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# Understanding the Consumer Enrollment Experience in Federally Facilitated Marketplaces

*A Review of Calls to the Assister Help Resource Center (AHRC), November 2015–January 2016*

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The Center on Health Insurance Reforms (CHIR), based at Georgetown University's McCourt School of Public Policy, is composed of a team of nationally recognized experts on private health insurance and health reform. We work regularly with a multidisciplinary group of faculty and staff dedicated to conducting research on issues related to health policy and health services.

CHIR faculty and staff study health insurance underwriting, marketing and products, as well as the complex and developing relationship between state and federal rules governing the health insurance marketplace. CHIR provides policy expertise and technical assistance to federal and state policy-makers, regulators and stakeholders seeking a reformed and sustainable insurance marketplace in which all consumers have access to affordable and adequate coverage.

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## Introduction and Methodology

The Patient Protection and Affordable Care Act (ACA) has ushered in the largest expansion of health insurance coverage since Medicare's creation in 1965. Approximately 20 million people have gained coverage under the law, 12.7 million of them through health insurance plans offered on the newly created health insurance marketplaces.<sup>1</sup>

Unlike previous national coverage expansions, the ACA has extended coverage through a combination of expanded Medicaid programs and a system of advanced payments of tax credits to help defray the costs of commercial health insurance products for eligible individuals. Applying for these tax credits, which are only available through the health insurance marketplaces, and enrolling into health plans can be a complicated process. The marketplaces must take into account a consumer's immigration status, income, household size, access to other forms of coverage, and multiple other factors to assess his or her eligibility for coverage and financial assistance. Furthermore, health insurance is itself a complex product, and consumers must consider premiums, benefits, cost-sharing, and network design in selecting the optimal plan.

Consumers can obtain in-person help through the marketplace application and enrollment process from a range of assistance organizations, such as local Navigator programs, certified application counselors (CACs), in-person assisters (IPAs) and insurance agents and brokers. During the first year of marketplace enrollment, marketplace assisters helped an estimated 10.6 million consumers obtain coverage.<sup>2</sup>

However, assisters have faced enormous challenges staying on top of the complicated laws and rules that govern the eligibility and enrollment process. In response to feedback from assisters after the first year of marketplace enrollment, officials running the federally facilitated marketplace (FFM) created a specialized call center to provide assisters with technical and policy support. This call center, called the Assister Help Resource Center (AHRC), was piloted in a few states during the 2015 enrollment season and rolled out to assisters in states using the Federally Facilitated Platform. AHRC call center operators help assisters resolve complex individual cases related to application filings, eligibility determinations and redeterminations, enrollment and re-enrollment.

The AHRC keeps detailed daily logs that record each call, the assister's question, and the resolution of the case. Over the course of the 2016 open enrollment period (November 1, 2015 to January 31, 2016) or OE3, the AHRC received 1,384 calls from assisters from over 40 states. In general, assisters receive extensive training from the FFM and have numerous fact sheets, training slides and frequently asked questions to consult when they have questions. They can also contact the consumer call center for the FFM. Assistors were encouraged to contact the AHRC when these other resources were exhausted and when they needed highly specialized policy expertise. By their very nature, then, the questions posed in these call logs paint a picture of the complexity of the eligibility and enrollment process, and are not representative of the millions of interactions that assisters had with consumers during OE3. The vast majority of consumer issues that assisters handled were fully resolved without the need to seek assistance through the AHRC.

### Methodology

Prior to the start of the 2016 open enrollment period, the AHRC contracted with experts at Georgetown University's Center on Health Insurance Reforms (CHIR) to review daily call logs, support training for call center operators, and provide other policy and technical assistance. The AHRC's call logs form the foundation for this report, which attempts to categorize and assess the range of eligibility and enrollment challenges that assisters help consumers overcome. The authors hope that the findings, detailed below, can give state and federal officials greater insight into systemic problems that may still need to be addressed and help identify the resources and training materials that will be in the highest demand for future open enrollment periods.

