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Planning ahead for Open Enrollment: what's new for 2018

Mira Levinson: Hello everyone and welcome to today's ACE TA Center webinar. I'm Mira Levinson, the ACE TA Center's Project Director and the Senior Consultant here at JSI. Our goal here at the ACE TA Center is to help Ryan White Program recipients and sub-recipients support their clients, especially people of color, to navigate the healthcare environment through enrollment in health coverage and improved health literacy.

One of our responsibilities is to provide clear, understandable and actionable information, and help you implement successful strategies at your organizations. We often do a webinar focused on getting ready for open enrollment, but this year we're doing it a bit earlier so that you can get all the information and resources you need to plan ahead.

Before we get started here are a few technical details for those of you who are new to our webinars. First you are in listen only mode, but we encourage you to ask lots of questions using the chat box, and you can submit questions at any time during the call or right at the end. Our presenters, along with ACE TA Center staff, will take as many of your questions as we can at the end of today's session and if you think of a question after that that's fine too. You can always email questions to us at acetacenter@jsi.com. The easiest way to listen to our webinar is through your computer. If you can't hear very well you can check to make sure your computer audio is turned on. Then, if you still can't hear us, or if you experience a delay in sound at any point, you can try refreshing your screen. And finally, if needed, you can just mute your computer audio and call in using your telephone. The number is 888-299-7210 and you'll need a passcode which is 355711, and we've also put that information into the chat box.

So, we have three guest presenters on today's webinar. Amy Killelea is the Director of Health Systems Integration at the National Alliance of State and Territorial AIDS Directors, or NASTAD, and Amy leads NASTAD's health reform public and private insurance and healthcare financing efforts, including providing resources and technical assistance for state HIV programs and developing recommendations to inform state and federal policy.

Rachelle Brill is a Senior Policy Analyst at Community Catalyst, providing policy expertise to a project aimed at supporting enrollment assisters, which she will tell you all about during her presentation. She researches and analyzes enrollment issues and trends and synthesizes them to share with federal and state policy makers.

David Stewart is the Program Director for the Western Maryland Health Insurance Connector, and he's also a veteran enrollment assister. David's

program provides assistance to people in Western Maryland who have questions, or who want to shop for and enroll in health insurance through Maryland Health Connection, which serves as the Maryland health insurance marketplace.

So we have a full agenda today. First, Amy is going to provide an overview of some key elements of a Market Stabilization Rule from HHS. Amy's going to focus on issues related to premium payments and cost sharing that are most relevant to Ryan White service providers, including case managers and enrollment assisters.

Next, Rachelle will talk about some changes to Special Enrollment Periods, or SEPs, that are also part of the new Market Stabilization Rule. In particular, Rachelle will talk about some new documentation requirements, new limitations on when people can change plan metal levels using an SEP, and a couple of other changes in eligibility for some SEPs.

After that we'll hear from David about how he is already getting his team ready for open enrollment. He'll talk about what you can do each month between now and November 1st when open enrollment starts to make sure your staff are ready to make sure all eligible clients get the enrollment support they need.

Then Amy will return for a bit, after David presents, and she'll talk about some specific strategies for Ryan White providers, and then I'll share some ACE TA Center resources your program can use to implement some of the key strategies from today's call. After that, as always, we'll have time for questions and, again, you can submit your questions any time and we'll take them at the end.

So let's get started with a quick poll. We have a great turnout on today's webinar and it would be nice to know how many new people we have. We'll use polls throughout today's webinar to find out more about what you all are thinking, and also to make sure the information we're sharing is clear. So click,"Yes," if you've been on an ACE TA Center webinar before, and click, "No," if you have not, and let's take a look at what's coming in. Once you submit your answer you'll be able to see what the tally looks like as well. It looks like about 50:50, maybe just a little bit lower for people who have not been on one of our webinars before. So I'm really happy to see we have a bunch of new people, and I'm also really happy to have a good number of returning people. I think today's presentation will have plenty for everyone.

So let's begin with some updates on the Market Stabilization Rule. Amy, can you start us off?

Amy Killelea: Sure thing, yes. Thank you, Mira, and good afternoon everyone. It's a pleasure to be with you this afternoon. So as Mira said, I'm gonna cover some of the pieces that were included in a federal rule that came out this

spring, the Market Stabilization Rule, that will impact, some changes going into effect immediately and Rachelle will talk a little bit about those, and then I'll cover some of the changes that are going to be new for this upcoming open enrollment period and for the 2018 plan year.

So a fairly significant change which was included in this final rule is that the open enrollment period is shortened to a 45 day period. It will begin on November 1st of this year and it's going to end on December 15th. And just to underscore, this is a change from last year when enrollment started on November 1st but went all the way to the end of January, to January 31st. So this will be a shortened open enrollment period for folks and this change apples to both the Federally-facilitated marketplace states and to state-based marketbase states, though I will say the caveat there is that the state-based marketplaces who are not using the healthcare.gov platform are allowed to, at their option, extend the open enrollment period using a Special Enrollment Period as a transitional measure for this year, to sort of transition this new open enrollment window.

We are actually going to chat out. If you're sitting there saying I don't know what kind of marketplace my state is, there's actually several different iterations of what forms marketplaces can take, we're gonna chat out a link to a great Kaiser Family Foundation chart so you can see exactly what type of [inaudible 00:07:16] you're in. If you are in a state-based marketplace state, and you can look at the color coded map to determine that, it may make sense to check with your state and see if your state is going to avail itself of the option to extend the open enrollment period using an SEP. We have heard a few states are going that route, California, Massachusetts and Washington states, but we suspect other state-based marketplace states will go that route as well. And just, I know we have lots of veterans on the call, but just as a reminder, I'm talking about open enrollment for the individual market for the marketplaces. Medicaid enrollment is continuous throughout the year so folks can apply for Medicaid throughout the year.

So I want to move to talk a little bit about, you know, what does this change really mean for programs? How could it potentially affect your work on the ground, working with clients and consumers to enroll in coverage. You know, first off, the change means that all enrollees will have full-year coverage. This is a little bit different from years past when, because the open enrollment period was longer and actually spanned across two plan years, you could have someone that enrolled kinda at the tail end of the open enrollment period and their coverage didn't start until February 1 or even March 1. So this will really mean that folks will enroll by December 15th, the last date of open enrollment, for a January 1 coverage effective date which is the first day of the 2018 plan year.

The other thing to remember too is that this was a direction that open enrollment was going, certainly this is sooner than I think anyone anticipated, but it was always the anticipation that eventually the ACA

open enrollment period would align with the Medicare open enrollment period. So the timeline on that was sped up and that's going to go into effect for this coming open enrollment period. So this shortened open enrollment period really does heighten the need for a strong consumer outreach and enrollment sort of response and support for clients. Plan assessments, assessment for eligibility for premium and cost sharing, that's gonna be just as important and there's gonna be less time to do it, so we're gonna be talking a little bit more later about some concrete strategies for addressing that challenge.

