Final Transcript

HUD-US DEPT OF HOUSING & URBAN DEVELOPMENT: Health Insurance Market Place
December 7, 2016/2:00 p.m. EST

SPEAKERS

Virginia Holman
David Santana

PRESENTATION

Moderator: Ladies and gentlemen, we thank you for standing by and welcome you to the Health Insurance Marketplace 101. At this time, all participants are in a listen-only mode. Later we will conduct a question-and-answer session with instructions given at that time. [Operator instructions].

I will now turn the conference over to Virginia Holman. Please go ahead.

Virginia: Good afternoon, everyone. I'm Virginia Holman with the Office of Housing Counseling, and we welcome you to this important webinar on

Health Insurance Marketplace 101. Before I turn it over to our speakers, I do want to go over some logistics slides.

The audio is being recorded, and we will be providing a playback number along with the PowerPoint and a transcript. In about a week, these will be posted on HUD Exchange. We'll also send out a listserv when they're available.

As the operator said, your lines are currently muted. We will open them up at the end for questions and answers. Your handouts were sent out this morning. As I mentioned, we will be having a question–and-answer period at the end, and the operator will give you instructions about how to get into the queue.

We also really want your questions, so there are a couple other ways that you can ask them. On your control panel, there's a box that says questions, and if you just type in your question where it says enter a question, we have people monitoring those questions so they will be answered as well. If, after the webinar is over, you still have questions, please send them to housing.counseling@hud.gov with the webinar topic,

in this case Marketplace 101 in the subject line so we can get it to the right people.

There will be a brief survey at the end. Please take a few minutes to fill that out. Your responses are very important to us as we strive continually to improve our webinars. Also, within 24 to 48 hours, you will be getting an email from GoToWebinar thanking you for attending. It's going to say, this is your certificate of training. There will be no attachment. It's the email itself, so print it out and save it for your records.

At this point, I'm going to turn it over to our speakers.

David Hello and welcome, everyone. Thank you, Virginia, for giving us the opportunity to be a part of this training. We are really appreciative of the opportunity to share some important information about, well not so new by now, Heath Insurance Marketplace.

I think for those of us who have some basic knowledge of the marketplace, this is an opportunity to do a refresher as we all need it every so often to make sure that we remain up-to-date with the information and more importantly, making sure that we gave those who relied on us for

information the up-to-date information to make sure that they make an informed choice.

My name is David Santana and I work for the Centers for Medicare & Medicaid Services in the Office of Communication. One of the things that we do in the Office of Communication is speak with professionals like you, and again, just give you basic information so you can help those who rely on you make informed choice about their healthcare coverage options.

Before we go over the slide presentation, I wanted to make sure that we highlight the fact that this is not a legal document or is intended for press purpose. Members of the press should contact CMS by the following email box, press@cms.hhs.gov. This is a summary of complex and technical legal standards. Official Medicare Marketplace program legal guidance is contained in the relevant statutes, regulations, and rulings.

Virginia, I'm looking at the screen now in terms of proceeding with advancing the slides.

Virginia You need to open up your presentation.

David Okay.

Virginia On David's desktop.

David Okay, allow me a minute here to pull up the presentation, and I'll be right with you.

Virginia They will be repeating their email previously given. So if you missed it, don't panic. Again, the Office of Housing Counseling's email is housing.counseling@hud.gov.

M It's the attachment. I sent it to you the other day.

David This one?

M [Indiscernible].

David That's where I went to the attachment.

M You got it, yes. Okay, great. The presentation is open, you'll see it shortly. Right now you're looking at the opening page, Marketplace 101.

David	Virginia, just wanted to—
Virginia	There you go. Yes.
David	Is the presentation up?
Virginia	Your presentation is up now. David, your presentation is showing on the screen.
David	Can you hear us now?
Virginia	Yes.
David	Okay, I'm sorry about that. All right, can you see the slides on the screen, Virginia?
Virginia	Yes.
David	Okay, great, thank you. Our apologies for the delay. All right, so we're going to begin by going over the objectives of today's webinar. First,

we're going to give you some very basic information about the Health Insurance Marketplace, such as what it is, the type of plans that individuals will be able to enroll, the type of benefits they can expect to get from those plans.