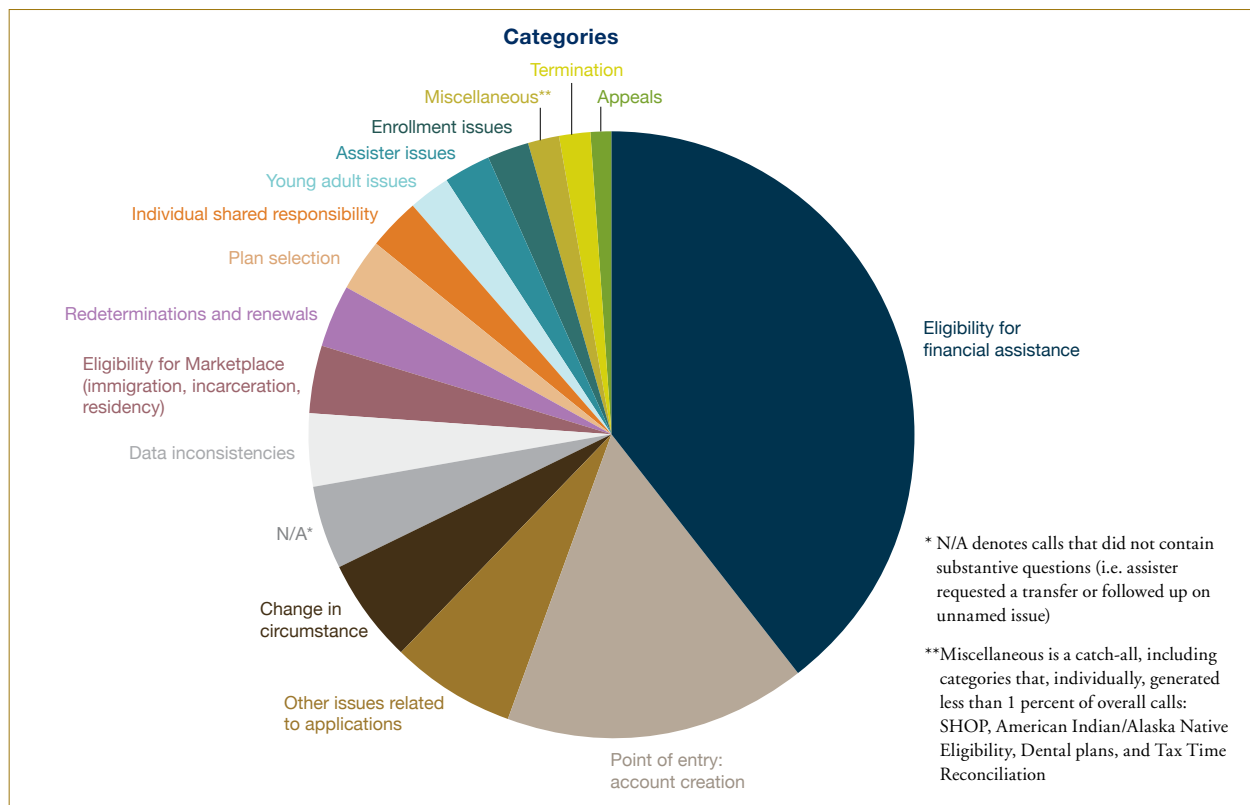
To prepare this report, Georgetown researchers tagged each call entered into the log between November 1, 2015 and January 31, 2016 with an eligibility and enrollment category label.<sup>3</sup> We then reviewed each question within each category in an attempt to capture the range of issues with which assisters were confronted. The report is organized by call category, in descending order by call volume. Within each section below, we provide examples of calls that exemplify common problems or concerns.

## The AHRC Call Logs: Key Consumer and Assister Challenges

Of the 1,384 calls that AHRC received between November 1, 2015 and January 31, 2016, the majority (546) requested help with the process of determining eligibility for marketplace financial assistance. (See Exhibit 1. For full table of volume of calls by category, see Appendix I). The next largest category (159 calls) related to account creation difficulties – primarily lost passwords and duplicate accounts from prior enrollment efforts. And although healthcare.gov has made great strides in functionality, a significant proportion of calls (93)

came from assisters confronted with technical or other challenges completing applications. Remaining categories, discussed in greater detail below, ranged from questions about assister training and responsibilities, eligibility to enroll in marketplace plans, renewing plans and eligibility redeterminations, selecting a new plan, including a young adult on a family plan, marketplace appeals, special enrollment periods, the requirement to maintain coverage, and reconciling the previous year's premium tax credits, among others.

**Exhibit 1. Volume and Categories of Calls Received by the AHRC**



### Eligibility for Financial Assistance

The AHRC received 546 questions relating to eligibility for financial assistance, representing 39.45 percent of total call volume. This was by far the largest category of questions for the AHRC. One of the most important responsibilities of the health insurance marketplace is to screen applicants for their eligibility for financial assistance – specifically, the advanced payments of premium tax credits (APTCs) and cost-sharing reductions (CSRs) that can help make premiums more affordable and health care services more accessible. However, determining who is eligible for these subsidies and at what

level is enormously challenging, involving multiple variables, including tax filing status, a family's annual income and household size, the availability of other sources of coverage, and this year, whether or not recipients of 2014 tax credits reconciled those tax credits on their 2014 tax return.

