# Virtual Cover Montana Summit

Beyond the Basics

Center on Budget and Policy Priorities

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Center on Budget and Policy Priorities

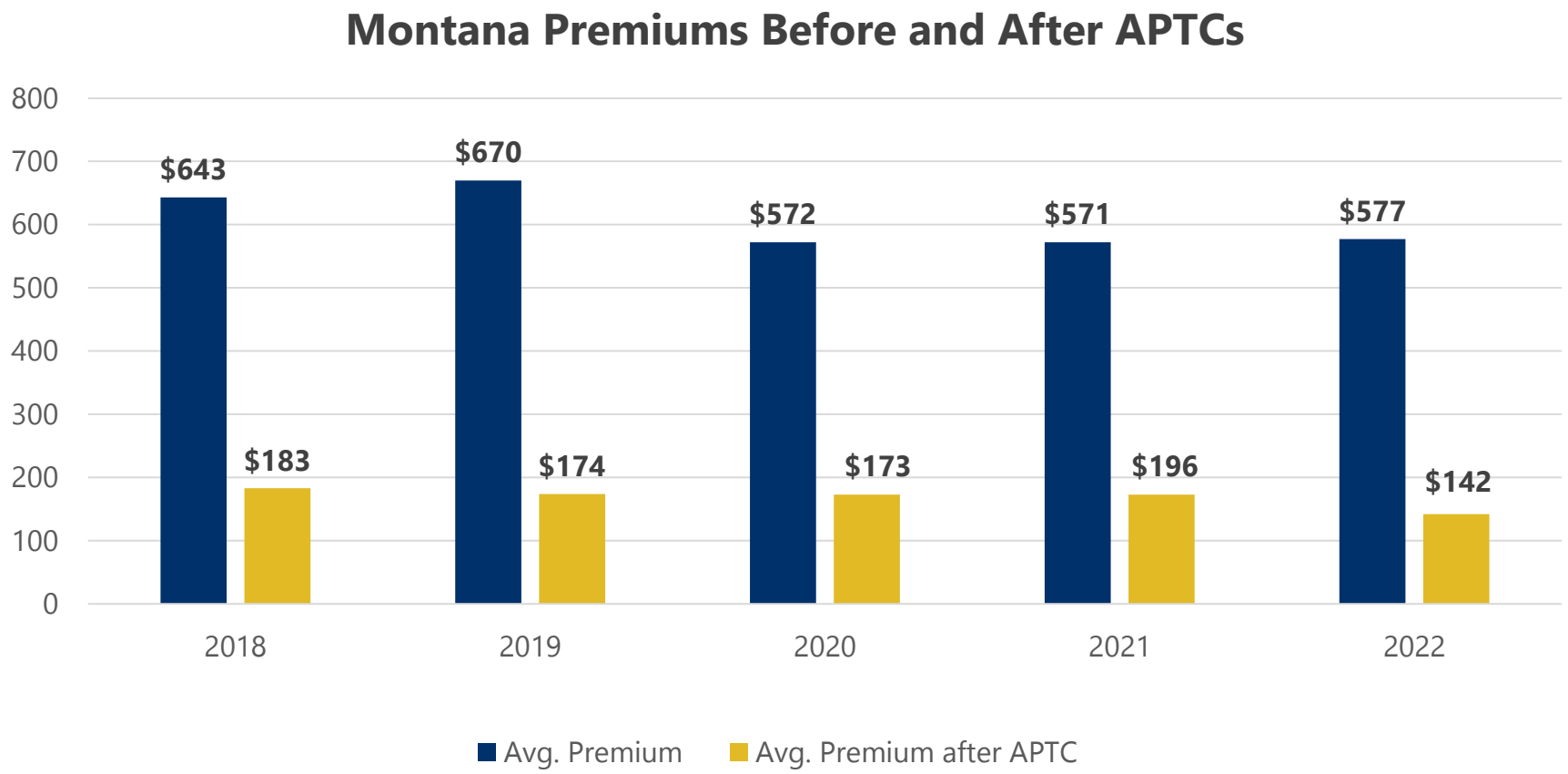
October 12, 2022

# Agenda

I. Looking Back: Lessons from OE9
II. New Federal Policy Developments
III. Preparing for OE10
IV. Q&A

# Looking Back: Lessons from OE9

# Lower Premiums




- Average annual premium after APTC = $648 lower in 2022 than in 2021
- Nearly 1/3 of all marketplace enrollees in MT had a premium <$10 (after APTC)

