rate Review team as was said in part of the Oversight Group of CCIIO. I will give you a quick run through of rate review and like the previous presenters we would be happy in rate review to answer questions you have afterwards if you could just relay those through the webinar or otherwise to the consumer support group. The purpose of the presentation is a high-level overview so you can help consumers who want to have some input into the rate approval process. So the slide I look at here is telling you there are three main parts to the Rate Review Division which is my division. There is a communications team and that staff communicates with states because states except for the four direct enforcement states they are responsible for reviewing their own issuer rates submitted to them so CCIIO does not have the responsibility of reviewing the rates for reasonableness except in four states and we will talk about that in a second. There is a grants team and those were provided to states for enhancing their rate review process just like any other grants provided to states when the exchanges began. An analytics team that looks at the data we receive, because even in those states in which we are not the primary reviewer or enforcer we still get the information that is given to the state so we can look at that data and analyze it and see trends in rates and so forth and that's what the team does. My role is the policy person so I write all of the regulations and guidance for the team and we have an individual who is an actuary and so he is the one that really understands trends and claims and experience in all of that stuff that goes into the actual rating the issuers do.

So the purpose of rate review nowadays is to improve the issuer's accountability and transparency. Before the ACA rate review was done in most states that the insurance department, but it was related issuer submitting the rate and in most cases the department would look at it and may or may not have had state standards whether or not they could go back to the issuer and ask for a change. It was really a state-by-state thing as to the level of accountability and the transparency was not nearly as much as we have now. The Secretary monitors premium increases inside and outside of the Marketplaces that was our analytics team that does that. We ensure compliance with Federal rating rules there are certain rules that govern for what factors and issuer can and cannot rate so for example you can no longer rate based on gender, based on health status those kind of things that you can charge more for a tobacco user and so that is where that comes into play.

Who must submit a rate filing? All issuers who have single risk plans which are most of those I won't go into risk tools, because it's confusing that most individuals in the market whether they offer to QHP's non QHPs only so whether they are inside the Marketplace or outside or both. All those issuers in the individual and small group market have to submit a rate filing. Small groups may choose to submit quarterly instead of annually but they must submit. The deadlines vary by state which we will get into in

a second. What is submitted? It depends on the amount of the increase what we go by for the amount of the increase that decides what has to be submitted this really the increase of the plan level so there is a product which might be an HMO or PPO and then there is a plan and the plan has certain networks has certain cost sharing associated. The plan is a more specific level than the overarching product and if the plan itself has a rate increase of 10% or more than the entire product and all of the plans within that product are subject to review so for the product then even though the reviewed trigger at the plan level because there is a plan even just one plan that has an increase of 10% or more all of the plans in the product then are reviewed and there are three parts a unified rate review template which is a form that issuers fill out in HIOS and it is a lot of numbers and that is the template. There is a written description justifying the increase this is only for increases of 10% or greater and that is the difference with the 10% which we will see in a second. A rate filing documentation which we call an actuary memorandum. So the parts of the rate filing justification tells you what is on the template its historical claims experience, projected trends related to utilization claims assumptions based on benefit changes of their benefits in the plan change from year to year. Per enrollee per month allocation of premium and a three-year history of increases for the product. That's what goes on the template it's mostly all numbers. Then you have the written justification which again is only required if there is a plan in the product that is 10% or more. This is a simple narrative that describes the data and assumptions used when developing the rate increase so this is simple and brief narratives. This is what the issuer gives us or the state that should be written for the consumers. This has an explanation of the most significant factors causing the rate increase and a brief description of the overall experience of the policy so that is really the part that is the most important thing for 10% are over. That may have an actuarial memorandum that contain the actuarial reason and assumptions supporting the numbers in the template. When we look at these three or two pieces depending on the 10% or more when we look at re-filings with those pieces of information we are looking at whether or not it's unreasonable if the increase is unreasonable as defined in our federal regulations and unreasonable means it’s excessive unjustified discriminative or otherwise unreasonable. This is the main point I think when you talk to your consumers because of course, as any of us would consumers are going to look at a rate increase of something above 10% and say that’s unreasonable why are you charging me more than 10 or 20% more than you did that's is such a jump. Even though subjectively it might seem unreasonable to charge so much more and it is not going to be deemed unreasonable unless it meets the federal definition. I have them here on the slide you will see them one slides are available I won't go through them with you but it has to meet the definition of unreasonable.