So there are also a couple of Ryan White Program specific considerations with this shortened open enrollment period, and particularly for those Ryan White Programs that are actually purchasing insurance for clients, but I'll note that these considerations, I think, are important for enrollment staff to know as well. The first consideration is that yes, we're gonna have a shortened open enrollment period but, unfortunately, the plan information is not going to be available any earlier. So this alone does speed up the time in which programs need to do their plan evaluations and assessments, get the information out both to enrollment staff and clients about what plans Ryan White Programs, whether they're AIDS or deficient programs, or other Ryan White insurance purchasing programs will support. You know some Ryan White Programs, particularly state health departments, have relationships with state departments of insurance and they've been able to get plan information a little earlier. But I think the bottom line here is we're talking about a compressed time period for that plan assessment to take place. So we'll talk about some strategies to deal with that, but that's going to be a challenge.

The second point is just a reminder that plans are allowed to, and are encouraged, to accept a premium payment from the enrollee, or on behalf, from a third party on behalf of the enrollee, so a Ryan White Program insurance purchasing entity, up to 30 days from the date of enrollment and many require this payment on or before coverage begins. I just want to underscore this. This is not a new issue, it's been a perennial issue, particularly from these newly enrolling clients for whom the Ryan White insurance purchasing program has to make that initial binder payment to effectuate coverage. It's just a consideration for Ryan White Programs who are purchasing insurance for clients to think about, particularly in the compressed time frame where everything has to take place, to make sure you're checking with the plan on what their policy is in terms of the binder payment timeline.

So to move on to a second piece that is new in the Market Stabilization Rule, this provision changed the ACA's guaranteed issue requirement, so that's the requirement that health plans have to offer coverage to everyone, essentially. For this upcoming plan year, consumers who owe premiums for coverage that they had in the past 12 months may not be allowed to enroll in coverage in any product offered by that particular insurer to whom the client owes that past due premiums until those premiums are paid. That is something that is new and that is something

that could be a challenge for insurance purchasing programs, for clients, and for enrollment assisters working with clients.

So what does this mean? First of all this does not apply to products sold by other insurers, it's only products sold by the insurer to whom that individual, the client, owes the past due premiums. So it's a little bit of a limited universe. One obvious option here if you find out that a client has a significant past due premium for a particular insurer is to move to a different insurer. I want to state the obvious here and note that many of you are in states with only one or two insurers so this becomes a little bit more problematic, there's just not a whole lot of other insurers a consumer could go to. So I want to note that that's a challenging solution. I also want to note somethings about the policy just to keep in mind is that this is an option for insurers, insurers do not have to apply this policy and they could very well choose not to.

Another thing to note is that insurers might accept installment payments, or they can set a threshold of payments, so if there's a large past due amount they could say all right, we will only accept this x lower amount and then you're good to go. In terms of how to figure out what policy your insurer has, there is a requirement that insurers provide their policy on past due payments in written way so you could inquire to the insurer about what that specific policy is.

Now the tricky part, and many of you who are working with clients and starting to prepare for open enrollment may be thinking well how will I know? How will I know if a client has racked up past due premiums with a particular insurer? And this is a tough one. There's no pro active duty on the part of the insurer to notify clients that they've got a past due premium building up, and think it's safe to assume that it's likely that folks would find out about their past due premiums, if they didn't know already, at the point of enrollment. In the perfect world people would be aware because they would have been getting correspondence from the insurer to say you're late on your premiums, you're late on your premiums ... but we know that that's not always reality in terms of that information making it to either the client and then to the case manager and then to program staff. So I think one thing that's a bit worrisome is that in some cases you might not find out until that initial binder payment is made to a plan and then it's automatically applied to the past due premiums. So I think some, and we'll talk a little bit about some concrete steps there, but I want to get to the bottom line of how to address this.

There is no easy answer to this problem. I think it's gonna be a little bit challenging, but I would say the best, and most efficient way to try to get at if clients have past due premium amounts owed for particular insurers is to start conversations with clients about the possible existence of those past due premium amounts. That's probably gonna be the most effective way to really try to get ahead of that issue and troubleshoot before enrollment begins.

So we talked a little bit about some of the enrollment specific considerations, and now I want to talk a little bit about what's gonna be new about the plans that are offered. The last provision that I want to talk about in the Market Stabilization Rule is a provision that gives plans a bit more leeway to meet the Affordable Care Act's what's called their actuarial value standards. So, as folks may remember, those standards were really in place to ensure that plans were offering a specific level of generous benefit, with a specific level of consumer cost-sharing versus what the plan was gonna pay for services. So essentially what the rule does is allow insurers to sell slightly less generous plans with higher consumer cost sharing than they had been allowed to offer under previous rules. So you may run into a situation where you're seeing maybe the premiums are a little bit lower and the cost-sharing is a little bit higher in some plans. A couple of notes though, one is that these changes do not apply to the cost-sharing reduction silver level plans. So if you've got folks who are 100 to 250% of the Federal poverty level, they're eligible for cost-sharing reductions, they're in a cost-sharing reduction silver plan, those requirements for these plans don't change, they're the same as last year.

The other thing that I think is important is these are not expected to be huge shifts. It's not like we're getting rid of the actuarial value requirements altogether, it's just something to see and keep in mind 'cause we could see slightly higher cost-sharing and some plans.

The other thing that I would add, and this is important every year, but when we've got a year of kind of [inaudible 00:18:09] I think this is even more important, is that that plan assessment piece is gonna be real important, and looking at the coverage and costs, so obviously premiums and now we're gonna take a closer look at the out of pocket costs for plans, and I would also note that it's important to look at provider network as well. You know, this is always on our list of assessment facts to check off when we're looking at plans, but there was another small change in the Essential Community Provider standard in the Market Stabilization Rule that lowered that standard a bit. It's not something we're anticipating having a huge impact on provider availability in plan networks but, as always, provider network [inaudible 00:18:55] is something to watch and something to assess to ensure inclusion of the HIV and the Ryan White's providers.

So I'll just underscore, the bottom line is that even though we're going to have less time to do it, it's going to be incredibly important to assess which plans are providing the best coverage, close attention to the out of pocket costs, and then we'll tag on look at the provider networks as well.

Mira Levinson: Great, thanks Amy. I know we'll hear a little bit more from you later. But now, before we hear from Rachelle, let's do one more poll. So Amy talked about a bunch of things providers will need to pay attention to over the coming months, but let's think about which ones you can start working on right now. So we have a little list here in the poll. We have assessing

plans, out of pocket costs, checking on any past due premiums, explaining 2018 updates to colleagues, monitoring coverage of HIV providers, or maybe it's more than one of those. So I'm gonna give you a moment to read through these and figure out whether it's one of these top four, or whether it's one of those combination options.

It looks like lots of you have already responded and it looks like the majority of you have actually responded with the right answer. So the correct answer is b and c, and so that means for those of you that said yes you should check on past due premiums, and those of you who said yes you should explain 2018 updates to colleagues, those are definitely things you can get started on now. To make sure that clients past premiums have been paid, before we get anywhere near the beginning of open enrollment. For the other two, assessing out of pocket costs and monitoring coverage of HIV providers, those are things you'll need to do later once the plan options have been released.

So now I'm gonna turn it over to Rachelle to talk to us all about Special Enrollment Periods, and you all might want to get your pencils out to start taking some notes 'cause this is a little complicated, but we're gonna try our best to break it down for you.

Rachelle Brill: Thanks, Mira. Hi everyone. My name is Rachelle Brill and, like Amy, I'm also going to be speaking with you today about some of the enrollment policy changes happening at the federal level that will likely affect your work helping consumers enroll in coverage. As Mira mentioned though, the focus of my presentation is gonna be on the current and upcoming changes to the marketplace's Special Enrollment Periods.