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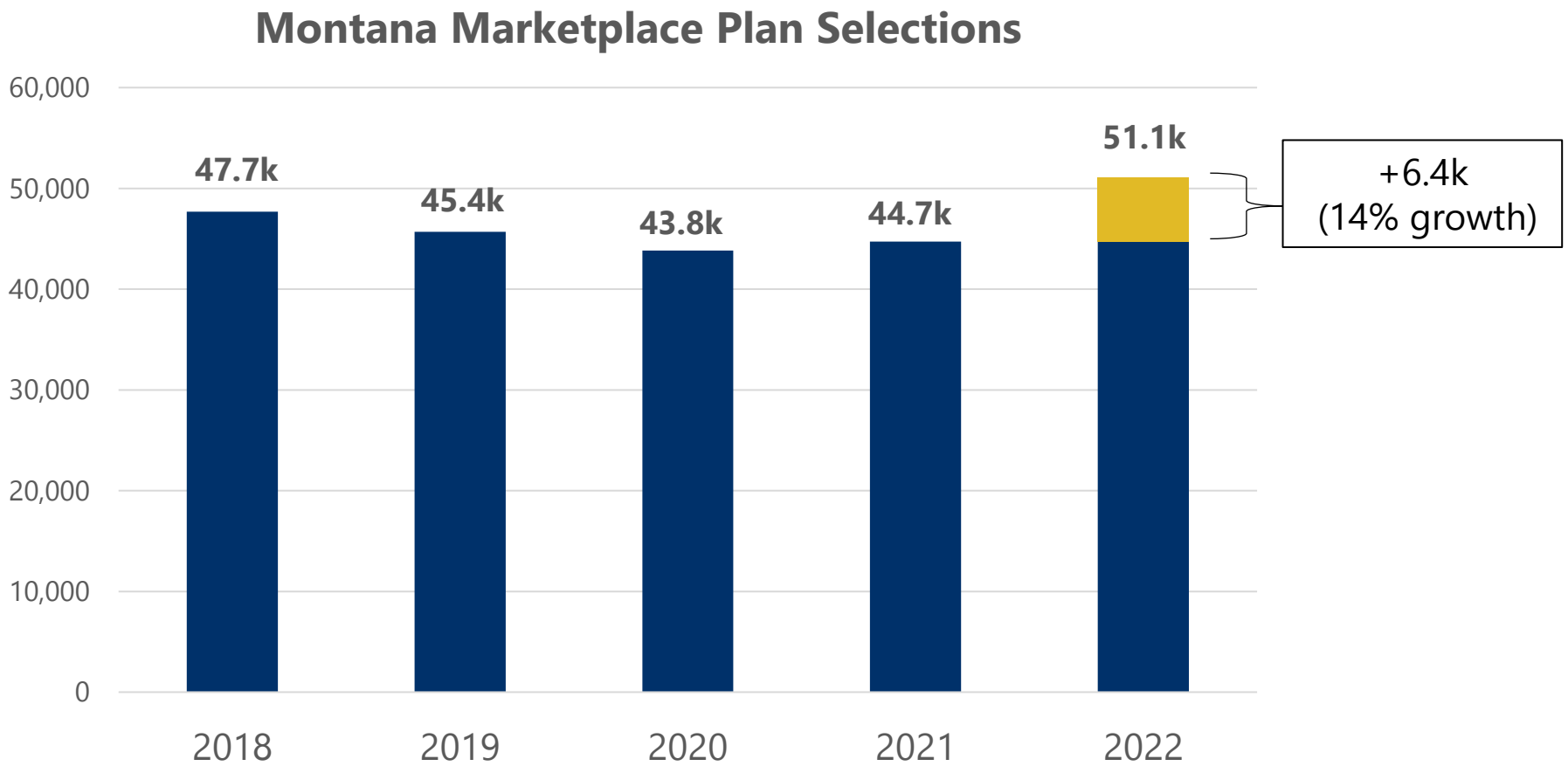
# Higher Enrollment

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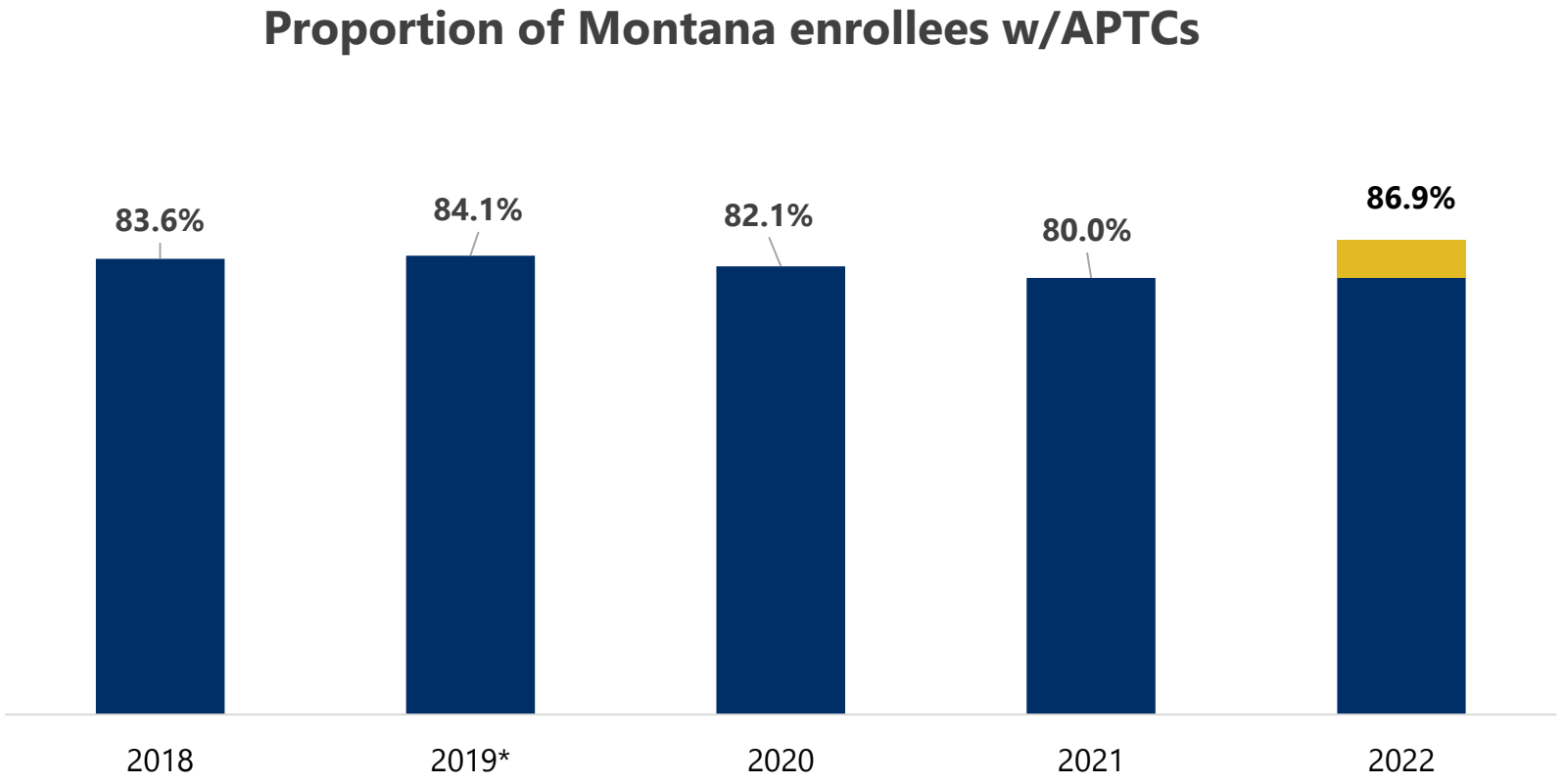
# More People with Financial Help