CMS as I said adopts the state determination of reasonableness for most state 46 states and the District of Columbia have an effective rate review program. CMS reviews the rate filings for the other four States and those would include Texas, Oklahoma, Wyoming and Missouri. So CMS looks at reasonableness for the rate filings for Texas, Oklahoma, Wyoming and Missouri and all other States and DC we adopt a State determination of whether or not the increase is reasonable or not.

As far as the input your consumers can provide when the state or CMS is determining reasonableness of the increase regulations require the rate filing information must be posted and I have a slide here that shows you an effective rate review state again all but those four must post a proposed filing if there is an increase subject to review 10% or greater and must have a mechanism to receive public comments. States can post it on their own website or post on CMS website. CMS also post the information for all proposed filings and we get the information from the state for all but those four. So consumers can go to the website RateReview.HealthCare.gov and they can see and pull up their state and see the proposed filing in the proposed increase and then although the mechanism and process differs from state to state there must be some kind of mechanism for the public to submit comments on the rate

increase so I would encourage you if you have consumers who are complaining about their rates to go ahead and have them look and have them at www.RateReview.HealthCare.gov so they can find out what the processes in their state to have input. That is the proposed filing and then the final filings with increases also get posted and that information will be posted November 1.

There is a difference between the proposed and the final because if through the rate review process it is found the proposed rate increase is unreasonable then CMS or the State can go back and forth and talk to the issuer about the reasonableness of the filing and that issue or may or may not make changes to reduce the amount so it does become reasonable if it was not to begin with.

My last slide is resources so you can see where regulations are, there is a consumer rate review fact sheet on the website and I have linked there and also a key dates table on the website that tells you when proposed filings and final filings are due. The State they are an effective rate review State which is all but those four I mentioned the State chooses their own date for when their proposed filings are due as well as it's a date no later than July 15 so that the other tricky part if you go on that website do not see the proposed rate increases for a particular State that State probably has determined there is a deadline that is closer to July 15 so it is a State-by-State deadline. Usually imposed by the insurance department in the State. That is what I had for now and again we are happy to take questions. We really would in the rate review division welcome any feedback from you as to what we could do to help get the word out there to consumers about what deems a rate increase reasonable or unreasonable and how they can be involved in the process and how they can submit comments to their State when they see a proposed increase and they want to take action or submit their thoughts.

Q&A

Thanks so much Lisa. I know we have a lot of questions so we will jump back to some of our SEP questions and then we will do a couple of rate review questions. First we are joined by Rachel and Carolyn to help answer questions.

First someone is having a problem trying to obtain a SEP for someone who lost health insurance along with their job the client got a SEP but was told they did not qualify for APTC they had insurance through their work on May 20 of the client entered the information they would lose insurance on June 1 do you have any advice or guidance for this problem?

This is Rachel. I think an important thing to keep in mind it sounds like in this scenario that the consumer is interested in taking advantage of advanced availability of the loss of minimum essential coverage special enrollment period. So when doing this the consumer should fill out the application according to the coverage status when it will be when he or she needs new Marketplace coverage and there are actually in the application in parentheses alongside the questions that ask about other coverage you will see some helpful guiding text that says don't check the box if the coverage ends before and it will give a date so even though the consumer still has his or her employer sponsored coverage at the time they are reporting a future loss of coverage the consumer should fill out the application and not indicate that coverage because it is ending and will have ended prior to the Marketplace coverage taking effect. That will enable the consumer to receive eligibility determination for any APTCs or CSRs, advance payments of the tax credit or cost in reduction that they are eligible for.

Thank you our next is about the age 26 or maximum age to qualify for dependence. So an assister asks that a consumer she worked with lost her coverage she had through her father is coverage in February

and applied to the Marketplace on March 1 and based on her income the Marketplace said that she qualified for Medicaid or State program insurance however at the end of April she was notified she did not qualify for State insurance Medicaid, but when we called the Marketplace she was told again she was not eligible for a SEP. Could you go over that situation?

