FACT SHEET #18
Renewals and Redeterminations

Introduction

This fact sheet is intended to help Navigators answer specific questions that people with disabilities might ask about the annual renewal process for Marketplace plans. People can change plans during the Open Enrollment Period that starts on November 1 (in most states), and in order to have a plan that starts on January 1, 2023, consumers must choose a plan by December 15.

Q1. What is automatic renewal?

A. Automatic renewal is when an enrollee's marketplace coverage is automatically renewed based on information from their prior application and most recent tax returns. This allows the enrollee to forgo filling out an application for Marketplace coverage and stay enrolled in the same plan as the prior year or be enrolled in a comparable plan if the prior plan is no longer available.

The Marketplace can automatically renew most current enrollees, but if they do not have enough information to do an automatic renewal, the enrollee will get a notice in their Marketplace account and in the mail (if they opted to receive mail notifications) telling them to return to the Marketplace to update their information. If they do not return to update their information and select a plan for the coming year, they will lose their premium tax credit and could lose their Marketplace coverage altogether depending on the situation.

Q2. What if a person is automatically renewed but their current plan is no longer available?

A. If an enrollee's current plan in no longer being offered for the coming year, they could end up in a different plan with the same company or if that company is no longer covering their area, they will be placed in a similar type of plan with a different company (e.g., HMO – health maintenance organization, or PPO – preferred provider organization). If a person is automatically enrolled in a different plan, it will be in the same metal tier. The different metal tiers for Marketplace coverage are[1]:

- Bronze – lowest monthly premium but highest out-of-pocket costs (covers about 60% of costs)
- Silver – slightly higher monthly premium but out-of-pocket costs are lower than bronze (covers about 70% of costs)
- Gold – even higher monthly premium but even lower out-of-pocket costs (covers about 80% of costs)
- Platinum – highest monthly premium, with the lowest out-of-pocket costs (covers about 90% of costs); best for those who use a lot of care

[1] https://www.healthcare.gov/choose-a-plan/plans-categories/.

Q3. How does someone know if they will be automatically renewed?

A. People can log into their Marketplace account on healthcare.gov and update their application for the coming year as early as November 1 but no later than December 15 (for the changes to take effect January 1). Their account will also show if the person (or household) chose to allow the Marketplace to automatically renew their coverage (in a plan with similar pricing and coverage to the previous year). People can allow their coverage to be automatically renewed for up to five years before they are required to return to the Marketplace to update their information.

When someone is automatically renewed, the Marketplace will create a renewal application with the most current data they have about the individual, their family, household income, and access to other forms of coverage.

Q4. If a person selects automatic renewal on the application and wants to change their plan, how do they make that change?

A. Even if a person selected automatic reenrollment on an earlier Marketplace application, they are still allowed—and encouraged—to actively renew during the annual Open Enrollment Period. People can log into their Marketplace account, update their income and household information, and choose a plan for the coming year (either the same plan or a different one). They can also make these changes by calling the Marketplace call center or working with an in person enrollment assister. People can also change their automatic renewal preferences in their Marketplace account at any time.

Throughout the year, people can also return to their Marketplace account to report life changes that could qualify them for other Marketplace plans (sometimes with additional financial help), or Medicaid.[2] Users can update their application online by:

- Logging into their HealthCare.gov account
- Choosing the application that they want to update
- Clicking "Report a Life Change"
- Selecting the kind of change to report (e.g., a change in my household's income, size, address, or other information)
- Updating any changes to income, household members, or addresses
- Once completed, the person will get a new eligibility determination which will show options to change plans, changes in eligibility for financial help, and any documentation that the Marketplace may need to verify eligibility.

Q5. Should people change their Qualified Health Plan (QHP)?

A. A qualified health plan (QHP) is an insurance plan, certified by the Health Insurance Marketplace, which provides essential health benefits (EHBs).[3] If the plan a person had last year did not meet all their needs, selecting a different QHP may be something they should consider. Additionally, if their current plan made changes to its provider network or other benefit design,

[2] https://www.healthcare.gov/reporting-changes/how-to-report-changes/.

[3] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.

making sure that it continues to meet their needs is important. Many people with disabilities have health care providers who they trust and want to make sure they can still see. Additionally, prescription medications can become costly if the health insurance plan has higher co-pays. Because plans and prices change every year, people should always be encouraged to return to the Marketplace to review their options, even if they have not had any changes in their own household or income.

To ensure that the plan will meet the person's needs, assisters should consider reviewing the following questions with a person during the renewal process:

- Is your qualified healthcare plan working for you?
- Is your provider still on your health care plan?
- Do you have a new specialist provider that is not covered by your plan?
- Do you take any medications where the cost can be lowered by changing plans?
- Does the overall cost of your health care plan make sense with your disability for the upcoming year (i.e., are you expecting any higher costs for the coming year like acquiring new DME)?
- Does your current plan limit provider visits (e.g., physical therapy, mental health treatment) that creates a barrier to receiving the care you need and is there another plan that would not have those limits?

Q6. How will a person's eligibility for advanced premium tax credits be redetermined?

A. When a person applies for coverage in a Marketplace plan, they estimate their expected income for the year using their prior tax returns. If they qualify for a premium tax credit (PTC) based on the estimate, they can use any amount of the credit in advance to lower their monthly premium. People with income up to 250 percent of the federal poverty level also qualify for cost sharing reductions (CSR), which unlock special Marketplace plans with lower cost-sharing requirements.

A person's eligibility for PTC and CSR must be redetermined every year, either through active or automatic renewal. With automatic renewal, the Marketplace uses available data on the person's household income, address, and the amount of people in the household to redetermine eligibility for premium tax credits.[4] The redetermination process is based on IRS information about a person's income from the previous two tax years. If this information is not available, the Marketplace will discontinue the PTC along with CSR on the plan unless the person contacts the Marketplace directly to update this information.

[4] https://www.healthcare.gov/lower-costs/qualifying-for-lower-costs/.

Conclusion

Whether a person's income, health care needs, or coverage status has changed, visiting the Marketplace to update information and actively reenroll is an essential step in securing the health coverage that meets people's health care needs for the coming year. People should act before December 15 so that their new coverage takes effect January 1! More resources are available to help assisters serve people with disabilities at all stages of the enrollment process at the National Disability Navigator Resource Collaborative.

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American Association on Health and Disability (AAHD)
National Disability Navigator Resource Collaborative (NDNRC)
110 N. Washington Street, Suite 407
Rockville, MD 20850
301.545.6140/contact@aahd.us

www.nationaldisabilitynavigator.org

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