- Higher proportion of enrollees receiving APTCs in 2022 than prior years
- 8,619 more people getting APTCs in 2022 than in 2021

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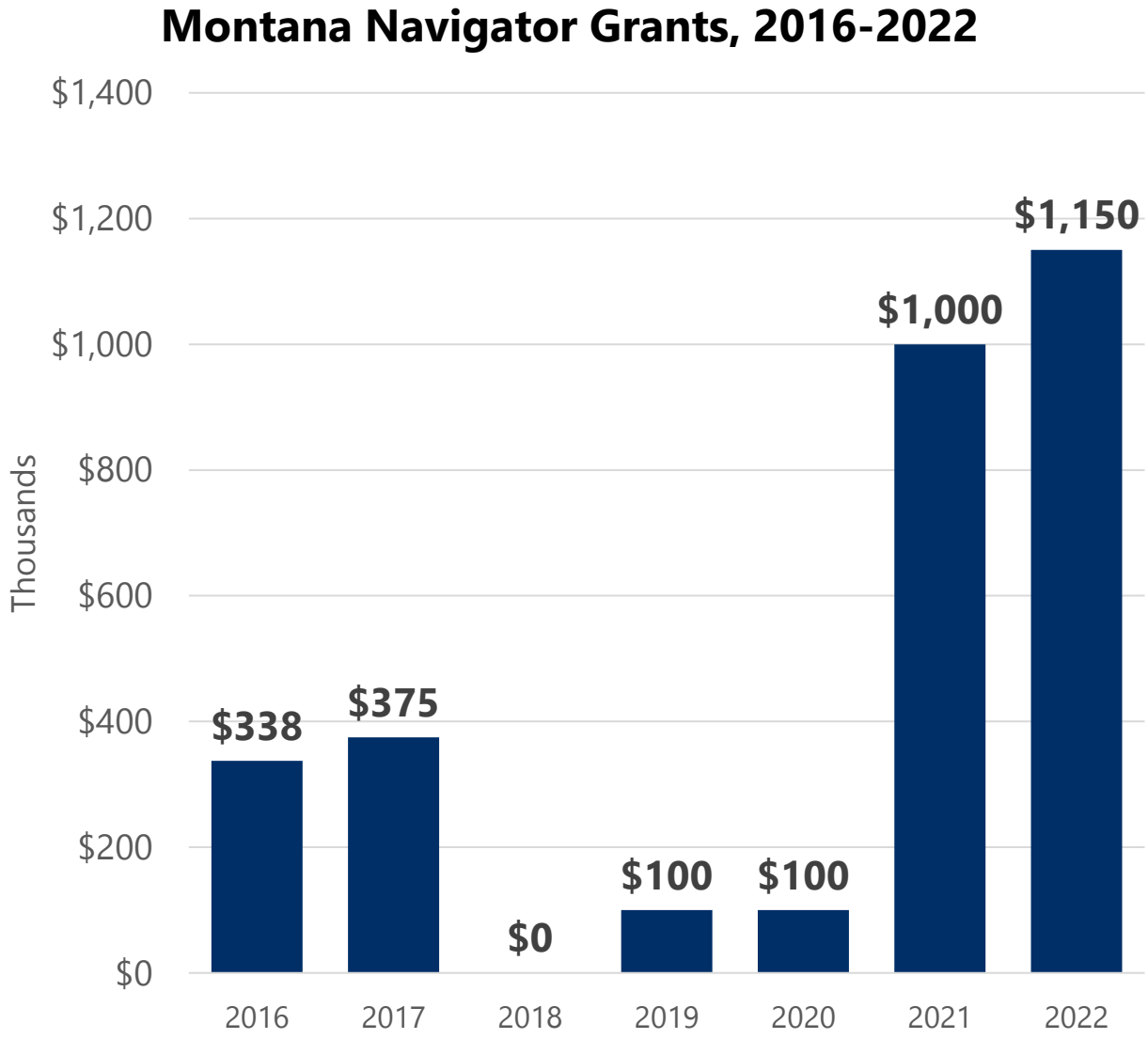
# Deeper Investment in In-Person Assistance