So the first part talks about maximum dependent age and this is going to be at least 26 and it varies by State. So the Affordable Care Act established the bar where they established a dependent age has to be at least 26 but some States have chosen to go above that. So it sounds like in this scenario this daughter has reached whatever the maximum dependent age is in her State and therefore has lost coverage under her parents plan. It sounds like she did the right thing she came in and applied for coverage and at that point was assessed potentially eligible for Medicaid and then later was determined from the State Medicaid agencies she was not in fact eligible. This is a qualifying event for a special enrollment. To come to the Marketplace for coverage. For consumers who come to the Marketplace due to a qualifying event which this daughter initially did she lost her minimum essential coverage and then are assessed but later determined ineligible for Medicaid or CHIP they can come to the Marketplace to get coverage and the best option to do this is to pick up an application that will be transferred back to the Marketplace from the state Medicaid or CHIP agency so when the daughter received an assessment for Medicaid eligibility her application information was transferred to the state and they will make the final eligibility determination that information will be transferred to the Marketplace in most states. The daughter will be notified when those applications have been received and she can pick it up and continue to enroll in coverage. Alternatively if she does not receive the application or is very anxious to enroll in coverage another pathway is to call the Marketplace call center and let those consumers know what has happened and she will be referred to caseworkers who process the case in enroll her in coverage and that coverage date is the first of the following month or an accelerated coverage date.

One question before we move on to rate review. Could you go over the SEP for change of living change place of living so someone has a permanent move within their coverage area does that qualify for a SEP?

So first the purpose of the permanent move is a special enrollment are that someone gains access to a new QHPs as a result of a permanent move her primary place of living. So those are the current parameters of the special enrollment. Important here are changes going into effect on July 11 and starting after that date and thereafter there is a new minimum essential coverage requirement for most people who qualify for the special enrollment period. The few exceptions are for those who are moving to the US from a broad or from a US territory, but for everyone else who comes through this special enrollment period and going attest to the permanent move question on the application there is a requirement that they had minimal essential coverage for one or more days in the past 60 days prior to the permanent move. So there was another related question about changes to the parameter of the coverage gap special enrollment. So the current special enrollment period are for those who are not in Medicaid expansion states and for previously ineligible for Medicaid due to their state not having expanded and ineligible for APTC due to the household below one hundred percent of the poverty level and they experience a change of income that makes them eligible for APTC. After July 11 those who are in a similar situation but have now moved to a Medicaid expansion state and are newly eligible for APTC will no longer be able to come through and qualify through the permanent move SEP because they did not previously have minimum essential coverage and they will qualify for the coverage gap so the pathway to coverage for these individuals differ slightly in that they will need to call the call center to qualify for this special enrollment period as opposed to attesting to the move question on the application but they will have pathway to coverage in the coverage effective date which follows a regular date rule the 15th of the month rule remains the same.

Thank you. We will turn it over to Lisa to ask a question about rate review. So Lisa is there a ceiling on how much an issue can increase their rates and similarly went do those rate increases get released from the insurance company?

Thank you. No there is no ceiling there is no limit on a rate increase again it has to be determined reasonable in most cases. There are some States in which even if the State said the increase was unreasonable the State does not have the authority to stop the increase in the issuer can still implement the increase in there are rules regarding that scenario where the issuer must put very obviously on its website that it is implementing an increase that was found deemed unreasonable but most of the time I don't know if that is ever happened actually but there is no limit. As far as when the issuer makes the information public again proposed rate increases must be submitted and made public no later than July 15 and then as far as a final increase goes that must be no later than November 1 and CMS takes all of the information from all of the States and we also publish all of the final rate in permission on November 1 prior to open enrollment is what it says in regulation but it is really November 1.

How effective is it for consumers to say premiums are unreasonable. Do you have advice for the type of information that is more helpful for example is it better for consumer to address a specific aspect of the filing that may be incorrect?

Yes definitely again like I said in no subject to it will seem unreasonable but I would encourage the assisters to check the regulations at 45 CFR 154 and you can see there on the slides when they are released what determines reasonability and it really has to be discriminatory unfairly discriminatory or excessive so although anecdotal stories are compelling I would say the best thing for the consumer to submit would be something that addresses whatever is in the filing which could be difficult because it is all trends assumptions and so forth but the anecdotal stories probably won't be that compelling. Before a hang up Michelle I would like to repeat the website is RateReview.HealthCare.gov.

Closing

Thank you so much. Thank you everyone for the questions you submitted I know there was a lot today we will follow-up with additional answers in our newsletter. A special thanks to the presenters Sarah, JA Carolyn, Rachel, and Lisa. Another reminder our next webinar is Friday, June 10 from 2:00pm to 3:30pm we will be joined by Out2Enroll and if you would like to sign up for the CMS Weekly Assister Newsletter listserv and webinar invitations, please send a request via the Assister Listserv inbox (ASSISTERLISTSERV@cms.hhs.gov) and write “Add to listserv” in the subject line and finally thank you for all of your hard work and have a wonderful rest of the week!