### Tax Filing Status

The AHRC received 39 questions about the appropriate tax filing status to report on a consumer's marketplace application, 2.82 percent of total call volume. The vast

majority of questions related to tax filing status (34 of the 39) came from married consumers. Married couples are ineligible for marketplace financial assistance if they file taxes as “married filing separately.”<sup>4</sup> However, many married individuals who would otherwise be eligible for tax credits file taxes separately for varied reasons, including an inability to locate an estranged spouse and in cases of abuse. The Internal Revenue Service (IRS) has created narrow exceptions to the rule for abandoned spouses and victims of domestic violence,<sup>5</sup> but the AHRC fielded numerous questions about whether and how these exceptions might apply. The AHRC also heard from individuals in the process of divorcing from their spouse, many of whom were in a period of separation. For someone applying for marketplace coverage in December 2015, it could be more than 16 months before they would be required to file a 2016 tax return. Because they were unsure of when their divorce would be finalized, these individuals were uncertain what filing status to report on their marketplace application.

#### *Separated spouses\**

“Counselor is seeking guidance on what to enter for filing status as married filing separately is not allowing any APTC. Consumer has been separated for 4 years from their spouse. The spouse lives in Texas and the consumer lives in South Carolina. The spouse provides support for the two children as needed. The consumer has filed as head of household on their taxes.”

#### *Divorcing spouses*

“Navigator called in because her consumer lives apart from her husband. They plan to file for a divorce in 3 months. Her husband’s income is not included in their household income. The consumer filled out the Marketplace application and answered the question about filing with her husband, she stated she will not file at the end of the year with him.”

\*Quotes excerpted from the AHRC call log have been lightly edited to fix typos, correct syntax and preserve anonymity.

### **Counting Income**

The AHRC received 203 questions about how to count or project income; these represented almost half of the questions about eligibility for financial assistance and 14.67 percent of the AHRC’s total call volume. This is not surprising - perhaps the most complicated issue for assisters and the consumers they serve is how to

report income on a marketplace application. Individuals applying for premium tax credits must understand what income to count to arrive at “modified adjusted gross income” (MAGI), project their income over the course of the tax year, and provide acceptable documentation to substantiate the estimate if federal data sources cannot verify their reported income.

Questions to the AHRC primarily focused on what sources of income to include as part of MAGI. They provide a window to the myriad sources of revenue that sustain American families, in addition to wages. These include survivor benefits, disability payments, unemployment benefits, supplemental security income (SSI), student loans, rental payments (including from rental properties in foreign countries), real estate sale proceeds, structured settlement funds, annuities, child support and foster care payments, housing allowances, interest on investments, firemen’s funds and veterans’ benefits. Determining what counts or doesn’t count towards MAGI is no easy task, particularly for non-tax professionals. Questions also revealed that many families don’t have a steady flow of income; for example, many asked whether and how to report one-time income sources such as 401K withdrawals, inheritances, and lump sum settlements.

Self-employed individuals also face unique challenges, particularly if their income is likely to fluctuate over the course of the year. The AHRC received several questions about how to project such income (including what deductions are permissible), and what to do if the ultimate income over the tax year is higher or lower than originally projected. Others called on behalf of consumers who had recently lost their jobs and did not know how to document their lack of income.

#### *Forms of income*

“The consumer she is dealing with has a unique situation in that he is a member of the clergy. He has a housing expense that is paid for him and is included on his W-2. The housing expenses shows up under a different box than the actual income.”

#### *One-time sources of income*

“Assister is assisting a consumer who in December will be selling some property that will affect a change in their income. The consumer wanted to know if she will have to pay back [tax credits] for the entire year or just for the month of December.”

*Projecting income*

“Navigator would like to know what happens if someone estimates their income and it is really low and they receive a lot of tax credits all year then at the end of the year their income is below 100% of the FPL which would have made them not eligible at all. Do they have to pay back all the tax credits or is there a limit on how much they pay back?”

*Foreign income*

“The assister will be working with a consumer that is a U.S. citizen that lives in the United States a little more than half the year. The consumer lives outside of the U.S. the rest of the time. The consumer is self-employed. He buys merchandise in the U.S. and then he sells it in Mexico. He does file taxes in the U.S., but he doesn't pay any taxes. He does file and pay income taxes in Mexico. The assister wanted to know if he would be eligible for advanced premium tax credits.”

**Determining Household Size**

The AHRC received 67 questions about determining household size, representing 4.84 percent of total call volume. An accurate portrayal of the applicant's tax household is critical to ensuring an accurate eligibility determination for financial assistance. To determine household size for premium tax credits, the IRS includes in the household anyone who is a dependent for tax filing purposes, regardless of family relationship or whether they live in the home. But the process can be complicated by the fact that Medicaid takes a different approach for people who don't file taxes and others who meet certain exceptions. For non-filers, for example, Medicaid does not include in the household dependents who are not immediate family members, even if they live in the home. It can be difficult for consumers and assisters to figure out how nuanced rules apply to often complicated family relationships.