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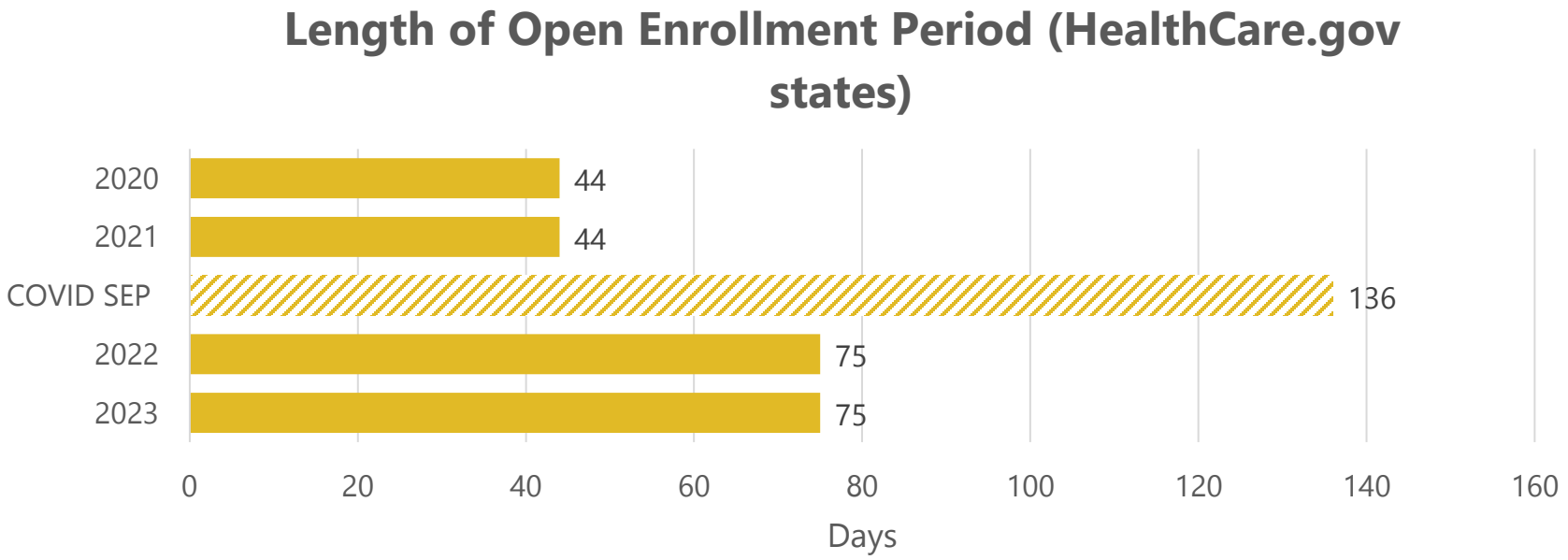
# Longer Open Enrollment Period

- Coverage in 2020: November 1, 2019 - December 15, 2019
- Coverage in 2021: November 1, 2020 – December 15, 2020 *plus April 1 – August 15 SEP*
- Coverage in 2022: November 1, 2021 – January 15, 2022
  - Extra month to enroll
  - Extra time to make a different choice after auto-reenrollment



# New Federal Policy Developments

# Enhanced Marketplace Subsidies Continue

| Annual Household Income | | Expected Premium Contribution | |
|---|---|---|---|
| % of FPL | Income Amount (For HH of 1 using 2022 FPL) | % of Income | Monthly Dollar Amount (For HH of 1 using 2022 FPL) |
| <150%[1] | < $20,385 | **0%** | $0 |
| 200% | $27,180 | **2%** | $45 |
| 250% | $33,975 | **4%** | $113 |
| 300% | $40,770 | **6%** | $204 |
| 350% | $47,565 | **7.25%** | $287 |
| 400% | $54,360 | **8.5%** | $385 |
| > 400% | > $54,360 | **8.5%** | varies |

[1] *Individuals who are eligible for Medicaid are ineligible for PTC*

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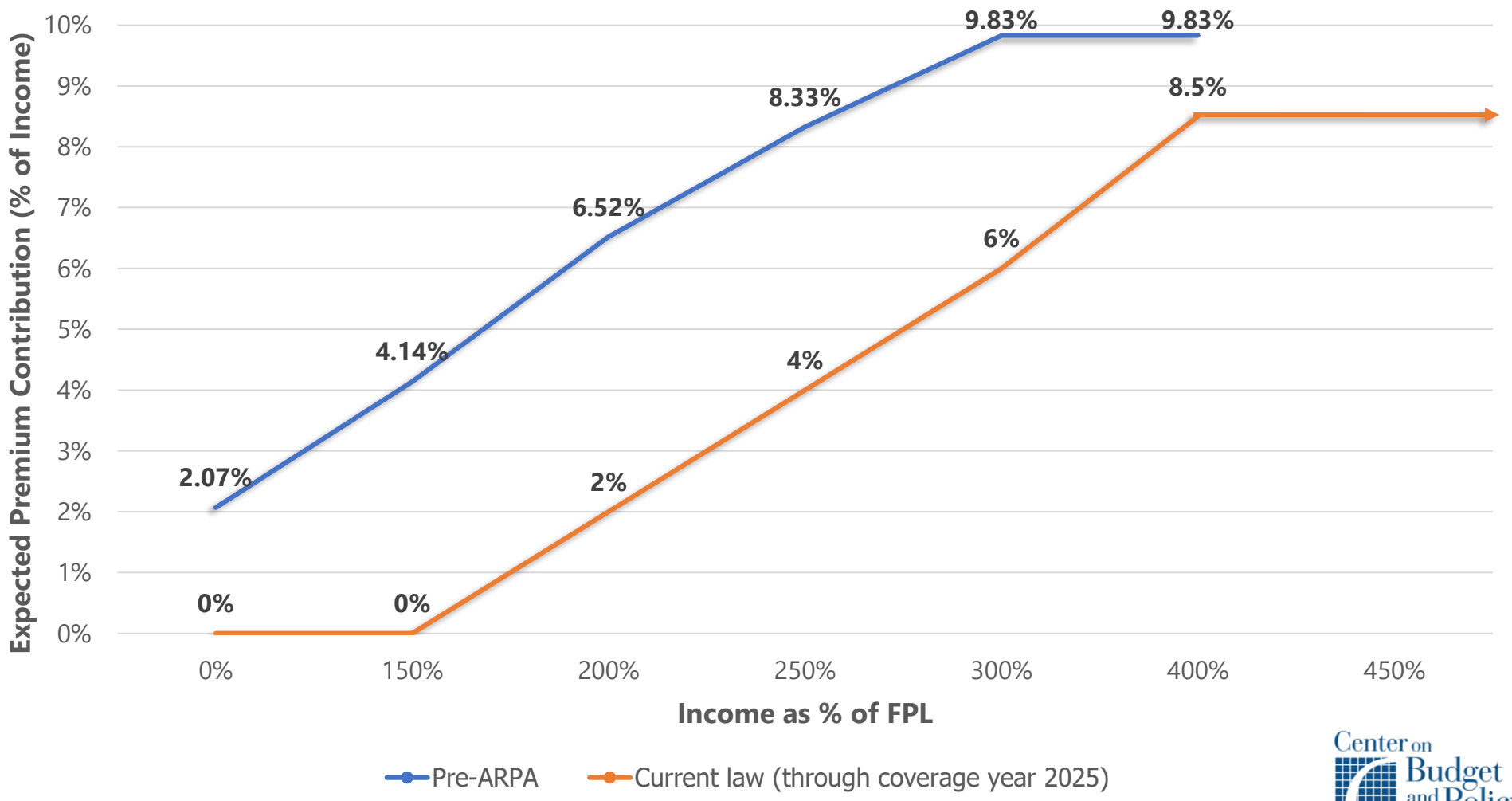
# How Much Will a Household Pay in 2023?