We're also going to define who is eligible to join the Health Insurance Marketplace, the options for those who have limited income and resources. We're also going to briefly explain the enrollment process and options available for those enrolled in Medicare. Of course, at the end of the presentation, we're going to give you some resources for more information.

To the basic question when the individual comes to you and asks, what is the Health Insurance Marketplace. The difference between this new Health Insurance Marketplace in the Affordable Care Act and the old way that individuals in the state had to buy health insurance is that fact that when you go to your state Health Insurance Marketplace, whether it's administered by the federal government or by the state or in partnership between the two, you should be able to fill one application to determine eligibility for all programs that you may be entitled or eligible for. For example, they will be able to tell you whether you are eligible for Health

Insurance Marketplace, qualified for Medicaid assistance, or you qualify for tax assistance. So, again, this is a place where health insurance plan will come and show individuals the plans that they're selling, and individuals and families can come in and compare those products and make a comparison based on their healthcare needs and their budget.

Much of the regulations written about the Health Insurance Marketplace, you may see that is also called an exchange. Now, Small Business Health Options Program is also an opportunity for small business in the states to join together and buy health insurance through the marketplace for their employees.

Again, how the marketplace works. As I mentioned, the difference here between this new marketplace and the old marketplace specifically is that you fill out one application and you will be able to see whether you are eligible for a qualified health plan, premium tax credit, reduced cost sharing, Medicaid, or Children's Health Insurance Program. That's the basic difference between what was there before and what is here now.

Now, as I mentioned, each and every state under the law will have a Health Insurance Marketplace where you can go and compare and choose

plans. States have the opportunity to have their own marketplace. If they don't establish their own marketplace, the federal government will be running the marketplace in there, or they have the option to partner with the federal government to run the marketplace. That opportunity was there before the law took effect and is there now.

Even the states who have decided not to open their marketplace have the opportunity to do so in the future. Even the states that are running their marketplace have the opportunity to hand over part of the marketplace or the entire marketplace to the federal government. So at the end of the day, each and every state in the country do have a Health Insurance Marketplace that you can go compare and choose plans.

Now, to the question when the individual comes in and buys health insurance, what a qualified health plan means for an individual. The qualified health plan had to be offered through the marketplace by a company that has been certified and in good standing in the state. They have to cover essential health benefits, and we're going to go over what essential health benefits mean, and it's offered by a plan that will be selling different levels of coverage. They are required to sell one silver and one gold plan. We're going to, in a little bit, review what that means.

Then, they also have to agree to charge the same premium whether they offer inside or outside of the marketplace for fair competition.

When we talk about minimum essential coverage, when an individual chooses a plan in a marketplace, they can expect to have access to all range of healthcare services such as hospitalization, emergency maternity care, and many, many more including prescription drug benefits. Again, when you have health insurance, you can expect to get a range of services to make sure that you are covered. It doesn't matter what type of medical needs you have.

I mentioned about the levels of coverage. What we're seeing on the screen is the basic levels of coverage that plans will offer to make sure that we're meeting the needs of individuals who perhaps are healthy and they don't need as much medical services and for individuals who have, for example, a chronic condition that needs a lot of medical services. You can see that the bronze plan, you are responsible to pay about 40% out-of-pocket while the plan would cover 60%. Silver will cover 70%, gold 80%, and platinum 90%.

When you compare between, for example, the bronze and the platinum, those individuals that are healthy and do not need many medical services, may be better off signing up for a bronze plan because the premium is going to be lower. But of course if they need medical service, they would have to pay a little bit more out-of-pocket because they are saving in premium. Again, if someone, for example, has a lot of medical needs, it may make sense for that individual to pay a little bit more in their monthly premium because when they go and receive the service, their plan will pay 90% of their service. So that's why the levels of coverage were established to make sure that we're meeting the medical needs and budgets of different individual's healthcare needs.