So I'm gonna be presenting a lot of new content so I wanted to start with an agenda for today. First I'll be going over a new pre-enrollment Special Enrollment Period verification process, also known as SEPV, and then I'll move on to discuss other changes to Special Enrollment Periods including new restrictions on the ability to switch metal levels during an SEP, and then other restrictions on SEP eligibility.

Before jumping into my agenda though, let's back up a bit to go over Special Enrollment Periods. What is a Special Enrollment Period? As a reminder, while most individuals can only sign up for marketplace coverage during the marketplace's annual open enrollment period, Special Enrollment Periods, or SEPs are times outside of open enrollment in which individuals can enroll in the marketplace if they've experienced a certain qualifying life event such as having a child, losing their job, or losing their current health coverage.

So now that we've reviewed what Special Enrollment Periods are let's jump into the new pre-enrollment SEP verification process. What is it? The pre-enrollment SEP verification is a new process that requires certain consumers to submit documentation verifying their eligibility for certain types of SEPs before they're able to enroll in coverage. As I mentioned

earlier, the Department of Health ad Human Services, or HHS, is currently referring to this process as SEPV, or SEP V. This new process only applies to states that use the Federally-facilitated marketplace, though state-based marketplaces are strongly encouraged to adopt and implement it as well. It's also important to note that the pre-enrollment SEP verification process only applies to new marketplace enrollees, or anyone who currently isn't enrolled in the marketplace. It won't apply to individuals currently involved in the marketplace who become eligible for an SEP and then want to switch coverage through that SEP, but I will discuss some of the SEP changes that do affect current marketplace enrollees a little later in my presentation.

So which SEPs does this new pre-enrollment SEP verification process apply to? It doesn't apply to all SEPs at this time, but rather it's going to be gradually phased in. So in late June the new SEPV process was applied to two types of Special Enrollment Periods, loss of coverage and permanent move. Then starting in August, or next week, this process will apply to three more Special Enrollment Periods, the SEP for marriage, the SEP for gaining a dependent through adoption, placement in foster care, child support, or another court order, and then what's referred to the Medicaid or CHIP denial SEP which is an SEP for individuals who applied for Medicaid or CHIP during open enrollment or Special Enrollment Period, but then only received notice of their ineligibility after the enrollment period has closed. It's important to note that the SEPV process does not apply to the birth SEP at this time.

But let's now go over the timeline for the SEPV process. As has traditionally been the case, when someone experiences a loss of coverage or any other event that makes them eligible for an SEP, they'll have 60 days from the date of that event to enroll in the marketplace. Once they've selected a plan they'll then have 30 days to submit verifying documents to prove their eligibility for this SEP. Until they do so, their plan selection and enrollment into the plan will be put on hold until they submit their verifying documentation. But then once those documents are submitted, reviewed and approved by the marketplace, individuals will receive the traditional coverage effective date that they were supposed to receive based on the SEP that they're eligible for. They'll also receive notices from the marketplace about when to submit documents, what types of documents to submit, as well as notice that their enrollment will be put on hold until they complete the SEPV process. If individuals don't submit the documentation right away they'll also be receiving reminder notices, follow-up messages and phone calls from the marketplace throughout this process to make sure they successfully enroll.

So if you're assisting an individual through this new process it'll be important to let them know that enrolling successfully through a Special Enrollment Period will now require three things, to both select the plan within their 60 day SEP window, and submit verifying documents within 30 days of plan selection, both review and follow any notices from the marketplace regarding which documents to submit, when to submit them

by, and then third to pay their first month's premium by the due date once their verifying documents have been submitted and their enrollment is put into effect. If individuals don't do one of these three things they won't be successfully enrolled in coverage.

So let's now walk through a case study for this new pre-enrollment SEP verification process. We have our consumer, Jane, and she's currently uninsured because she lost her employer sponsored insurance on July 1st, and so she now wants to enroll in marketplace coverage. Since she lost coverage on July 1, she now has 60 days, or until September 1, to enroll in the marketplace through the loss of coverage SEP, and so she decides to pick a plan today, July 26th. Because Jane is both a new marketplace enrollee, she's not currently enrolled in coverage, and she wants to enroll through one of the SEPs that's subject to SEPV, Jane must now submit documents to verify her loss of coverage within 30 days of plan selection, or by August 26th, before her marketplace coverage can begin. However, if she submits documentation and it's approved by the marketplace, she'll receive her traditional coverage effective date under the loss of coverage SEP, so her effective date will be August 1st. So Jane knows she has until August 26th to submit documents now that she's selected her plan. She decides to send them in on August 15th. The marketplace reviews them and then lets her know on August 20th that her document was sufficient to prove that she lost coverage, and so her coverage will begin retroactively back to August 1st.

So I know that was a lot of information to give you right up front, so let's now take a poll question to test your knowledge of the new SEPV process. Going forward, what do new marketplace enrollees need to do to successfully enroll in coverage through the new SEPV process? Is it A, pick a plan within your 60 day SEP window, B, submit documentation within 30 days of plan selection, C, pay your first month's premium, or D, all of the above? And I'll give everyone a minute to answer.

Okay, great. It looks like most of you have weighed in and the vast majority picked the right answer which was all of the above. But going forward, there'll really be three things individuals will have to do and two of them they're required to do already, which is pick a plan within your 60 day SEP window and then make sure that you pay your first month's premium, but the new SEPV process adds this third requirement to submit documentation within 30 days of plan selection. So now, going forward, individuals will really need to do all three to be able to successfully enroll in an SEP. So good job everyone.

So we've now covered the first section of my presentation. Now let's turn to the other changes to Special Enrollment Periods, restrictions on the ability to change metal levels and then other SEP eligibility restrictions.

Before getting into the restrictions on changing metal levels though, let's review marketplace plan metal levels more generally. So as a reminder, marketplace plans are available at four different metal levels, bronze,

silver, gold, and platinum, with bronze plans having lower premiums, but also covering less out of pocket costs, and then platinum plans having higher premiums but covering more out of pocket costs, and so therefore they typically have lower deductibles and copay amounts. It's also important to remember that plans at any metal level qualify for advance premium tax credits on the marketplace, but only silver level plans qualify for both tax credits and cost sharing reductions.

Going forward, most current marketplace enrollees will not be able to switch metal levels during a Special Enrollment Period. They will only be able to switch plans within the metal level they've already chosen. There are a few exceptions to this rule though. For SEPs that the marketplace felt that the qualifying life event might have caused someone to be enrolled in the plan that they didn't want to be enrolled in, and so SEPs that aren't subject to this restriction are the SEP for survivors of domestic violence or spousal abandonment, the error or misrepresentation or misconduct SEP, and the exceptional circumstances SEP. In addition, individuals who are eligible for services from the Indian Health Service are exempt from this restriction. These restrictions on the ability to switch metal levels applies to all types of marketplaces, though state-based marketplaces are allowed to delay implementation until it's technologically feasible for them. This new restriction also applies to new enrollees who are being added to a current enrollee's application, such as someone who wants to add their spouse or newborn, but there's an important exception for a household that when adding an individual to their application changes their eligibility to a silver level plan. In that case, if adding someone makes the whole household eligible for a silver plan, the household is able to switch to a silver level plan.