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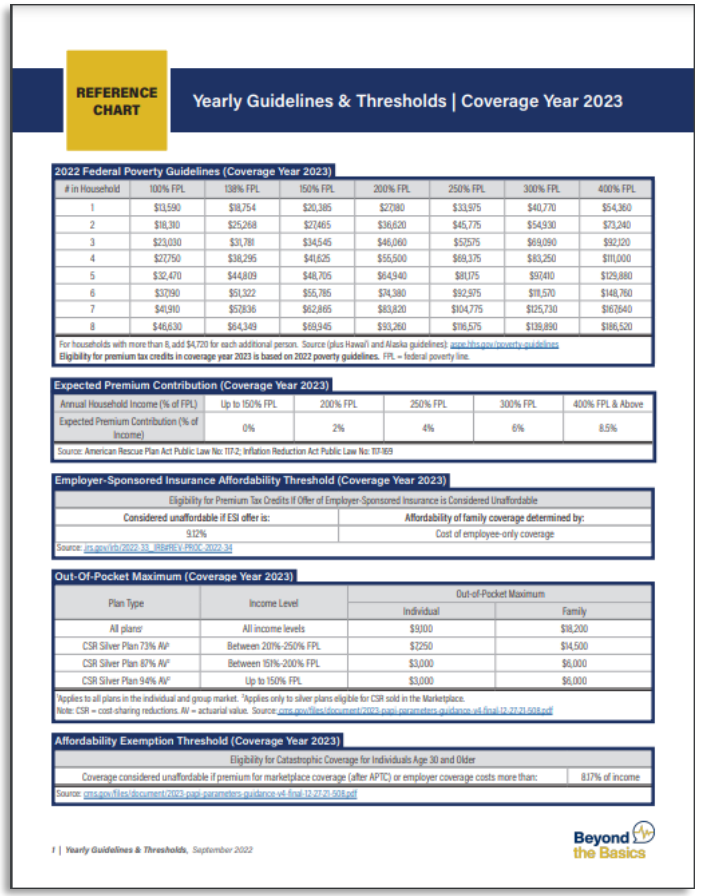
# Annual Updates to Guidelines/Thresholds

- 2021 and 2022 Poverty levels (use 2022 levels for 2023 marketplace coverage)
- Employer-sponsored insurance affordability threshold: 9.12%
- Out-of-pocket maximums

| | Income | Individual OOP Max |
|---|---|---|
| All plans | All income levels | $9,100 |
| CSR Silver Plan 73% AV | Between 201%-250% FPL | $7,250 |
| CSR Silver Plan 87% AV | Between 151%-200% FPL | $3,000 |
| CSR Silver Plan 94% AV | Up to 150% FPL | $3,000 |

- Affordability exemption threshold for catastrophic coverage (ages 30+): 8.17%
- Tax filing thresholds
- Repayment limits on APTCs



REFERENCE CHART

Yearly Guidelines & Thresholds | Coverage Year 2023

**2022 Federal Poverty Guidelines (Coverage Year 2023)**

| # in Household | 100% FPL | 138% FPL | 150% FPL | 200% FPL | 250% FPL | 300% FPL | 400% FPL |
|---|---|---|---|---|---|---|---|
| 1 | $13,590 | $18,754 | $20,385 | $27,180 | $33,975 | $40,770 | $54,360 |
| 2 | $18,310 | $25,268 | $27,465 | $36,620 | $45,775 | $54,930 | $73,240 |
| 3 | $23,030 | $31,781 | $34,545 | $46,060 | $57,575 | $69,090 | $92,120 |
| 4 | $27,750 | $38,295 | $41,625 | $55,500 | $69,375 | $83,250 | $111,000 |
| 5 | $32,470 | $44,809 | $48,705 | $64,940 | $81,175 | $97,410 | $129,880 |
| 6 | $37,190 | $51,322 | $55,785 | $74,380 | $92,975 | $111,570 | $148,760 |
| 7 | $41,910 | $57,836 | $62,865 | $83,820 | $104,775 | $125,730 | $167,640 |
| 8 | $46,630 | $64,349 | $69,945 | $93,260 | $116,575 | $139,890 | $186,520 |

For households with more than 8, add $4,720 for each additional person. Source (plus Hawai'i and Alaska guidelines): aspe.hhs.gov/poverty-guidelines
**Eligibility for premium tax credits in coverage year 2023 is based on 2022 poverty guidelines.** FPL = federal poverty line.