Now, I want to call to your attention a plan that is actually different from those four levels of coverage that we just mentioned. This plan nevertheless, the coverage of this plan had to meet all of the requirements that the other plans meet. For example, they can't be denied coverage because of preexisting conditions, meaning that they can't charge you more if you have a preexisting medical condition, or again, deny services or discriminate in any way.

Also, they have to provide a mandatory out-of-pocket protection. Meaning that if you are insured, you likely will never go bankrupt because you have catastrophic out-of-pocket expenses. This year, it's about $6,650. Next year, it's going to be about $7,150. This is a catastrophic coverage meaning that you would not be paying more. So, you get to that amount, you're not going to be paying more throughout the year, so even if your bill ends up being $100,000, $200,000, $300,000 if you end up in the hospital, your out-of-pocket expenses will be about $7,100. Again, everyone that is insured is going to be protected from going bankrupt.

Now, the catastrophic plan is what we call a high-deductible plan. These plans, you would have to pay the deductible first, and then when you meet your deductible, then the plans step in and pay for the rest of the year. This plan is offered at a lower cost than the other plans that we just mentioned in the previous slide. This is mainly for young adults, individuals under 30 years of age.

We also offer these plans for individuals who cannot afford coverage. We look at an individual in terms of determining whether they can afford coverage to calculate how much health insurance will cost them whether it's an employer plan or it's a plan in the marketplace. If it costs them

more than 8.13% of their annual household income, then we consider that coverage to be unaffordable and it doesn't matter their age, they could actually purchase the catastrophic plan.

One interesting feature about these catastrophic plans is not only that they are offered at lower cost than the rest of the plans, but also before you meet that deductible, the plan is required to cover many, many preventive services at no cost to the individual. They also are required to offer three primary visits per year even if you haven't met your deductible. So, not only are you getting a plan at a lower cost, you are protected from catastrophic medical events, but also the plan helps keep you healthy by offering primary care visits and free preventive services. Again, this is mainly for individuals under 30 years of age and individuals who are determined that they can't afford other health insurance, they can choose to purchase this type of plan.

Now that we have an idea of the type of plans that individuals could get, the type of benefits they are expected to get in each and every plan, let's take a quick look and see who is eligible to participate in the marketplace. As you can see, the eligibility's pretty straightforward. You have to be a resident of the state that you are buying a marketplace plan from. You

have to be a US citizen, a national, or someone who is locally present here in the US and cannot be incarcerated. That basically tells you that anyone who meets these three requirements can go and purchase at Health Insurance Marketplace with very, very few exceptions.

Now, more importantly, the question before the Affordable Care Act created a marketplace was that there are plans out there, there are private plans for sale out there with good coverage; however, many people could not afford. Of course, if you have preexisting medical conditions the plan could deny you coverage for that specific condition. So, the lower cost is part of the marketplace to help individuals with their premium as well as out-of-pocket expenses.

It is based on the household income and family size and is between 100% and 400% of the federal poverty level in a sliding scale. So if you are between 100% and 400%, you could qualify for premium assistance. One point that we want to drive home here is that eight out of ten people that are eligible for coverage in the marketplace qualify for premium tax credit.

So, it is important for us to, we know individuals that are not insured because they think that they would not be able to afford it, to go ahead and

file an application and see if they can qualify for assistance because again, eight individuals out of ten would qualify for assistance. So I would highlight the fact that this is available. The vast majority of individuals in the marketplace that qualify for assistance pay as little as $75.00 a month, so that definitely sounds affordable for the majority of individuals who get the assistance.

One thing that we highlight in here is that to be eligible for lower cost, you cannot be eligible for minimum essential coverage such as government sponsored health insurance such as Medicare, Medicaid, Children's Health Insurance Program, TRICARE, and other government-sponsored programs. If you are eligible for one of those programs, you are not eligible for premium tax credit. If you also are eligible for an affordable employer group health plan, then you are not eligible for premium tax credit. Again, I think the main message here is if you know someone that doesn’t have health insurance, I would definitely encourage them to apply and see if they qualify for assistance because again, eight times out of ten, they will qualify for assistance.