So going forward, when helping consumers enroll, it will be critical to emphasize the importance of really thinking through the right metal level plan for them because if they, or their family, want to change metal levels later on they may not be able to.

All right, so we've now covered the first two parts of my presentation on pre-enrollment SEP verification and restrictions on metal levels, so let's turn to the last section and talk about other SEP eligibility restrictions. So there are three eligibility restrictions that I'm gonna go over and the first one is the one in bold on this slide, the prior coverage requirement. HHS has added this prior coverage requirement to the marriage and permanent move SEPs, which means that individuals will only be eligible for these SEPs if they can show that they had a coverage for at least one day in the 60 days prior to the move or marriage. This new requirement applies to all states, although again state-based marketplaces are permitted to delay implementation until it's technologically feasible. There are also two exceptions to this requirement. For individuals who were living outside the United States, or in the United States territory, for one or more days during the previous 60 days, and then the individuals who consider themselves American Indian or Alaskan Native. I also want to point out that if someone is new to the marketplace when they try to enroll

through either one of these SEPs they'll have to submit two types of documentation now, documentation that they had prior coverage for at least one day in the last 60 days, and then as well as documentation for their marriage of move under the pre-enrollment SEPV process.

The second new eligibility restriction is for applicants who have missed premium payments. So going forward, HHS is going to allow insurers to reject applications for the loss of coverage SEP if an individual has outstanding premiums due to their insurer. So in other words, a consumer might not be able to apply for coverage using the loss of coverage SEP unless, or until, their past due premiums are made up.

Then finally, for the remainder of 2017 and going forward, HHS is going to significantly limit the use of the exceptional circumstances SEP by changing it's definition. Currently, exceptional circumstances are defined as experiencing a serious medical condition or an unanticipated event that prevents someone from enrolling, such as an unexpected hospitalization, or a natural disaster. But instead, HHS is going to be implementing a truly exceptional standard and will require verifying documents to prove these exceptional circumstances where it's practicable, but we expect to be receiving more guidance about this change later from HHS.

So that concludes my portion of today's presentation on Federal enrollment policy changes, but the last thing I want to mention is just a resource that might be helpful to you going forward which is In the Loop. In the Loop is a joint project of Community Catalysts and the National Health Law Program. It's one of the projects that I work on in my role at Community Catalysts, and the description that I like to give about it is that it's a password protected private online community created for enrollment assisters and other enrollment stakeholders to share their experiences, ask questions, trade best practices and have a resource library at their fingertips. As of right now we have over 4800 members, or Loopers as we like to call them, from all 50 states and DC, and the community is specifically for non-profit enrollment assisters, so groups such as Navigators, Certified Application Counselors, and other enrollment specialists working at community health centers or other social service organizations. So if you're an enrollment assister, or someone else helping individuals enroll in coverage, please feel free to register at www.enrollmentloop.org. We recently started a partnership with NASTAD to bring ADAP coordinators and others onto In the Loop and so we would love to have more ADAP staff and other individuals involved in Ryan White on the site.

Mira Levinson: Thanks so much, Rachelle. So, everybody, it's great to know that there's this new relationship between In the Loop and the ADAP coordinators, and it's open now to ADAP coordinators and their staff.

So before we hear from David I want to do one more poll. Rachelle provided the answer to this one during her presentation, so heres the

question. Which of these Special Enrollment Periods now has a prior coverage requirement? So remember, the prior coverage requirement means that individuals must show that they had coverage for at least one day in the 60 days before this event in order to be eligible. So the options are change in income, permanent move, change in household size, loss of a job, and marriage, or it might be two of those. So take your time because this is a hard one, but we want to make sure that we're really communicating clearly and that you all are getting the information you need.

So it looks like lots of people are submitting responses. And I think we're gonna go ahead and, I'll go ahead and start reading through them. So it looks like there's a good number of you who are correct. The answer is B and E, permanent move and marriage. Individuals will only be eligible for these two SEPs, permanent move and marriage, if they can show that they had coverage for at least one day in the 60 days before their marriage or permanent move. So, all right. We made it through the SEPs. That was the hardest part.

Now, you may be wondering how you're going to explain all this to your clients. Well, we have just finished adding some of the most important points from Rachelle and Amy's presentations to our updated Special Enrollment Periods fact sheet for consumers and we'll chat out a link now. The changes that we've incorporated into the consumer resource are pretty basic, they're nowhere near as detailed as what we just went through, but updates include some guidance on the most common SEPs that now require verification. For example, we've added a new text box that says, "Getting married or moving? If this is your first time enrolling in a marketplace plan you may need to provide documents to verify your life event. The marketplace will contact you with instructions." And we've also added a text box letting consumers know that the marketplace may send a notice asking for documents to verify any application for a special circumstance SEP.

So now we're gonna have a little change of pace. For the rest of the webinar we're going to focus on strategies and resources to help you get ready for the changes we've just presented. First we'll hear from David, who's gonna talk about the strategies he's already implementing with his team at the Western Maryland Health Connector. We're really excited to have David join us today. He's gonna break things down into a manageable set of tasks that you can implement now and over the coming months.

David.

David Stewart: Thanks, Mira. I just want to let folks know that while I'm the Program Director now of Connect [inaudible 00:40:00], which is like a Navigator agency, I've been either a navigator or a certified application counselor since the beginning, and I've provided assistance from day one in a very rural area. Right now I'm in Maryland, but prior to this I was in

Pennsylvania and I actually enrolled people from Pennsylvania and West Virginia using the Federal marketplace. Next slide.

So basically plan now, right? The way I look at this is what can do before open enrollment. When I'm talking to my team we look at how we approach appointments, we look at ... we're literally picking apart the, we call it the flow, and we just pick it apart and we're looking for what's most important. We also realize that we want to maximize the amount of time that our staff can be available to people, and we have limited staff, so we're looking at our staffing pattens, and hours, and all that kind of stuff. Then the other thing that I'm gonna focus on is consumer expectations. We are the fact people, right? It's our job to make sure that we let the consumers know what they can expect from a factual basis. Next slide.

Then just, you know, Amy was talking about this earlier, it is really important. Now is the time to be out in your community, looking at the stakeholder organizations and agencies, community health centers, putting your message out there now. Shorter open enrollment period, things are changing, lining up those partnerships and referral sources now that will maximize your ability to get folks enrolled during open enrollment. Next.

Then I have a little special shout out for how to use a call center. Now I'm in a state-based marketplace but I loved healthcare.gov even though, you know ... I use it all the time and what I tell people is don't spend more than two minutes on a problem. If you're in there with a consumer, and particularly during the upcoming shorter time period, if you're doing more than two minutes you're spending too much time. If you don't have a, like I escalate internally because we're in a state-based marketplace and we have a little different process, but when you're in the Federal marketplace you escalate to healthcare.gov to the call center. I just never spend more than two minutes on a problem. I just want to keep re-emphasizing that. When you're on hold waiting for them to call, use that hold time to educate consumers. You can compare plans while you are on hold and then ... Really importantly is know in advance like if you're part of a team talk it out in your team, when do you want to escalate?

Now if you're an experienced person then you probably know exactly when you're going to escalate, but if you're new to the game I say talk with people and find out what are those important things? Like if you hit, for example, it doesn't pass, something happened like the social security number doesn't verify or identity doesn't verify, those kinds of ... anything that stops that application, a technical glitch, maybe, go right to the call center and often they will take you right over that hurdle and get you back on track. Next slide.