Nineteen of the 67 questions were from assisters uncertain whether and how to include on the application older dependents, i.e., elderly parents or adult children. Divorced parents with children were also a common source of questions, particularly when non-custodial parents are obligated to purchase coverage for their children under divorce decrees. And the AHRC fielded several questions from “mixed status” families, in which one or more members of the household were undocumented.

*Non-custodial parents*

“CAC inquired about her client's complex case. He has a court mandate to provide health insurance to his two children. The children live with his ex-wife in Illinois. The father and mother do not communicate at all and are not married. The mother is the one that claims the children in her taxes. How can the father get the children health insurance?”

*Older dependents*

“The assister is working with a consumer that has a marketplace plan and is preparing to renew him for next year. The consumer has a wife and his 94-year-old father that he claims as a dependent. Both his wife and father are on Medicare. The assister wanted to know if they should be included on the application.”

*Mixed-status families*

“The navigator is currently working with a family that is trying to insure their 15-year-old daughter. The daughter is a U.S. citizen and has her social security number. The parents are not legal residents but do have an ITIN (Individual Taxpayer Identification Number). Navigator insists the consumer should be eligible for the tax credits and it would help the family immensely if they can gain access to the financial help.”

**Access to Other Minimum Essential Coverage**

The AHRC received 197 questions about the interplay between access to other forms of insurance coverage and marketplace financial assistance, 14.23 percent of total call volume. Under the ACA, individuals eligible for or enrolled in other forms of coverage, such as employer-sponsored insurance (ESI), retiree coverage, Medicaid, Medicare, and COBRA may not be eligible for financial assistance. But those other forms of coverage must be assessed on a case-by-case basis to determine whether or not they qualify as minimum essential coverage (MEC).

*Employer Sponsored Insurance*

The most common question (86 received) in this category came from consumers with access to an employer-based plan. If an individual is eligible for an employer-based health plan, and that plan is found to be both affordable<sup>6</sup> and adequate,<sup>7</sup> then the individual is not eligible for financial assistance through the marketplace. Many



assisters called the AHRC with questions about how to determine whether someone's ESI was either affordable or adequate or both. The largest category of ESI questions was on behalf of consumers caught in what is commonly referred to as the "family glitch;" these represented over one-third of all ESI-related calls. Under federal rules, if the premium for self-only coverage in the employer's lowest cost plan is less than 9.66 percent of household income, then no family member eligible for the employer's plan can qualify for a premium tax credit, no matter how expensive the premiums are for a family plan.

Several assisters also called on behalf of consumers who missed their employer's annual open enrollment season; others were in an employer's waiting period and not yet eligible for the ESI. Assisters wanted to understand what their clients' coverage options would be.

#### *Variable employment*

"Counselor is seeking guidance on determining the unaffordability of employer sponsored coverage for seasonal employment. Consumer is offered employer sponsored coverage at the cost of \$212/month. The cost of premium may be more than income earned in a slow month."

#### *Family glitch*

"Certified Application Counselor has a family of 3 she is working with. The husband has health coverage through his job and is given the option to cover the wife and child but the cost to cover all 3 family members is too expensive. The CAC would like to know if the wife and child are eligible for tax credits."

#### *COBRA Coverage*

The AHRC received 13 questions about consumers' access to COBRA coverage. Consumers with access to COBRA face unique issues. COBRA coverage is considered to be MEC, but unlike employer-based coverage, generally an individual can be eligible for COBRA and still receive APTC, so long as she or he is not enrolled.<sup>8</sup> Most callers were working with consumers who had been offered COBRA coverage and were trying to determine their best options for maintaining affordable, comprehensive insurance. Some callers were enrolled in COBRA but found the premiums too expensive; they wanted to know if they could drop their COBRA coverage and obtain marketplace subsidies instead.

#### *COBRA*

"Navigator has a consumer who has active COBRA coverage that will end in June 2016 and they are looking to find something cheaper through the Marketplace. The Navigator would like to know if the consumer is stuck with the COBRA or does it act like employer insurance."

#### *Medicaid/CHIP*

The interaction between Medicaid or CHIP eligibility and marketplace coverage was another significant source of questions. The AHRC received 68 such questions, approximately one-third of all calls relating to access to MEC. When consumers are eligible for their state's Medicaid or CHIP program they are generally not eligible for marketplace subsidies, but there are some important exceptions. For example, certain state Medicaid programs, such as coverage for low-income pregnant women, coverage for "medically needy" individuals, and some waiver programs may not meet MEC standards. Seven questions required an assessment of whether the consumer was eligible for or enrolled in one of these non-MEC forms of Medicaid coverage.