How do they use the tax credit when they qualify? The majority of individuals choose to get the premium tax credit in advance meaning that

we will pay the plans that they are enrolled in part of their monthly premium depends on how do they fall within the premium tax credit. Then, at the end of the year, when they file their taxes, they reconcile their premium tax credit.

Sometimes they may get an additional check. Sometimes they may have to pay back. One thing that we tell individuals is that when you apply for premium tax credit and you are found eligible, make sure that if you have any change in your household composition or household income to go ahead and report it to the marketplace so they recalculate your credit and you get the appropriate credit based on the information that you provide to the marketplace.

The other way that individuals can go about getting the credit is to just file for your taxes at the end of the year and not get the credit in front. So, in other words, you qualify for the credit but opt to not get the credit in advance, when you file your taxes at the end of the year, you get a one lump-sum payment. Again, the majority of individuals opt to get the tax in advance to help them with their premium payment.

There is also assistance with our-of-pocket expenses, cost-sharing reduction. As we know, health insurance is not different than other forms of health insurance out there. You usually have monthly premiums, and then when you use the service, whether it's an automobile insurance or homeowners' insurance, you usually have a deductible, co-payments, and so forth. So that out-of-pocket expenses, when you go and receive the service is where we offer assistance. For those who are below 200% of the federal poverty level in the sliding scale, those who are at a lower bracket and are below 150% of the federal poverty level, the plan will pay 96%, and the individual's usually responsible for only 4%.

Now this group, to get this cost-sharing reduction, they're required to sign up for the silver-level plan that we just reviewed on those levels of coverage whereby the plan covered 100%, and the individual is responsible for 30%. Again, if you qualify for the cost-sharing reduction, what would happen is, instead of the plan covering 70%, the plan will go up to 96%, you only pay 4%, again, for those below 150%. Those below 200% and 250% will also pay less than the 30% when they go and receive the service. So we want to make sure that we highlight the fact that even for out-of-pocket, when you go and receive the service, there is assistance for that. We also just want to quickly mention that members of the

federally recognized Indian tribes who are below 300% of the federal poverty level qualify for zero out-of-pocket expenses under the marketplace.

Now, we're going to quickly touch on Medicaid eligibility. It is a plan that has been in effect since 1966. The plan was primarily designed to help people with limited income and resources. The traditional Medicaid plan covers mandatory groups such as pregnant women, children, people with disabilities, seniors, and parents, and caretakers.

Now, the Affordable Care Act expanded the groups that would be covered under Medicaid. The next slide just tells you, you can see that the additional groups expanded under the Affordable Care Act. The first one is individuals between the ages of 19 and 64 with income below the federal poverty level and not pregnant and not eligible for Medicaid. We did not include children in this group because they're already covered by those mandatory groups that we had in the previous slide.

The Affordable Care Act also expanded Medicaid coverage for children who were in foster care at the age of 18 or if they age out of foster care at a later date, those children, or mainly young adults, are able to stay in the

Medicaid program until the age of 26. There's really no asset test for these individuals.

The last group is an optional group for individuals above 133% of the federal poverty level. This could include children who otherwise did not qualify for Medicaid under the 133%, people enrolled in Medicare, and pregnant women. Again, this is the expansion under the Affordable Care Act.

The Affordable Care Act also gave the state the opportunity to not review the eligibility for a 12-month period, meaning when you found the individual eligible for Medicaid under the expansion, the states are not required to review their eligibility for 12-month period. Before that varied by the state. It could have been 6 months, 7 months, 3 months, so now they extended it to 12 months, so that's another great thing that happened.

Now, the eligibility application is a pretty straightforward process. You can see on the screen how it flows. You submit the application, and that could be done online, by phone, by mail, or in person. Once you submit the application, again we verify and determine whether you are eligible.

