2019 HealthCare.gov Open Enrollment FAQ - NHID Consumer Services

Version 10/31/2018

Open Enrollment

1. When is Open Enrollment?

- Open Enrollment is the one time of year when you can enroll in health insurance coverage through the Exchange without having a qualifying life event.
- Open Enrollment begins November 1 and ends December 15, 2018.
- New plans will be effective on January 1, 2019 once the first premium payment has been made by the policyholder.
- After Open Enrollment ends on December 15, 2018, you will be able to enroll in an ACA-compliant plan only if you experience a qualifying life event. If you do not purchase insurance during the open enrollment period, you run the risk of not having coverage if you need medical services during 2019.

2. Do I need to take any action if I liked my 2018 health plan?

- Consumers should check their options, even if they like their current plan.
- Every year during open enrollment, consumers should log into their HealthCare.gov accounts and update their applications. Changes in household status and income may have an impact on the amount of Advanced Premium Tax Credits (APTCs) received. APTCs can help decrease the amount of premium owed to the insurance company each month.
- Consumers should double-check that the plan they select covers their doctors and prescriptions and is a good fit for their health needs and budget. Premiums can change from year to year, but so can the amount of APTCs, so selecting a different plan may be a better option. If consumers do not actively re-enroll in a plan, HealthCare.gov will auto-enroll them into a 2019 plan that is comparable to their 2018 plan.

3. How do I get help with enrolling in a plan?

- If you need help selecting a plan that fits your health needs, your budget, and includes your doctors and prescriptions, you can set up an appointment with an insurance agent or broker or enrollment assister. Find a list of eligible insurance agents on the NHID website or find other local help on HealthCare.gov.
- **Agents and Brokers** can help you select a plan that works for your needs and your budget. They are able to recommend specific plans. These appointments are free of charge during open enrollment.
- **Enrollment Assisters** complete training provided by the federal government to help consumers as they look for health coverage options through the Marketplace, including assistance in completing eligibility and enrollment forms. They are required to be unbiased, meaning they cannot recommend a specific plan. You can meet with an enrollment assister for no cost.

Financial Assistance on HealthCare.gov

4. Does the renewal letter I received from my health insurance company reflect the 2018 tax credits (APTC)?

- No. Renewal letters may use the previous year's APTCs and CSRs. Consumers can view estimates of their APTCs and CSR qualification status on the plan preview tool on HealthCare.gov.

5. **What are the Federal Poverty Level (FPL) threshold amounts for financial assistance eligibility?**
   - Advance Premium Tax Credits (APTCs) for individuals and their families are available to offset premium costs, based on a sliding scale up to 400% of the Federal Poverty Levels.
   - For 2019 Open Enrollment, income thresholds are based off of the 2018 FPL.
   - View Federal Poverty Levels here.
   - Cost Sharing Reductions (CSRs) lower the amount of out-of-pocket costs, such as deductibles, copayments, and coinsurance, a person or family must pay. These discounts are available for households with an income up to 250% FPL, but only for Silver level plans bought on HealthCare.gov. If the income and family size information entered on HealthCare.gov show that an individual or family qualifies for CSRs, the Silver plans displayed will reflect CSR discounts.

Rate Increases

6. **I cannot afford my 2019 premium rate:**
   - If you are eligible for Advance Premium Tax Credits (APTC), the rates you received on your carrier's renewal letter may not reflect your final costs. To view the impact of APTCs on your 2019 premium, visit the plan preview tool.
   - If you aren't eligible for tax credits, you can shop on HealthCare.gov or visit a producer/agent who can help you look for plans that may be less expensive and still meet your healthcare needs. You can find a list of brokers on the Find Local Help tool on HealthCare.gov or from a list of licensed agents/brokers on the NHID website.

7. **What causes high health insurance premiums?**
   - High medical and pharmaceutical costs.
   - Higher health care utilization rates.
   - Elimination of the Cost Savings Reduction payments by the federal government to the carriers.
   - General uncertainty regarding the future of the federal health care law.
   - A detailed analysis of premium rate drivers is available on the NHID website.

8. **Can I look at plans and rates before I apply?**
   - Individuals may visit the plan preview tool on HealthCare.gov to look at plans and cost estimates based on their "tax household" size and income.

9. **What are the premium rate differences on-exchange vs. off-exchange?**
   - Premiums off-exchange (off-HealthCare.gov) vary greatly depending on the carrier, the product, the plan of benefits, cost sharing, age, tobacco use and the number of dependents and their ages.
   - Individuals should contact an insurance agent or broker or individual carriers (either directly or through the carrier's website portal) to learn more about specific product offerings.