Then this is something that we're doing and we're actually making the phone calls now. We call them account tune ups. All those past due premiums that Amy was talking about, now's the time to call people and ask them, hey, have you been getting any notices from the marketplace?

Do you know your consumer ... do you know your password? Do you know your security questions? Do people actually have accounts that are active, right? Are they ready to do an income estimate? Now we're calling and we're offering people appointments in September, everybody wants October at the moment, but I would say if you ask people if they've received the notice from the marketplace, and ask them if they've understood it, because we heard this ... One of the number one things that I see, I'm an avid Looper, I'm on In the Loop, and one of the things that I see all the time is consumer did not respond to a notice and therefore they lose there tax credits, they lose their coverage, et cetera. Before open enrollment ask them about past due premiums, ask them if they received the notice, ask them if they've taken the actions requested.

We had this thing. In Maryland we're lucky. We're going to be able to see plans in October, that's what we're being told. So we're encouraging people to come in and shop. So if you're lucky enough to be in a state-based marketplace, and maybe you get to see the plans a little earlier, tell consumers to come in, pick their plan in October, and so all they have to do is come back in November ... Or at home on their own they can select the plan. The two most time consuming things from my experience is income estimates and picking a plan, and as much work as you can do before they get there like get them prepped to do an income estimate. If they're self employed it's a little more complicated than people who just get a regular paycheck. But consumers who know what they want ae much easier and faster to deal with than those who don't. Next slide.

We give folders to everybody, and I got this document that you're looking at, we call it the cover sheet. It allows you to record their passwords or security questions and answers, the name of their plan, if they get a tax credit, what their premium is, and we give them that and a folder along with all the other documents that come with an application. They take it with them, and then when they come back to see us they bring it back and they have it all organized. We also encourage them to put any notices they get in this folder, and I find it very helpful. I've given Mira a copy of this document so if anybody wants one they can edit it to suit their marketplace. In the Loop has several versions of this that you can download as well. Next slide.

So let's talk a little bit about that appointment flow. Our focus is on securing coverage given the shorter timeframe, so we're looking at what do we actually want to do in appointments? What takes the most time and, obviously, an enrollment is what's most important. So to get us there we're trying to triage as much as possible either by phone calls before hand, like these tune up, that account tune up thing is a triage measure. Then when people are actually walking in the doors, and when people schedule, we give them checklists. We make sure that we give them information so they know what to bring with them, and then when people actually arrive on site we're planning to make sure they're all asked a series of questions to make sure they're really ready to go into that appointment. Depending on your work environment there may be ...

When I was at the Community Health Center in Pennsylvania when I started this it was just me. There was nobody to ... so I had to ask these questions of them when they first walked in the door, but some folks may be lucky and have people that can actually sort of triage people as they come in. You may want to talk with front desk staff, et cetera, maybe just if they could hand them a little document they could look at before they come in.

Then, again, I want to emphasize you know if you're an experienced Navigator you probably have your quick problem solving resources already mapped out and you know exactly where to go and where not, but I find it's always very helpful to have a list handy so that can just look right at it and understand, know in advance, where I'm gonna go for what circumstance. Then the other thing is know when it's time to quit. In the past I think we're very dedicated so sometimes we try to fight that application through to the end and maybe it's not gonna happen. So just don't put a lot of time in trying to move the unmovable. Next slide.

Then we're changing how we schedule. We know consumers like evening and weekend appointments, and so it's very simple, we're just staggering. We're gonna have a group of employees that work Tuesday to Saturday, and some that work Monday to Friday, and we're gonna stagger start times as well. If you work in a, like when I was at the health center you might want to plan this around the schedule of when are patients coming in, 'cause community health centers often have weekend and evening hours so you might wanna, anywhere where patients are receiving care or if you're in a provider setting, I guess, you can tailor your schedule to match that. Next slide.

This is part of, it's another, for those who like spreadsheets as I do, I've also given this spreadsheet to Mira for folks who want it. You can change it and adapt it as you see fit. Basically, we're now working on our schedule. This is actually our schedule and it just allows you to put out the date, the location, I have three counties that I'm covering, and different locations where we'll be and start and end times. If we go to the next slide it just pops it out and it will show you that on 11/1 Washington County has 23 and a half hours of appointments scheduled, and if you look down at the different individuals, Allyson, she's scheduled for seven and a half hours that day. It's just a planning tool.

Off to the left, these are thing like I have limited, I have 40 hours of overtime that I can allocate, and so this just reminds me and when I'm looking at this little grid that's on the right hand side I can make sure that I'm not adding too many hours for Henry, or for Clarke. And then on the last, the staff on the regular hours, that's just four times eight, six times eight, seven times eight. That just gives me a sense of if I have eight employees working on a day I have 64 hours to fill. Again, if you want something like this, you're welcome to have it and change it. Next slide.

The last thing that we're gonna, and I just think that it's a little different this time around, we really want to keep consumers focused on what the facts are and the facts will be this. There will be insurance plans that people can purchase and we will understand those plans and we will be able to guide people through them. So I just say we should make sure that we're driving the bus in terms of the appointment, I actually meant to say that earlier.

One of the things that I know, it's easy when somebody's come to you four years in row, you want to ask about their kids and the one that went off to college, and, you know, I got to know many people in my community through this job, but this time around I have to be able to say to folks, you know what, maybe we do all that at another time, let's just get you enrolled. Let's just make sure that you've responded to all your notices, that you're good to go, that you have coverage secured for next year. So we call that driving the bus, and what we say to our Navigators is you've gotta be driving the bus. The consumers are more comfortable when they feel like you're confident, so I feel that we should be confident, calm, and just the facts. Avoid all the extraneous stuff that's happening around us right now, just the facts. And again, limit the amount of time that you spend on a problem. I know that it's really easy to get hung up on dukeing it out with a problem, but sometimes they're just not gonna happen.

Exceptional circumstances can and do happen all the time, and I'll just bring you back to if you're managing a program, just put some thought into how you escalate. If you have a team and you have an internal escalation process make sure that those resources are known to the case workers, the case managers, the Navigators, et cetera. If you're by yourself just have that ... I found it helpful to have it written down. Like whenever this happened I called the call center. So just let consumers know that we have less time to help them secure their coverage, so let's just set that up front with them, and be polite, answer all their questions. I have a Navigator who's amazing at it. He can take somebody from start to finish in 15 to 20 minutes, and people always leave very happy. He gets rave reviews, and I think part of the reason why people like him so much is he gets them out quicker. They don't have to agonize over this. It's very confusing for consumers and when you're sitting down with somebody who really understands it you feel good about it. So just putting that out there. Next slide.

And that's it. That's my contact information and, again, I'm on In the Loop, you can always catch up with me on In the Loop.

Mira Levinson: Thank you so much, David. So, again, for people who are interested in receiving that folder and the documents and so on, you're welcome to email me at the ACE TA Center. Our email address is acetacenter@jsi.com and just request a copy of David's resources and we'll send those to you.