Of course, again as I mentioned, you will be able to see if you qualify for enrolling in a plan, premium tax credit, cost-sharing reduction, or eligible for Medicaid or CHIP. If you're eligible for Medicaid or the Childrens Health Insurance Program, your application is sent to the state to be enrolled in one of those programs. If you're not eligible for Medicaid or CHIP or Medicare, you could be eligible for premium tax credit, and then you would choose the plan and enroll and then get the premium tax credit as we mentioned before. As you can see again, this is a very straightforward process.

Now with that information in mind, the Affordable Care Act does require that individuals either have a minimum essential coverage, have a coverage exemption from the share responsibility payment, or pay a fee. We're going to review quickly what those three things mean. What is a minimum essential coverage? You can see that there is a listing of minimum essential coverage on those two slides. Any of this coverage can qualify as minimum essential coverage. What it means is that you're already covered when you file your taxes, usually you will get a form, it's called 1095. The 1095 would have a letter A, B, or C, it depends on the source of health insurance that you're getting, letting you know that you have essential coverage, and when you file your taxes, you just basically

put the information in there in your taxes to make sure that you don't have to file for an exemption or be penalized for not having minimum essential coverage.

Who is eligible for an exemption? This slide and the next slide give you a list of individuals that could be eligible for an exemption. When you are ready to file your taxes every year, you will file a form 8965, and that is the coverage exemption. You could file an exemption through the marketplace, depends on the type of exemption, or through the tax filing. Individuals who have any questions, they didn't have minimum essential coverage, and they wanted to find out if they can qualify for an exemption, they can either do it through healthcare.gov, which walk the individual through filing the application to the right place, or they can call the marketplace for information about looking to see if they qualify for one of those exemptions. I can tell you that the majority of individuals that are uninsured, they may qualify for some form of exemption.

Now, if you don't have minimum essential coverage and do not qualify for an exemption, you will be subject to a fee. What is the fee? As you can see for this year, when the individual files their taxes in 2017 for this year, the fee will depend on the higher of 2.5% of your yearly household

income or a flat dollar amount of $695.00 per person, half of that for child, up to the maximum of $2,085 for a family. Again, individuals who choose not to have health insurance, do not qualify for an exemption, they may end up paying the fee, and again, it's going to be the greater of those two amounts, 2.5% of their yearly household income or $695.00 flat dollar fee per person, half of that for children, up to the maximum amount of $2,085.

What is the message here? There's health insurance available for everyone. There is assistance available for everyone. There is also exemptions for those who meet certain requirements.

If none of that applies, then you end up paying a fee. Paying the fee doesn't mean that you actually have health insurance. That's what I usually tell an individual. Paying the fee doesn't mean you have health insurance. If something happened to you and you end up in the hospital, you could end up bankrupt, and you could end up having to pay a fee for not having health insurance.

With all that information in mind, when can individuals join the marketplace plan? They could do it during the open enrollment period.

This year, it's from November 1st through the end of January. So, we are almost halfway through the open enrollment period.

Again, any individual who is already enrolled, we encourage them to go back and update their application, go back and compare plans again to make sure that they're getting the best option for their needs. Individuals that are not currently enrolled in marketplace, this is the opportunity to come in and join the marketplace plan. Individuals could also do it during the special enrollment period, and this is for any life-changing event that transpired through the year such as getting married, having children, moving, all of these life-changing events could prompt an individual to qualify for a special enrollment period.

How do individuals find out if they could qualify for a special enrollment period? You could basically get this information in healthcare.gov. On the front page, you will see a tab on there indicating if you wanted to check to see in you qualify for a special enrollment period, or they could do it by phone by calling the marketplace plan.

Now, the federally-facilitated marketplace, as well as the states that work with us in partnership, we kind of reviewed this already, but it's a flow of

the application. Technically, if you go to the website, first you create an account. Then, once you create an account, then you apply and the marketplace will tell you whether or not you are eligible for Medicaid, CHIP, premium tax credit, cost-sharing reduction, and then you go and compare the plans and the options, and you enroll in a plan.