Thirty-six questions – over half of those related to Medicaid – spoke to the often slow and uncoordinated efforts to align marketplace eligibility determinations with the process of the state's Medicaid agency. Consumers often got caught between the two: once the marketplace assesses them as eligible for Medicaid (and therefore ineligible for subsidies), their applications must be submitted to the state for an eligibility determination. This process is not easy, short or streamlined in most states, and assisters' questions reflected this.

Twelve assisters wanted to know if their clients could turn down government coverage (Medicaid or CHIP) and enroll in a marketplace plan instead. A number of these families expressed anxiety about the numbers and types of providers they would have access to if they enrolled in Medicaid.

#### *Medicaid eligibility determination process*

"The assister will be meeting with a family later today to enroll in a qualified health plan. The parents were found eligible for advanced premium tax credits and the children were assessed as possibly eligible for Medicaid. The parents would like to enroll their children in a qualified health plan without premium tax credits while they are waiting to determine if their children will be found eligible for Medicaid by their state. They are very concerned about the children not having any coverage."



*Medicaid that is not MEC*

“Navigator called in because she is helping a young woman who recently became pregnant. On the Marketplace eligibility determination she was directed to Medicaid. The consumer will qualify for Medicaid’s pregnancy-only services; it does not meet MEC requirements. The consumer should technically qualify for the tax credits. The Marketplace call center suggested the consumer ‘Click Denied Medicaid in last 60 days.’ But she will not get denied Medicaid, she will get pregnancy-only services.”

*Medicare*

The AHRC received only 22 questions (1.59 percent of total call volume) from assisters about the interaction of Medicare eligibility and marketplace coverage, but these often came with high financial stakes for consumers. Specifically, the AHRC received several questions on behalf of consumers over 65 who don’t qualify for premium-free Medicare Part A (usually because they didn’t contribute a sufficient number of working hours). However, determining whether a marketplace plan is the best option for these individuals requires highly specialized expertise and a case-by-case assessment. If an individual is eligible, failure to enroll in Medicare on a timely basis can mean higher health care costs, gaps in health coverage, disrupted access to needed care, and tax penalties.<sup>9</sup>

*Beneficiaries with Medicare Part A only*

“Consumer is concerned that her Medicare Part A is not considered minimum essential coverage (MEC). She would like to supplement her Part A with a marketplace plan.”

*Medicare disability coverage*

“The Certified Application Counselor called regarding a consumer that she assisted with applying for a QHP during the last two Open Enrollments. The consumer was planning on re-enrolling for 2016. However, she received a card in the mail stating that she was approved for Medicare Disability coverage Parts A & B, effective as of June 1, 2011. The consumer, based on this coverage, will not re-enroll in a QHP for 2016. During the last two Open Enrollments, the consumer received premium tax credits. The CAC questioned if the consumer will have to pay back the premiums she received for the past two years?”

*Beneficiaries with Medicare Part B only*

“Certified Application Counselor called in to advise she has a consumer who has Medicare Part B only, and cannot afford Part A premiums. The Counselor would like to know if the consumer can enroll in a catastrophic plan.”

**Failure to file and reconcile 2014 APTCs**

This year, for the first time, eligibility for 2016 financial assistance was contingent on consumers having filed and reconciled their 2014 APTCs, if they received them. The AHRC received 16 questions from assisters about this topic (1.16 percent of total call volume). These calls were frequently triggered when consumers received the marketplace notice about their failure to reconcile APTCs, or because they were surprised to discover that they would no longer be eligible for subsidies in 2016.

*Failing to file 2014 tax return*

“The assister had worked with two consumers last week that did not know they had to file their taxes. They are on social security and previously have not been filing taxes. The assister helped them complete their Marketplace application for 2016. That is when the couple discovered they had to file their 2014 taxes since they had received advanced premium tax credits. Their eligibility results showed they would no longer receive advanced premium tax credits until they file their taxes.”

**Point of Entry: Account Creation, I.D. Proofing, Personal Information**

Of the calls logged during the third Open Enrollment period (OE3), 223 calls, representing 16.11 percent of the AHRC’s total call volume, focused on the point of entry to the application system.

**Account Creation**

The AHRC received 159 calls (11.49 percent of overall call volume) from assisters helping consumers that had problems creating an account, resetting a password, or with duplicate accounts. Many called requesting help unlocking accounts or resetting passwords, including those who had requested the reset online but stated they never received the temporary password. Some assisters believed they were talking to the Marketplace Call Center or that the AHRC could unlock accounts. A frequent inquiry came on behalf of consumers who could not recall

the email address they had used to create their original account, nor could they remember the answers to security questions. Assisters also asked about handling duplicate accounts, especially about how to combine accounts or link applications completed by phone to the online system. Some consumers forgot they had an application in the system from a previous year, while others purposefully created a new application in order to correct personal information or use a different email address.