**Expected Premium Contribution (Coverage Year 2023)**

| Annual Household Income (% of FPL) | Up to 150% FPL | 200% FPL | 250% FPL | 300% FPL | 400% FPL & Above |
|---|---|---|---|---|---|
| Expected Premium Contribution (% of Income) | 0% | 2% | 4% | 6% | 8.5% |

Source: American Rescue Plan Act Public Law No: 117-2; Inflation Reduction Act Public Law No: 117-169

**Employer-Sponsored Insurance Affordability Threshold (Coverage Year 2023)**

| Eligibility for Premium Tax Credits If Offer of Employer-Sponsored Insurance is Considered Unaffordable | |
|---|---|
| **Considered unaffordable if ESI offer is:** | **Affordability of family coverage determined by:** |
| 9.12% | Cost of employee-only coverage |

Source: irs.gov/irb/2022-33_IRB#REV-PROC-2022-34

**Out-Of-Pocket Maximum (Coverage Year 2023)**

| Plan Type | Income Level | Out-of-Pocket Maximum | |
|---|---|---|---|
| | | Individual | Family |
| All plans[1] | All income levels | $9,100 | $18,200 |
| CSR Silver Plan 73% AV[2] | Between 201%-250% FPL | $7,250 | $14,500 |
| CSR Silver Plan 87% AV[2] | Between 151%-200% FPL | $3,000 | $6,000 |
| CSR Silver Plan 94% AV[2] | Up to 150% FPL | $3,000 | $6,000 |

[1]Applies to all plans in the individual and group market. [2]Applies only to silver plans eligible for CSR sold in the Marketplace.
Note: CSR = cost-sharing reductions. AV = actuarial value. Source: cms.gov/files/document/2023-payo-parameters-guidance-v4-final-12-27-21-508.pdf

**Affordability Exemption Threshold (Coverage Year 2023)**

| Eligibility for Catastrophic Coverage for Individuals Age 30 and Older | |
|---|---|
| Coverage considered unaffordable if premium for marketplace coverage (after APTC) or employer coverage costs more than: | 8.17% of income |

Source: cms.gov/files/document/2023-payo-parameters-guidance-v4-final-12-27-21-508.pdf

1 | *Yearly Guidelines & Thresholds, September 2022*

Beyond the Basics

*Beyond the Basics Reference Chart: [Yearly Guidelines & Thresholds | Coverage Year 2023]*

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# Highlights from 2023 Payment Notice

- People can't be locked out of enrollment due to past-due premiums
- Pre-enrollment verification for Special Enrollment Periods: Only for the loss of Minimum Essential Coverage SEP (HealthCare.gov states)
- No verification required for people who attest they are not enrolled in coverage and/or do not have an offer of job-based coverage
- Standardized plans are back (HealthCare.gov states)
- HHS will resume monitoring and enforcement of network adequacy standards (federally-facilitated marketplaces)
- Stronger requirements for Essential Community Providers

Also (not in Payment Notice):

- Failure to Reconcile: HHS extended existing flexibilities through the 2023 coverage year

# Standardized Plans

## What is a standardized plan?

- Standard AV, maximum out-of-pocket (MOOP), deductibles, and cost-sharing for a given metal level of coverage

## Why require standardized plans on the marketplace?

- Can make it easier for shoppers to compare choices based on premiums, provider networks, and quality ratings
- Response to growing number of plan choices in HealthCare.gov states / "choice overwhelm"
  - Average in 2022: >100 plans, >45 Silver plans

## What's required in 2023?

- Issuers must offer standardized plans at every product network type, at every metal level, and throughout every service area that they offer non-standardized options
- Plans will be "differentially displayed"
- Immediate result: more net plans (but possibly easier comparisons between standardized plans)

# Public Charge Update

- A new rule (takes effect in December) largely codifies the longstanding policy known as the "1999 Field Guidance" in place now
- Under both policies:
  - Accessing health insurance affordability programs is **not** negatively factored into public charge.
  - Officials try to determine if an individual is "likely to become primarily dependent on the government for subsistence" as demonstrated by use of public cash assistance for income maintenance or long-term institutional care paid for by the government (i.e. Medicaid LTC)
- The new policy provides some helpful clarifications and protections
  - Long-term care at government's expense does **not** include: short-term rehabilitation, imprisonment for conviction of a crime, or home and community-based services
  - Receipt of benefits only counts when the individual seeking an immigration status was the beneficiary of the benefits

For more information on the 1999 Field Guidance, see this webpage from U.S. Citizenship and Immigration Services (USCIS): https://www.uscis.gov/green-card/green-card-processes-and-procedures/public-charge/public-charge-resources

# Family Glitch Fix?

- Proposed IRS rule would eliminate the "family glitch" (beginning with 2023 coverage if finalized before the start of Open Enrollment)
  - Affordability for employee's spouse/family determined based on employee portion of premium for *family* coverage
  - Application would ask new question about the employee's cost of coverage for just themselves and themselves *and* family members
  - New possibility that family members may qualify for PTCs while employee does not; important to help families with this math
- Final rule expected soon

# Example: Offers of ESI and Eligibility for APTC

| Summary of Plan Costs and Household Income | |
|---|---|
| Household Income: | $40,000 |
| Employee-only premium cost: | $150/month |
| Family premium cost: | $450/month |
| Minimum value (MV): | ✓ 80% AV |

## Are Monica and her family eligible for PTC?

**Employee test:**

***Is Monica's plan affordable?***
(So, is her lowest-cost premium for a minimum value plan less than 9.12% of household income?)