We are so excited to have heard all of these concrete strategies from David, and now we'd like to take a moment to hear from you about which of these activities you are most interested in implementing within your own programs. So David talked about reviewing staffing, he talked about doing some account tune ups in September, he talked about where possible doing some shopping and getting ready in October. He shared his folders and cover sheets. He talked about reviewing work flow and procedures. So which of these are you all most interested in? Let's take a look at how people are responding.

All right, great. So lots of different responses coming in. One of the things that I'm noticing is that fewer people are talking about reviewing staffing. I will say this. Now is a good time to start thinking about reviewing staffing to make sure that you have enough people on deck to do all of the enrollment work, as well as all of the important case management work that you already are responsible for year round. So there may be opportunities for partnerships, there may be opportunities for doing some creative scheduling, and you may need to fine tune that down the road, but that's certainly something else that you all should be starting to think about as well.

So let's go on to the next slide and before we ask Amy to talk about some additional strategies for Ryan White providers, I want to share a few ACE TA Center resources that you can use to implement some of the strategies that David talked about. Last year we developed this pre-enrollment worksheet, and the worksheet is specifically designed to help clients prepare for open enrollment. It would ideally be completed by the client and their case manager during an account tune up session like the ones David suggested. There's space to write down the client's preferred providers, and the medications they need, where they like to go for care and how they prefer to get their medications. There's also space to document key information that will be needed for the application, and a space to write down key marketplace account details like username and a hint for their password. Don't write their actual password on the form, just a hint to help them remember. You can use the worksheet in a variety of ways as you help clients prepare for open enrollment, and also keep track of their application details here. You can even write down plan options for the client, and this is especially useful if the client is going to an outside enrollment assister and needs to bring a list of plans that have already been reviewed by your ADAP or another party.

So once the client has enrolled in a plan there's also a place to document information about the client's newly selected insurance plan. We're gonna chat out a link to you for that one right now.

A related resource is the Health Care Plan Selection Worksheet, and if you have more than one plan to choose from in your area you can use this to do side by side comparison. It can be used preparing for or during a client visit to help the client find the healthcare plan that best meets their needs for coverage, particularly with medications and providers, and

also looking at costs. Of course, many of you are in jurisdictions that are already doing plan assessments for people in general, and people living with HIV, but even then you may still want to help your individual clients compare plans to see which one is going to make the most sense for each of their needs.

Another key activity that you can work on early is to reach out to clients that are not yet enrolled in coverage but are eligible. Perhaps their life circumstances, age or income have made them newly eligible, or perhaps it's just that they're now ready to start talking with you about the idea of getting covered. So this resource is designed to walk case managers through a four stage process using some key strategies and resources. Step one is focused on how to determine whether a client is eligible for coverage. Step two is designed to help case managers engage eligible consumers in conversations about coverage, and steps three and four are focused on how to document and monitor all the important work that goes into engagement and enrollment. Step four also includes some same self affestation forms, so we'll chat a link out to that one now as well.

David also talked about making sure you have enough staff to do all the enrollment work, as well as all the other year round tasks that you need to get done, and some of you may be engaging with enrollment assisters outside of your HIV program to do that. These assisters are often really, really good at enrollment work, but they may need your help learning about what your clients need with regard to HIV medication coverage, preferred HIV providers, and the role of the Ryan White Program including ADAP and helping with costs. So to make sure your enrollment partners can truly support your clients' needs, we've developed a fact sheet and a video. First, this one page fact sheet covers eight key things that enrollment assisters need to know about working with people living with HIV, including the need to maintain continuous medication coverage, and to help clients find a plan that includes their medications and providers. The fact sheet also covers the role of the Ryan White Program including ADAP, in providing care and support to all consumers. So we have a page specifically for enrollment assisters where you can find both the fact sheet and the video, and it's targethiv.org/assisters. We're gonna chat that out to you now as well too.

So here's an image of the assister video which you can find on that same webpage, and it covers the same content as the fact sheet in less than three minutes. It's a nice, easy way to start the conversation with partner assister organizations as you think about training them on the needs of your clients. If you haven't watched it yet definitely take a couple of minutes to watch it after today's webinar.

So now let's hear from Amy again, this time with a few more strategies to help Ryan White Programs get ready for open enrollment. Amy.

Amy Killelea: Sure thing. Let's dive right in. I'm really just gonna talk about three additional strategies, really focused on Ryan White providers, and I think these are very much in line with what we heard from David earlier.

So the first one, I think, is likely that this is the most important one, and this is something that as we discussed can really start happening right now, and that's to start intentionally and thoughtfully preparing your enrollment workforce. We talked about the tune up appointments to update accounts. The only thing I would add is just to add that sometimes challenging but really important conversation about taxes to the mix. We found in years past that the tax conversation that folks are receiving and advance premium tax credit, they have to file their Federal taxes to go through reconciliation for that year in which they received the premium tax credit, and if they don't they may not be eligible for the premium tax credit going forward. So that's a conversations that really anyone working with clients, enrollment staff, should be having kind of earlier rather than later, 'cause this compressed open enrollment time period is just gonna make it harder to resolve those issues kinda at time, so that the most that we can do ahead of open enrollment, I think, the better.

Along the same lines of preparing the enrollment workforce, I think that because of the compressed time period we may need to be a little bit more creative when we think about our enrollment staff, our enrollment village. So I think tried and true partners have been navigators, certified application counselors, other assisters in the jurisdiction, reaching out sort of early, making sure they're aware of the Ryan White Program, including the role of ADAP or other Ryan White insurance purchasing programs. I think, you know, the other partner I would add to the mix that's perhaps not a traditional sort of Ryan White enrollment partner have been agents and brokers. That may be a partnership to consider in your jurisdiction. It may not work for every jurisdiction but agents and brokers are there, they are working to get folks enrolled in coverage, and they may be another partner to kind of bolster our enrollment workforce.

I would also add, and I think this has happened in years past, particularly in some of the beginning years when we saw a sort of swell of enrollment, that many programs, AIDS Drug Assistance Programs and other Ryan White entities have utilized sort of contractor, temporary workforce during open enrollment, particularly for larger jurisdictions where you're anticipating a whole lot of clients coming in. That's something to consider. And then we mentioned the Federal taxes. That is always going to be important. It is not too late to file Federal taxes for the 2016 tax year, and that's gonna be important to maintain access to those premium tax credits.

The other, or the second sort of strategy is really around plan assessment, and this is another one that I don't think we can emphasize enough, particularly for Ryan White Program providers who are doing insurance purchasing, this plan assessment is always important. It was important last year, it's important this year, but it's going to be harder with

a compressed open enrollment time period. So if we're anticipating really not getting all of that plan information in the majority of states, there'll be some exceptions so you can get the information earlier, up until November 1st, then we really need to think about having our ducks in a row to have that plan assessment ready to go as soon as the plan information is available. So some insurance purchasing programs are contracting with a third party to do that plan assessment once the plan information becomes available, so obviously that's a relationship that needs to start early so that third party understands the first stage of of the insurance requirements when it comes to Ryan White insurance purchasing and knows the program.

I think, as was true last year, but this year too because we are going to be in a bit of a chaotic healthcare environment, I think all plan options should be on the table. We've seen in recent years, because of some challenges in certain jurisdictions with access to marketplace plans, some AIDS assistance programs, other Ryan White Program purchasing entities have started looking at off marketplace individual market plans. That not gonna be an option everywhere, but that's another avenue to get at. How do we ensure that the most amount of people can have access to comprehensive insurance coverage? So that's another sort of element to think about for this coming year.