Now, another point that we wanted to highlight in this presentation also is that solely enrolling in a marketplace plan by just submitting an application, and that you are desiring to enroll in that plan, doesn't mean that you are entitled to the benefits yet. Until you make that first monthly payment, you are not really legally enrolled in that plan. So, it is important to tell individuals that filing an application by itself doesn't mean that you have health insurance. You've got to make sure that you make that first monthly premium to the plan.

We require the plans to accept paper check, cashier, money order, electronic funds transfer, prepaid debit card, and so forth. Plans are not required to accept payment online, but the majority of them do. So, make sure that you check with the plan to make sure that you do that first monthly payment because if not, you simply are not going to be enrolled in the plan.

There is an appeal if the individual gets a decision from the marketplace that is adverse to what they were applying for. So, definitely if the individual thinks that the marketplace made an incorrect decision, they have the right to appeal.

We wanted to let you know that there is an enrollment assistance in the form of the marketplace call center. In person help available, as you can see, individuals can find local help by typing localhelp.healthcare.gov. There's also language assistance for those who are speaking English as a second language. You can see the phone number again for the call center, open 24 hours a day, 7 days a week, and there's also interpretation in more than 240 languages. Those who have questions about Small Business Health Options Program, also there is a toll free number in there that a small business can call for information.

Lastly, I just wanted to mention about Medicare. The main message in here is that if you are enrolled in Medicare, the marketplace platform is not the place to go to look for health insurance or try to enroll in the health insurance plan. In fact, it is illegal for the Health Insurance Marketplace to be sold to someone who is already enrolled in Medicare, so this is

basically the main message that I will tell someone who is already enrolled in Medicare.

Coverage to Care is also another form of information that we have on our website, and you can see the link in here. It provides information for those individuals who are new to health insurance to work them through the process on how health insurance actually works for individuals. Also marketplace.cms.gov has a lot of information including a slide deck like this one that you're seeing is posted on the marketplace.cms.gov. So, I encourage you to go there and look for information because again, this information is mostly geared towards individuals who help others make decisions. You could also stay connected on Twitter, Facebook, YouTube, and also sign up for the listserv.

Lastly, there are some key points to remember here. The marketplace is a unique way to qualify for health insurance where plans offer their service and families can come compare their plans and choose their plan based on their healthcare needs and budget. There's also a Small Business Health Options Program available through the marketplace. States have flexibility in terms of how they go about establishing the marketplace. Individuals and families may be eligible for assistance, and again, I can't

say that enough that eight out of ten individuals would qualify for assistance. If you don't agree with the decision, as I mentioned, they can always file an appeal.

This basically concludes a quick overview of the Health Insurance Marketplace. I hope that with those highlights on the slides that we see, we have the main messages that we can give to individuals so they can make an informed choice when the time is right.

With that, I'm going to go to the operator to open the line and see if anyone has any questions.

Moderator [Operator instructions].

Virginia At this point, we have no written questions.

Moderator It turns out there are no questions from the phones either.

Virginia All right.

David I just wanted again to say, Virginia, that we encourage individuals out there to go to healthcare.gov. On the front page right there is the information that will walk an individual through the enrollment process. Again, calling to everyone's attention that the open enrollment in marketplace is closing at the end of January, so again I would encourage any individual that you know that isn't insured to go to healthcare.gov and see if they qualify for assistance. Just make sure they evaluate their options and see, based on their situation, what would be the best option for them.

Virginia Okay, well we want to thank you, those people that have attended and gotten this very important information, and you, David, as our speaker. Now, just as a reminder to the participants, within a week, we will post on HUD Exchange the PowerPoint, the audio replay number, and a transcript of this webinar. So don't feel if you didn't take the right notes you will have missed something important because we will provide all of that information to you. Again, thank you very much for attending, and we hope to see you again. Thank you.

David Thanks.

Moderator That does conclude our conference for today. Thank you for your participation and for using the AT&T Executive TeleConference Service. You may now disconnect.