- Yes, Monica's share of the premium for coverage just for her is 4.5% of household income

✗ Monica is not eligible for PTC

**Family test:**

***Is Monica's plan affordable for her family?***

- Family coverage costs 13.5% of income
- Because it costs more than 9.12% of income, family coverage is considered unaffordable

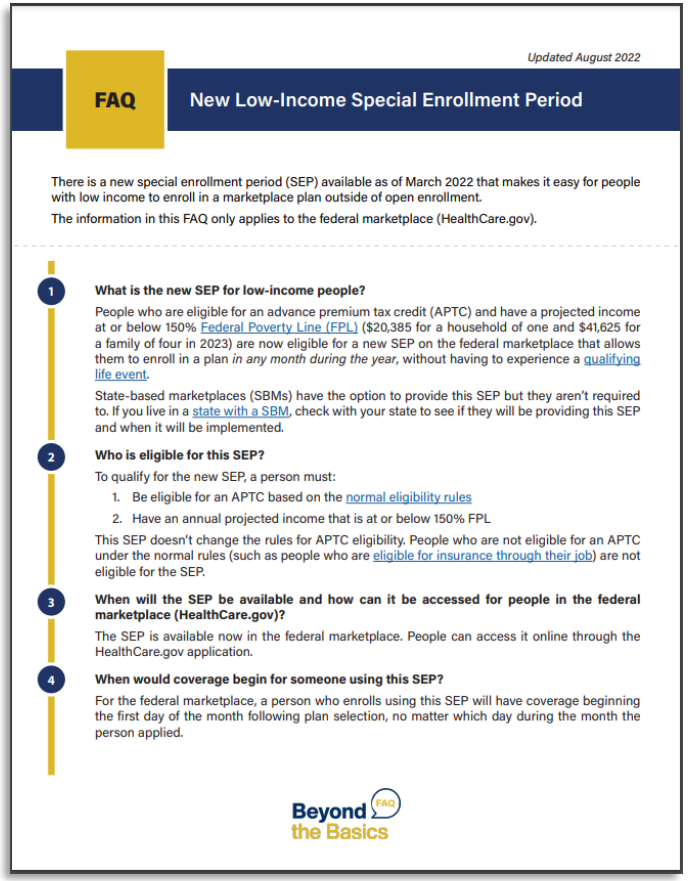
✓ Monica's family is eligible for PTC

***Tip:*** *If the family qualifies for PTCs, but not the employee, the employee may still need to buy ESI or a full-cost marketplace plan. Help families understand how their premium costs will add up.*

# Low-Income Special Enrollment Period

Access to coverage and financial help for some people with low incomes

- Annual household income is expected to be no greater than 150% of the federal poverty level
  - About $19,320 for an individual in 2022 (increases to $20,385 in 2023)
- Must be eligible for premium tax credits
- No prior coverage required
- May enroll in a QHP or change from one QHP to another one time per month
- Continues through 2025 plan year (SEP linked with availability of $0 premium plans; Inflation Reduction Act extended enhanced APTC availability through 2025)



*Updated August 2022*

**FAQ** **New Low-Income Special Enrollment Period**

There is a new special enrollment period (SEP) available as of March 2022 that makes it easy for people with low income to enroll in a marketplace plan outside of open enrollment.

The information in this FAQ only applies to the federal marketplace (HealthCare.gov).

1. **What is the new SEP for low-income people?**

   People who are eligible for an advance premium tax credit (APTC) and have a projected income at or below 150% Federal Poverty Line (FPL) ($20,385 for a household of one and $41,625 for a family of four in 2023) are now eligible for a new SEP on the federal marketplace that allows them to enroll in a plan *in any month during the year*, without having to experience a qualifying life event.

   State-based marketplaces (SBMs) have the option to provide this SEP but they aren't required to. If you live in a state with a SBM, check with your state to see if they will be providing this SEP and when it will be implemented.

2. **Who is eligible for this SEP?**

   To qualify for the new SEP, a person must:

   1. Be eligible for an APTC based on the normal eligibility rules
   2. Have an annual projected income that is at or below 150% FPL

   This SEP doesn't change the rules for APTC eligibility. People who are not eligible for an APTC under the normal rules (such as people who are eligible for insurance through their job) are not eligible for the SEP.

3. **When will the SEP be available and how can it be accessed for people in the federal marketplace (HealthCare.gov)?**

   The SEP is available now in the federal marketplace. People can access it online through the HealthCare.gov application.

4. **When would coverage begin for someone using this SEP?**

   For the federal marketplace, a person who enrolls using this SEP will have coverage beginning the first day of the month following plan selection, no matter which day during the month the person applied.

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# Proposed Changes to Nondiscrimination Rules

- Proposed rule issued in August, comments due October 3
- Rule prohibits discrimination based on race, color, national origin, sex, age, and disability
- Reverses elements of the 2020 1557 rule and expands on original 2016 rule
- Would apply to any entity that provides or administers health-related services and receives federal funding, directly or indirectly (including health care providers, insurance issuers, marketplaces, and even Navigators)

# Implications of Nondiscrimination Rules

## Broader interpretation of discrimination on the basis of sex

- Includes sex stereotypes, sex characteristics (including intersex traits), pregnancy or related conditions, sexual orientation, and gender identity