Sort of along the same lines of developing this strategy, for Ryan White Program case managers, and other enrollment staff the communication is just going to be really important, to be checking in with AIDS drug assistance program if you're in a state with an insurance purchasing program that covers marketplace or off marketplace plans, or other Ryan White insurance purchasing programs, to check in about okay, what are the plan options? After the assessment what has the ADAP or other Ryan White purchasing entity decided in terms of what's going to make most sense for clients and for cost effectiveness? Mira mentioned the plan assessment tool that the ACA Center has developed. I think that's an awesome tool, there is no need to recreate the wheel, and certainly for anyone out there from ADAP you are well familiar with NASTAD's ADAP specific plan assessment tools as well. I think this is gonna be a year when we have to kind of rely heavily on the work that has been done before, and on assessment resources that have worked.

I want to end with, and I really, I could not have said it any better than David, to just say that we should all remain confident, calm and just the facts. We should probably have that tattooed somewhere. I think that's important. Even right now I know that there are some grueling anxiety questions on behalf of clients who are worried about this coming open enrollment period, and as the front line staff who are communicating with clients it's really important to address those anxieties, to get out the facts of what is happening, what is not happening, and address those questions and concerns, again all in the end goal of making this open enrollment period as smooth as possible.

We've talked about starting ahead. I think we've identified some things that folks can be doing now. The only other thing I would throw on there is just to continue to monitor, for your own jurisdictions, what is coming out of your Department of Insurance and other enrollment partners. Your Department of Insurance in your state, that department is gonna play a large role in terms of managing any shifts in plan availability, for instance. So if you've got a lot of plans who are leaving the marketplace, or you've got plans who are coming in, you're anticipating client transition on and off new plans, the Department of Insurance will have helpful resources. They are really there to make sure that consumers are protected. So that's another resource to follow to make sure that you have all the facts that you need.

Mira Levinson: All right. Thank you, Amy. These are great strategies. So now, before we go to questions, let me briefly remind everyone about a few additional ACE resources, and also let you know about our next webinar.

So this is our Stay Covered All Year Long consumer resource, and it's designed to help consumers understand what they can do to maintain their coverage like paying premiums on time, reporting income and household changes, and what to do if they lose coverage. A section on premiums provides clear, basic information including how often premiums need to be paid, and what to keep in mind if the Ryan White Program is paying the premiums. The premium section also goes over what happens if a payment is missed, and there's a section on consumers and what they should do in the case of coverage gaps or change in coverage.

We've also just added a new set of posters to our series of My Health Insurance Works for Me posters. The new set is called Stay Covered, and I would definitely encourage you to check those out whether or not you've seen our other posters. We're gonna chat out a link to our new set of posters right now. This series includes a variety of messages designed to help clients keep track of paperwork, particularly focused on making sure their premiums get paid, and staying in touch with the Ryan White Program, including ADAP and their case manager. Other groups of posters focus on messages to encourage enrollment as well as active plan renewals.

If you haven't seen our videos yet definitely check those out. You can show them in waiting rooms, during case management discussion, or even to promote discussion during group sessions. The videos focus on basic health insurance literacy concepts including what's covered by insurance, key insurance terms, where to go for different types of care, and hot tax credits work.

Finally, I want to tell you about our next webinar. It's called Basics of Health Coverage Enrollment Strategies and Resources for New Program Staff. It's designed for program and health department staff, including case managers that are new to the ACE TA Center. During the webinar we'll provide an overview of the unique health coverage needs and

concerns of people living with HIV, share strategies with participants on how to stay covered, how to answer clients' basic questions about enrolling in health coverage, and we'll present some practical strategies and tools to engage, enroll and retain Ryan White clients in health coverage. We'll also talk about how the Ryan White HIV/AIDS Program, including ADAP, complements health coverage and supports continuity of care.

We'll be sending an email about that webinar soon so that you'll be able to share it with colleagues. Just make sure that you're on our email list. I'll show you how to do that in a moment after the question and answer period. So we're also going to chat out a link to our webinars page and you can register right now for the August webinar if you want to. You'll also find more than 25 archived webinars there on a variety of other topics.

So there are lots of questions that have come in, and we're gonna start taking them now. You can go ahead and submit additional questions. If we don't have time to take them today then we will, in fact, try to get at them through a question and answer document which we will be posting soon. I also want to let you know, lots of you have asked whether you'll be able to get a copy of slides from today's webinar. We will be posting the slides, by the end of the week, to our webinars page and we'll also be posting an archived recording of the whole webinar that you can share with folks, so this is not the last time you can get access to this information.

So let's go ahead and get started. The first question is, many insurers are ignoring their requirement to accept third party payments from Ryan White agencies, and we end up having to fight with them over their non acceptance. Is there a way to report them?

My colleague from the ACE TA Center, Molly Tasso, is gonna take that one.

Molly Tasso: Great. Thanks, Mira. So in situations where insurance companies are not accepting third party payments they are in violation of existing regulations, and in these situations we encourage you to contact your individual state's office of the Insurance Commissioner. They can often contact the insurance company and direct them to become compliant in their acceptance of third party payments, and we've seen in the past that policies have changed after such conversations. We also encourage you to reach out to NASTAD and report these issues, 'cause they are also then communicating them with the Center for Consumer Information and Insurance Oversight at CMS.

Mira Levinson: Great. Thank you, Molly. So now we have a question about the Market Stabilization Rule. Someone has asked, you mentioned that the Market Stabilization Rule allows health insurers to collect past due premiums from individuals before they start covering that individual. The question is

can Ryan White HIV/AIDS Program recipients pay clients past due premiums in these instances?

Great. So yes, that's a great question. Based on a recent conversation with HERSA, they have stated that these unpaid past due premium bills can be covered. So the background information there is that Ryan White HIV/AIDS Program recipients that pay client health insurance premiums under ADAP, and also under the Health Insurance Premiums and Cost-Sharing Assistance Service Category can pay past due premiums for clients with just a couple of caveats. First, doing so must remain cost effective in the aggregate. Second, premiums must be for insurance that covers at least one drug in each class of core retro antiviral therapeutics, and that must also cover appropriate outpatient ambulatory health services. If you have more questions about that let us know, and you can also speak with your project officer for additional information.

There's another related question which is, in determining cost neutrality for the purchase of insurance for ADAP, if a client has very high costs related to past due premiums and this moves the aggregate expenses for ADAP to no longer being cost neutral, do we deny insurance coverage for the client? This assumes no other coverage is available to the client.

So, in a nutshell, that's really up to the ADAP to do that cost effectiveness assessment, and make that determination. Amy, do you have any other details you want to give on that question?

Amy Killelea: Yeah, I think that the point, your first point about ADAP doing that cost effectiveness assessment is important. They do that assessment proactively, so before providing information out to enrollment staff, case managers and clients about what plans ADAP is able to support. They do that assessment. That assessment has, I think the question sort of states it is an aggregate, so I think that's important. It's not case manager or enrollment staff who's making those decisions on the fly with clients. You'd have to have the information from ADAP or the other Ryan White Insurance Purchasing entity of what plans has the ADAP decided are cost effective for clients to enroll in. I think that this is a case that underscores the importance of that communication between case managers, enrollment staff, clients and ADAP.