#### *Application errors*

“Assister is assisting consumer who has updated her application information. Upon updating her information consumer put in the wrong information. Assister went ahead and created a new Marketplace application for the consumer. Now they are in the process of trying to remove consumer’s old application.”

### **Identity Verification**

Identity proofing was another challenge for consumers and assisters during OE3. The Marketplace requires consumers to verify their identity before creating an account to ensure the correct authorized person is signing up for health coverage. Identity verification uses information in a consumer’s credit report, through consumer reporting agencies such as Experian and Equifax. This can pose challenges for young adults, recent immigrants, or others without significant credit histories. The AHRC received 61 calls, representing 4.41 percent of all calls received, about identity proofing issues. Most questions asked for advice on how to verify a consumer’s identity after calls to Experian produced no resolution – whether as a result of Experian placing them on hold for extended periods of time, dropping their calls, or being unable to verify – and several assisters noted that they were “caught in the loop” between the Marketplace and Experian, where each was referring the consumer to the other. This “loop” seems to describe the process in which the online system directs consumers to call Experian after two failed attempts at identity proofing, and, if Experian is unable to verify identity, the system requires a subsequent failed attempt online before an option to upload verifying documents appears on the screen.<sup>10</sup>

Eleven of the calls included questions related to the consumer’s immigrant status during the identity proofing process. Consumers were also unclear whether the documentation they submitted resolved the issue or what the timeline would be for getting verification so that they could get covered. Additionally, consumers renewing their

coverage expressed confusion over being asked to contact Experian to verify their identity when they had not been asked to do so previously.

#### *Proving identity*

“In-Person Assister called while assisting a consumer with completing his online application. The consumer was unable to verify his identity with Experian. However, proof of identity documents were uploaded to the Marketplace account - income verification, resident card, and tax forms. A message displayed on the screen that the Marketplace was ‘Still trying to verify your identity.’”

### **Tobacco Use**

One of the first things consumers do when creating an account is indicate whether or not they use tobacco products. Those who do are subject to a premium surcharge of up to 50 percent.<sup>11</sup> Three calls to the AHRC suggest that some consumers who use e-cigarettes are uncertain whether to answer “yes” to the tobacco-use question. The federal Food and Drug Administration has proposed that e-cigarettes be classified as a tobacco product, but the federal marketplace has not provided any guidance for consumers or assisters on this issue.

### **Other Issues Related to Applications**

The AHRC received 93 questions from assisters related to problems or questions about completing consumer applications, representing 6.72 percent of total call volume. Slightly less than half of the questions (52) related to accessing healthcare.gov online or through the mobile application (41). These included a handful of questions about why the website was slow or “freezing.” Other questions were from those with difficulties completing or updating applications by phone (11). Fourteen questions came from consumers having problems editing their submitted applications or accessing their applications. The remaining 27 questions included general inquiries about the application process, including the legitimacy of other insurance websites besides healthcare.gov, about AHRC itself, and about functions on healthcare.gov. These included questions about whether open enrollment would be extended, a report of broken links on an insurer’s website, and a couple of inquiries on how to upload documents on healthcare.gov.

### **Data Matching Inconsistencies**

Assisters had 53 questions related to data matching inconsistencies (DMIs), representing 3.83 percent of

total call volume. The Marketplace uses information from federal sources to verify citizenship or immigration status as well as projected income when an individual applies for Marketplace coverage.<sup>12</sup> In general, a DMI or inconsistency occurs when the Marketplace cannot verify an individual's citizenship, immigration status or projected income with its federal sources.<sup>13</sup> Income related inconsistencies occur when there is no income source on file or when an individual's projected income is ten percent lower than the amount from its federal sources.<sup>14</sup>

In the case of a DMI, the Marketplace provides individuals with a temporary determination that allows them to enroll in a plan with financial assistance, if applicable. Individuals, however, have 90 days to resolve an income inconsistency and 95 days to resolve a citizenship or immigration related inconsistency. If an income DMI or citizenship/immigration DMI is not resolved, the Marketplace will either redetermine the amount of financial assistance based on the information available through their federal sources (for income DMIs) or terminate eligibility (for citizen and immigration related DMIs).<sup>15</sup>

Of the 53 questions related to DMIs, more than half were from assisters working on behalf of consumers that had sent or uploaded verifying documents, but the Marketplace indicated there was still an inconsistency or requested additional verifying documents. Most of these questions were related to income DMIs. Assisters and consumers were also frustrated by the process and the time it takes for an inconsistency to be resolved once consumers submitted documentation. Eighteen questions focused on what types of verifying documents qualified, particularly to allow self-employed or unemployed individuals to prove income. A handful of questions focused on problems uploading documents through the Marketplace system.