## Would prohibit specific kinds of discrimination

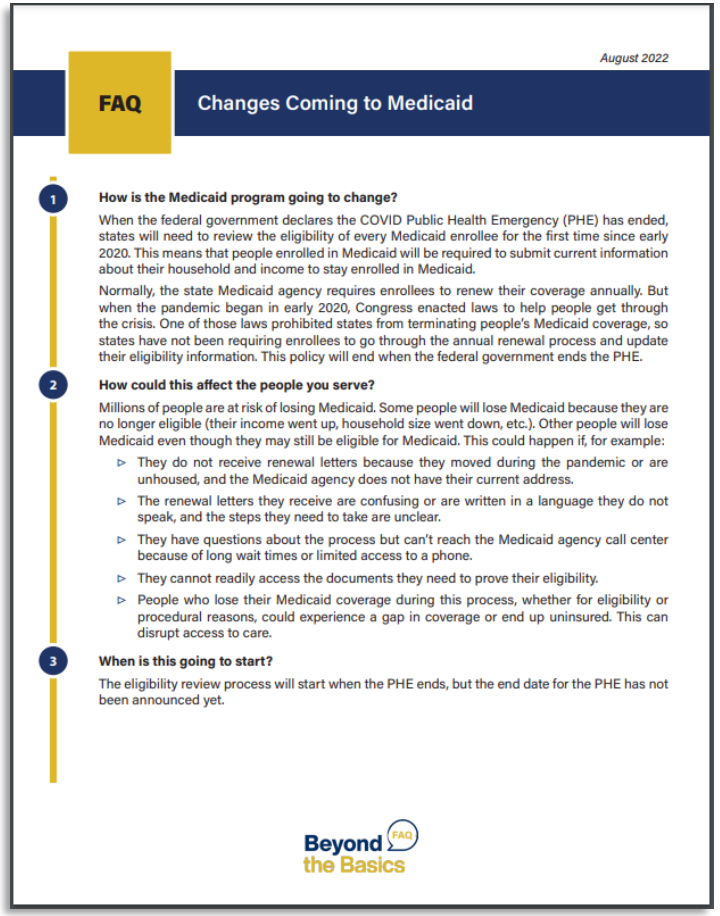
- Insurance benefit designs that do not provide coverage in the most integrated community setting appropriate for individuals with disabilities
- Discrimination based on association, against people with disabilities, against people with limited English proficiency

## Would create new requirements of covered entities

- Notices of anti-discrimination protections and availability of language assistance and auxiliary aids and services
- Covered entities to develop written Section 1557 plan and procedures and provide training to staff

# Preparing for OE10

# Medicaid Unwinding in 2023



August 2022

**FAQ** Changes Coming to Medicaid

**1 How is the Medicaid program going to change?**

When the federal government declares the COVID Public Health Emergency (PHE) has ended, states will need to review the eligibility of every Medicaid enrollee for the first time since early 2020. This means that people enrolled in Medicaid will be required to submit current information about their household and income to stay enrolled in Medicaid.

Normally, the state Medicaid agency requires enrollees to renew their coverage annually. But when the pandemic began in early 2020, Congress enacted laws to help people get through the crisis. One of those laws prohibited states from terminating people's Medicaid coverage, so states have not been requiring enrollees to go through the annual renewal process and update their eligibility information. This policy will end when the federal government ends the PHE.

**2 How could this affect the people you serve?**

Millions of people are at risk of losing Medicaid. Some people will lose Medicaid because they are no longer eligible (their income went up, household size went down, etc.). Other people will lose Medicaid even though they may still be eligible for Medicaid. This could happen if, for example:

- They do not receive renewal letters because they moved during the pandemic or are unhoused, and the Medicaid agency does not have their current address.
- The renewal letters they receive are confusing or are written in a language they do not speak, and the steps they need to take are unclear.
- They have questions about the process but can't reach the Medicaid agency call center because of long wait times or limited access to a phone.
- They cannot readily access the documents they need to prove their eligibility.
- People who lose their Medicaid coverage during this process, whether for eligibility or procedural reasons, could experience a gap in coverage or end up uninsured. This can disrupt access to care.

**3 When is this going to start?**

The eligibility review process will start when the PHE ends, but the end date for the PHE has not been announced yet.

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- Recap:
  - Could begin as early as January 2023
  - Should know more by mid-November (60 days' notice expected from HHS prior to Public Health Emergency declaration expiring)
  - If doesn't end in January, next possible end date is April 2023
- Assisters' job:
  - Help people keep Medicaid coverage
  - Help people losing Medicaid enroll in marketplace coverage if eligible
  - Mobilize community partners who can help

*Available at:*
*https://www.healthreformbeyondthebasics.org/medicaid-unwinding-tips-for-community-partners/*

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# No Surprises Act

- No Surprises Act (new law in 2022) protects people from "surprise medical bills" in two ways:
  - People with private insurance who receive emergency care from an out-of-network provider can't be billed more than in-network cost-sharing amounts
  - People with private insurance who receive non-emergency care from an out-of-network provider at an in-network facility can't be billed more than in-network cost-sharing amounts
- Every Explanation of Benefits is required to include instructions for how to file an appeal

**Step 1**
Contact the insurance company to see if the provider made a mistake. Follow insurer appeals process if needed.

**Step 2**
Contact the provider and ask them to correct the bill.

**Step 3**
If provider refuses to correct the bill, file a complaint by calling the No Surprises Help Desk at (800) 985-3059 or online at https://nsa-idr.cms.gov/consumercomplaints.

Most of the law's protections only apply to people with private insurance and not to people who are uninsured or enrolled in Medicaid, CHIP, or Medicare.

For more information, see the Beyond the Basics FAQ

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# Resources and Contact Info

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***Policy papers, news, blog:***

www.cbpp.org

***Resources, tools, and training for enrollment assisters:***

www.healthreformbeyondthebasics.org

**Annual Open Enrollment Webinar Series (in progress now)**

- **Part VIII: Tying It All Together**

  Thursday, October 13 | 2 pm ET (11 am PT)

- **Part IX: Asistiendo a consumidores hispanos a obtener cobertura médica: consejos y mejores prácticas**

  Thursday, October 20 | 2 pm ET (11 am PT)

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