Mira Levinson: Great. Thanks, Amy. All right, so now we have a question about the case study. Somebody's asking when Jane should pay her first premium. So Rachelle, do you want to give that one a try?

Rachelle Brill: Sure thing. So yeah, this is a great question. There are different Federal rules regarding when insurers can require that the first premium payment be due. It depends on when the consumer's applying. If they're applying during open enrollment, or a Special Enrollment Period, and then within that what their coverage effective dates are. So in Jane's case, because she's applying through the loss of coverage SEP, which has special, what are called special coverage effective dates, her insurer should be

required to require Jane's first premium payment to be due no earlier than 30 days after they receive the enrollment transaction. So in the case study example, the marketplace approved Jane for the loss of coverage SEP on August 20th. Theoretically, they could send that enrollment transaction to the insurer on that date, and if that's the case the insurer can require that Jane pay her first premium by September 20th, but no earlier.

I think what's important for everyone to know about payments through SEPV process is that when someone completes the process they'll receive a notice from the marketplace, letting them know that they've successfully completed it, and then reminding them to contact their insurer to pay their first premium as the last step to start coverage. So they'll receive notices reminding them to pay the premiums, but to check on when the exact due date will be, my best recommendation would be for them to contact their insurer.

Mira Levinson: Thanks, Rachelle. So I think we actually have another question for you, and that is what if the 30 day verification period extends beyond the 60 days to choose a plan?

Rachelle Brill: So if that happens that's totally fine. That won't prevent or stop the SEPV process from happening. What's important to remember is that the 30 day clock starts once someone has selected a plan, so if someone selects a plan on day 59, or day 60 of their Special Enrollment Period window, the 30 day clock starts from that point.

Some things to keep in mind though is that the longer someone takes to complete the SEPV process, even though their coverage effective date could be retroactive, they may experience some issues if they're trying to get care during that time period. The longer that time period goes on, the more they might have to deal with getting a retroactive claim reimbursed by their insurer which might be complicated. So while someone's totally able to let's say make the SEPV process 90 days, to sort of tack on the 30 to the 60, it just might cause complications down the road if they received a claim for services while they were waiting for their enrollment to be processed, and then want to get it processed from their insurer retroactively.

Mira Levinson: Great. Thanks, Rachelle. Can you also just speak briefly as to why somebody might become eligible for a silver plan through an SEP? Someone wanted clarification on that.

Rachelle Brill: Oh, sure. That's a great question. So someone could experience a change in eligibility, such as a change in income, or household size, that could move them into the silver level, or the range for cost-sharing reductions through a silver level plan. So let's say, yeah, someone gives birth, or a family member is removed from the household for whatever reason, a dependent gets married and so they're no longer in the tax

filer's household, that sort of change could change someones income eligibility, as well as just a change in income in general.

Mira Levinson: All right, thank you. All right, so we had a question asking, and a couple of people asked this one, does everybody have to select a new plan in 2018 even if they're happy with the plan they have now? And the answer is yes. Everyone should look at plans for 2018. Everyone should compare plans for 2018. What we always say is that plans change and people change. This means that plans themselves can change over time, for example, in terms of medication costs and coverage, and which providers are in networks and, of course, people's health needs change too, including what medications they need and what else they need covered by the plan. So it's important to look at what's out there to make sure the individual is enrolling in the best plan for their needs.

In addition, sometimes plans are not available the next year, and in that case the insurer will automatically enroll and individual in a plan that they consider equivalent, but it may not be what the consumer needs. That's why we encourage active enrollment or plan comparisons, where people look at plans every year. We'll talk quite a bit more about that on our next webinar on August 23rd and we'll share some resources you can use to encourage consumers to actively compare plan options.

So Rachelle, we have another one for you regarding an example you gave. You used the example of someone applying for coverage in late July with a policy effective date backdated to August 1st. So I'm wondering if you could just talk a little bit about that in terms of the effectuated cover date?

Rachelle Brill: Oh, sure. Yeah, this is another great question. So some Special Enrollment Periods have what are called regular coverage effective dates, which are the coverage effective dates that were included in the question, which is someone who enrolls between the 1st and the 15th of a given month should start coverage the first day of the following month, but if they enroll through 16th through the last day of the month, their coverage will start the first day of the second month following enrollment. Those are what are called regular coverage effective dates, and SEPs, such as the permanent move SEP, follow regular coverage effective dates, but other SEPs don't. They have what are called special coverage effective dates which really means just any other coverage effective dates besides the regular ones, but for the loss of coverage SEP in particular, if someone enrolls after they've lost coverage their coverage effective date is the first day of the month following plan selection.

So in the example of Jane, because she enrolled after she lost coverage on July 26th, her coverage effective date is then the first day of the month following the date she selected her plan, so July 26th, so she has an August 1st coverage effective date.

Mira Levinson: Okay, great. We have time for a few more questions, and I can see that there are a few more questions that have come in that we have time for, but like I said don't worry we will take a look at your questions and we'll get them answered for you and we'll send out an email as soon as the questions and answers are all set. So let's just take a couple more quick questions, maybe one or two, and then we will deal with the rest of them over the next week or two.

We had one question for Amy. Can you provide examples on what types of third parties can conduct plan assessments?

Amy Killelea: Sure thing. I think some of the examples that we've seen have been a community based organization, for instance, that's worked hand in hand with the AIDS Drug Assistance Program to do those plan assessments. That's played out in a couple of different states. I know at least one jurisdiction, I think this is less common, but at least one jurisdiction has used a broker to do that plan assessment piece. So those are the two examples. I would say in the vast majority of cases though, and I'll speak for AIDS Drug Assistance Programs here, that when the AIDS Drug Assistance Program is doing the purchasing they are also themselves, in house, doing the plan assessment. That's the most common kind of route.

Mira Levinson: Okay. And one last question that we'll take for today before we wrap up and get to having people complete that evaluation form, and that is, again, for Amy. What are some situations where people might want to consider off marketplace plans? And is there any relationship there in terms of eligibility for premium tax credits?

Amy Killelea: That's a really good question, and I'll answer the first part first, or the last part first. The off marketplace plans, one downside of going off marketplace is that enrollees, clients, wouldn't be eligible for either the premium tax credits or the cost-sharing reductions. Now, that said, in recent years, and this wasn't the case from the get go, but in more recent years as some plan availability issues has emerged in some jurisdictions ADAPs have gone that route for a couple of different reasons. One is that the plan in marketplace that folks were enrolled in left the marketplace but still continued to have an off marketplace presence. Off marketplace plans are still ACA compliant, so yeah, you're not getting that financial assistance but in a lot of jurisdictions the plan coverage is the same as an on marketplace plan. So that is the biggest reason, sort of the plan availability and just wanted to expand the universe in terms of plan options, and I suspect that we'll see that going forward too.

Mira Levinson: Great, okay. So thanks everyone for all the great questions, and special thanks to today's amazing presenters, Amy, Rachelle and David. As I mentioned, we'll post a summary of today's questions on our webinar page as soon as we can and we'll let you know when that's ready.

So before we close, I'll just remind you to keep your webinar window open to complete the evaluation when it pops up and to sign up for our mailing

list if you haven't already. If you have more questions after the session ends you can just email us at acetacenter@jsi.com.

Thanks everyone, and have a great afternoon. Goodbye.