2018 Open Enrollment FAQ - NHID Consumer Services

Version 11/28/17

Open Enrollment

1. **When is open enrollment?**
   - Open Enrollment began November 1 and ends December 15, 2017.
   - New plans will be effectuated on January 1, 2018 once the first premium payment has been made by the policyholder.
   - This is a shorter time frame than previous years, when open enrollment extended into January.

2. **Do I need to take any action if I liked my 2017 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 in the amount of Advanced Premium Tax Credits (APTCs) received. APTCs can help decrease the amount of premium owed to the carrier each month, but it is important to check each year to make sure they are accurately keyed to your current income and household size.
   - Consumers should double-check that their plan still 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 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 2018 plan that is comparable to their 2017 plan.

3. **The plan I had in 2017 will not be offered in 2018. What do I need to do?**
   - All Minuteman Health plans on the individual exchange will terminate on December 31, 2017. The New Hampshire Insurance Department (NHID) advises consumers currently enrolled in a Minuteman Health plan to select a new carrier for the 2018 plan year by December 15, 2017. If they do not enroll in a new plan, HealthCare.gov will auto-enroll them into a 2018 plan deemed comparable to their Minuteman plan.
   - Harvard Pilgrim Health Care will not offer its New Hampshire Network plans on the exchange for plan year 2018. However, the company will continue to offer its ElevateHealth Network. Consumers with the Harvard Pilgrim New Hampshire Network are encouraged to review their provider needs and select a plan accordingly.

4. **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 a Federal Navigator. Find contact information for local help on the NHID website or 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.
   - Navigators are funded and trained by the federal government to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms. They are required to be unbiased, meaning they cannot recommend a specific plan. You can meet with a Navigator for no cost.

Financial Assistance on HealthCare.gov

5. **Does the renewal letter I received from my health insurance company reflect the 2018 tax credits (APTC)?**
   - Consumers can view estimates of their APTCs and CSR qualification status on the plan preview tool on HealthCare.gov.
   - Consumers received renewal letters from their insurance companies – but the letter's estimate of what they would pay in monthly premium might be not accurate if they receive APTCs. This is because precise subsidy information was not available at the time these letters were prepared.
     - The second lowest Silver Plan in 2017 from which the 2017 APTC was calculated is no longer applicable and the 2018 basis for the APTC is increasing by approximately 78%.

6. **What are the Federal Poverty Level threshold amounts for financial assistance eligibility?**
   - Advance Premium Tax Credits (APTC's) 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 2018 Open Enrollment, income thresholds are based off of the 2017 FPL.
   - View Federal Poverty Levels here.
   - Cost Sharing Reductions (CSR's) are available for households with an income up to 250% FPL. A CSR is a discount that lowers the amount an individual has to pay for their out-of-pocket costs, such as deductibles, copayments, and coinsurance. If the individual or family is qualified, the plans on HealthCare.gov and SHOP will reflect CSR discounts. Those who are eligible for CSRs may only apply CSR assistance to Silver level plans on HealthCare.gov.

Rate Increases

7. **My 2018 rate increase is high and I can't afford it:**
   - If you are eligible for Advanced 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 2018 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.

8. **What caused the large premium increases for 2018 plans?**
   - 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 accessible on the NHID website.

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

10. 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.

11. What are the options for more affordable coverage?

- The NHID encourages individuals searching for more affordable coverage to contact an insurance agent/broker, a Federal Navigator, by visiting HealthCare.gov, or by contacting insurance companies directly.

Premiums

12. 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.

13. 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, 2017. For more information on checking enrollment status on HealthCare.gov, click here.

Individual Mandate

14. How much will the tax/fine for not purchasing insurance be for 2018?

- The 2017 fine was $695 per adult and $347.50 per child; Maximum of $2,085 OR 2.5% of household income, whichever is higher.
- The 2018 has not been announced. It is anticipated to be greater than the 2017 fine.
- Consumers may visit here for additional information.

15. Will the federal government enforce the tax/fine if I don't have coverage?

- The individual mandate has not been repealed or overturned and at this time; it is still in effect for 2018.
- Any change to that position will be released by Centers for Medicaid and Medicare Services or the U.S. Treasury.

Networks

16. 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 provider is in-network.

17. 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. Starting in 2018, carriers 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.

18. How am I protected from balanced billing charges?

- Issuers must continue to comply with state law regarding balance billing.
- State law requires health insurance carriers to include in their contracts with participating providers a provision stating that the provider shall not "bill, charge, collect a deposit from, seek payment or reimbursement from, or have recourse against a covered person or a person acting on behalf of the covered person (other than the health issuer or intermediary) for services provided pursuant to this agreement" including, but limited to, in the event of nonpayment by the issuer, issuer insolvency, or breach of agreement. Issuers are expected to include this provision in all provider agreements. Issuers that offer HMO products for the 2018 plan year are reminded they are subject to the bulletin, entitled Network Based Hospital Services, issued by the Department in 2006 (RSA 420-J:8).

Prescriptions

19. 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).

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

- No.

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

- Individuals should pursue exceptions through their insurance company's appeal process(es).

Other

22. How many total insured lives are there in NH; on-exchange and off-exchange?

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

23. I have coverage through the NH Health Protection Program (Medicaid Expansion). What do I need to do?

- Low income NH residents may be eligible for low- or no- cost health coverage through the NHHPP. If you are already enrolled in the NHHPP, you will receive information from the NH DHHS about how to pick a plan for 2018.
- If you do not have NHHPP coverage, but think you may be eligible and want more information, you can
    - Call the Medicaid Service Center at 1-888-901-4999 Monday – Friday, 8:00 a.m. - 4:00 p.m.
    - You can 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.
- In addition, you may be referred to the NHHPP by www.HealthCare.gov, if you appear to qualify for the program based on income.