#### *Uploading documentation*

“The CAC stated that she has several clients that have received a letter stating coverage will be canceled unless they resolve inconsistency issues. CAC stated that she uploaded all the supporting information on application and system stated that the information was successfully uploaded at the time of application and when she checks now it is not showing that.”

#### *Documenting income changes*

“Certified Application Counselor (CAC) called regarding a consumer whose job based coverage will end this month. Beginning January 2016, the consumer will be self-employed. His income while employed was four times what his estimated income will be as self-employed. What information can he provide as proof of income?”

#### **Eligibility for Marketplace Coverage**

The AHRC received 50 questions about eligibility requirements for Marketplace coverage, representing 3.61 percent of total call volume. Under the ACA, an individual must meet three requirements to be eligible for Marketplace coverage: 1) be a U.S. citizen or lawfully present individual living in the United States; 2) not be incarcerated and 3) be a resident of the state where the individual is applying for coverage.<sup>16</sup>

The majority of questions (39 of the 50) focused on what categories of lawfully present status would qualify an individual for Marketplace coverage, and what supporting documentation would be needed. There are currently eleven broad categories of lawfully present immigration statuses, each with subcategories. For example, under a valid nonimmigrant status, individuals with various types of visas (i.e., student, worker visas) qualify for Marketplace coverage.<sup>17</sup>

Assisters also asked about the immigration requirements for the Marketplace versus for Medicaid. Unlike Medicaid, the Marketplace does not require lawfully present immigrants to be living in the United States for five years before they can access coverage. Others asked how to work with families with mixed immigration status, i.e., some members of the household were legal residents and others were undocumented. A handful asked questions about whether lawfully present individuals needed social security numbers to be eligible for Marketplace coverage. The remaining few questions related to the effect of an incarcerated spouse on a family's application and how the residency requirements apply in situations when individuals lived and worked or went to school in two different states.

*Mixed status families*

“The Certified Application Counselor (CAC) called regarding an immigrant family. The husband and children qualified for Medicaid; however, the wife has resided in the state for four years. Therefore, she does not meet the 5-year Medicaid residency threshold. Can she apply for health coverage through the Marketplace?”

*Incarcerated individuals*

“Navigator called to inquire about a consumer who is interested in signing up for health coverage on the Marketplace. However, the issue is that the husband has been convicted of a crime and is awaiting sentencing. The court date is set for some time in December. The husband will begin serving his sentence sometime in January 2016. The questions are: 1) Can the consumer include the husband on the application? 2) Should the consumer sign up for coverage now for herself, the child and the husband now?”

*Meeting the residency requirement*

“The assister is working with a couple that lives in Michigan six months out of the year and six months in Wyoming to attend school. She wanted to know what they needed to do when they are in Wyoming. They qualify for Medicaid while they are in Michigan.”

### Special Enrollment Periods and Changes in Circumstances

The AHRC received 49 questions related to special enrollment periods and 28 calls about reporting changes in circumstances; combined these represented 5.56 percent of total call volume. The calls included system-based questions about the process for reporting a life change or how to remove someone from an application because of divorce or death.

Marketplace consumers are required to update any changes in circumstances affecting their eligibility for coverage or financial assistance within 30 days of the change.<sup>18</sup> The Marketplace must also allow consumers who have a qualifying life event, such as losing minimum essential coverage, permanently moving, having a baby or getting married, to qualify for a special enrollment period

to either obtain a health plan or to change their health plan, as well as qualify for financial assistance.<sup>19</sup>

Of the 49 calls related to special enrollment periods, a little less than half reflected consumers who were losing other minimum essential coverage (usually employer-sponsored insurance). Others asked about the timeframe for taking advantage of a special enrollment opportunity, which can vary depending on the triggering event.

Other special enrollment-related inquiries were from people having a baby, getting married and moving. Most often assisters asked whether a particular event would qualify for a special enrollment period, or how the special enrollment period worked. There were a handful of questions about coverage effective dates under special enrollments and switching plans or adding household members throughout the year.

Most of the 28 calls related to changes in circumstances were about how to remove people from pre-populated applications during open enrollment. Other questions focused on the effect of a change in circumstance like income or marriage on premium tax credits, or what would happen to consumers who had not reported a change in circumstances within the prescribed timeframe.

*Loss of MEC*

“The assister wanted to know the time frame for a special enrollment period for someone who had lost their job. The consumer and his spouse moved from California to Missouri to start a new job in August. In November the consumer lost his new job.”