10. **What are the options for more affordable coverage?**
    - The NHID encourages individuals searching for more affordable coverage to contact an insurance agent/broker or an enrollment assister, visit HealthCare.gov, or contact insurance companies directly.
    - In searching for affordable coverage, consumers should exercise caution and ask questions if considering an unfamiliar plan. Here is a link to information put out by the NHID to help consumers understand some of the options they may hear about outside of the Marketplace.

Premiums

11. What are the grace periods for premium payment?

- The health insurance grace period is usually 90 days, provided both of the following are true:
  - An individual has a Marketplace plan and qualifies for an APTC, and
  - The individual has paid at least one full month's premium during the benefit year.
- The HealthCare.gov website provides information for on-exchange grace periods.
- Off-exchange plans have a 31-day grace period.

12. I picked a plan. What do I need to do next?

- To ensure coverage begins on January 1, consumers must pay their first premium by the insurance company's deadline, which in most cases is December 31, 2018. For more information on checking enrollment status on HealthCare.gov, click here.

Individual Mandate

13. Will I be fined if I do not purchase insurance in 2019?

- The individual mandate will not be enforced by the IRS in 2019. If you do not purchase insurance for 2019, you will not be fined.

Networks

14. How do I find an insurance plan that will allow me access to out-of-state providers?

- Individuals may access insurance plan network directories through the insurance companies' websites to determine if a desired out-of-state provider is in-network.

15. If I have health care costs from an out-of-network provider, will those costs count toward my maximum out-of-pocket (MOOP) amount?

- Possibly. Insurance companies are required to count cost-sharing paid for Essential Health Benefits to out-of-network providers and ancillary providers located at in-network locations, towards the in-network annual cost-sharing limit unless the issuer provides **written** notice to the enrollee by the longer of: a) when the carrier would typically respond to a prior authorization request, or b) 48 hours prior to the provision of the benefit.

16. How am I protected from balanced billing charges?

- **Balance billing** occurs when an insurance company's payment to an out-of-network medical provider does not cover the full amount charged for the service, and the provider bills the patient for the "balance" of the charge.
- Patients in New Hampshire are now protected from balance billing when they have chosen an in-network hospital or surgery center.
  - Anesthesiologists, pathologists, radiologists, and emergency medicine providers are prohibited from billing an insured patient for more than regular cost sharing, as long as the hospital is in-network.
  - Insurance companies are expected to contract with these providers and pay a commercially reasonable amount for treatment in order to meet network adequacy standards.

- The law only applies to fully-insured health plans, so it does not protect patients covered by a self-insured employer, even when the benefits are administered by a local health carrier. If your member card includes the NHID's phone number, your plan is fully-insured.

Prescriptions

17. How often can a formulary be changed and how will I be notified?

- Carriers may change formularies every 30 days (monthly) with a 45-day advance notice of any drug deletion or tier change (RSA 420-J:7 III).

18. Will a formulary change trigger a Special Enrollment Period (SEP) to seek other coverage?

- No.

19. What are my options if a carrier removes a drug I need?

- Individuals should pursue exceptions through their prescribing physician who will work with the insurance company to make a determination.

Other

20. How many total insured lives are there in NH?

- Current on-exchange (HealthCare.gov) enrollment numbers can be found on the NHID website.
- Enrollment for other markets can be found in the annual hearing rate report.

21. Can I get coverage through Medicaid Expansion?

- Low income NH residents may be eligible for low- or no- cost health coverage through ***the NH Granite Advantage Program,*** New Hampshire's Medicaid Expansion, which replaces ***the NH Health Protection Program (NHHPP) on 1/1/19.***
- If you are already enrolled in the NHHPP, you will receive information from the NH Department of Health and Human Services (DHHS) about how to pick a Granite Advantage plan for 2019.
- You may be referred to the Granite Advantage program by www.HealthCare.gov, if you appear to qualify for the program based on income.
- If you do not have coverage, but think you may be eligible and want more information, you can do any of the following:
  - Call the Medicaid Service Center at 1-888-901-4999 Monday – Friday, 8:00 a.m. - 4:00 p.m.
  - Apply online at NH Easy from 6:00 a.m. – midnight, seven days a week
  - Visit a DHHS district office or download an application; or
  - Visit your local ServiceLink center for help with the application.