*Failure to report changes in circumstances*

“Certified Application Counselor called in to advise his consumer applied for 2015 coverage. During the year she was offered job based insurance but did not accept it, nor did she report it to the Marketplace. He also advised that the consumer job based coverage was considered affordable and meets minimum standards for coverage. CAC wanted to know if the coverage will end due to the consumer not reporting the offer from her job to the Marketplace.”

*Removing household members*

“Certified Application Counselor is not able to remove a stepfather who is no longer a part of the household from a 2016 application. The counselor attempted to Report a Life Change on a 2015 application to reflect the change. The 2016 application is not allowing a Report a Life Change.”

**Redeterminations and Renewals**

The AHRC received 48 calls related to the redetermination and renewal process, accounting for 3.47 percent of total call volume. The Marketplace, on an annual basis, must redetermine the eligibility of current Marketplace consumers for the next coverage year. The Marketplace must also re-enroll eligible consumers automatically to prevent a disruption in coverage. The redetermination process also includes a reassessment of eligibility for premium tax credits and cost-sharing reductions using the most recent household income data available through federal sources.<sup>20</sup>

For 2016 coverage, consumers could go back to the Marketplace to actively renew (which means to update their account information and select a plan). Active renewal ensures that consumers provide the Marketplace with the most recent information and that they have an opportunity to review and to select plans. Since health plans and their prices change year-to-year, including the second lowest cost silver plan that determines the amount of premium tax credits for eligible consumers, the Marketplace encouraged consumers to actively renew. Alternatively, if eligible consumers took no action, the Marketplace automatically reenrolled them (except for some specific and rare scenarios), but used information through federal sources and 2016 information (i.e., 2016 plan prices, updated federal poverty levels) to determine premium tax credits.<sup>21</sup>

Assisters had questions about the renewal process itself, both active and passive. In particular, there were questions about changes to premiums and the amount of premium tax credits when consumers had reported no changes to their income or household size. The substance of the calls suggest that consumers are unaware that the amount of premium tax credits can change annually depending on the price changes of plans in their area and updates to the federal poverty levels. There were also a number of questions from consumers who wanted to switch health plans and whether or not consumers would have to proactively terminate their old plans when doing so, particularly in situations in which health plans would

no longer be available in 2016. Assisters also appeared to have problems with the Marketplace IT system when helping consumers update information, particularly when trying to remove household members from pre-populated applications.

*Eligibility redeterminations*

“A certified application counselor is helping a consumer who was enrolled in a Marketplace plan this year with premium tax credits. When they updated application for coverage this year it is not showing her eligible for premium tax credits and they would like to know why.”

*Updating account information*

“The assister is helping a consumer re-enroll for 2016 Marketplace coverage. They are attempting to remove a dependent from the application for 2016. She has attempted two times to do this, and each time the dependent remained on the application. She also said this year she can no longer remove the previous application and can only update to make changes.”

**Selecting a Health Plan**

Assisters called the AHRC with 37 questions about health plan selection, representing 2.67 percent of total call volume. These questions ranged from general inquiries about viewing and comparing plans, understanding the ability to switch plans during open enrollment, and clarifying the benefit designs of specific health plans.

Sixteen of the questions the AHRC received related to the availability of plans or plan information. There were questions about why some consumers could only see one plan offered in their area; others complained that too many plans were available. Assisters also had questions about how to use the plan preview tool as well as the provider and prescription look-up tool.

Seven assisters had questions about what certain plans covered (e.g., pregnancy, cochlear implants) and how cost-sharing worked under a plan. Six questions were from consumers seeking to switch plans during open enrollment, in some cases because they had discovered that a provider was not in-network or that they faced high cost-sharing amounts after they had effectuated coverage.

Lastly, a handful of questions related to multi-state plans, particularly from assisters and consumers who were under the mistaken impression that all multi-state plans offer



access to an out-of-state network of providers.<sup>22</sup> Others had questions about how to assist consumers whose health plans were no longer offered.

#### *Locating benefit information*

“The assister was working with the consumer to compare plans and enroll. The consumer has certain prescriptions that she takes and wanted to select a plan that offered them. The assister wanted to know how to locate that information.”

#### *Locating cost-sharing information*

“Certified Application Counselor from Kansas inquired about her client’s plan enrollment. Her client filled out an application in her home and called the CAC to ask about choosing a plan. The client wants a certain plan but wants to know if in that plan, you have to meet the deductible before services are provided.”

#### *Multi-state plans*

“The CAC wanted to know if the consumer, who lives in Indiana, can get a Multi-State plan to have coverage in Illinois where his current doctors are.”

### **Individual Shared Responsibility Penalty and Exemptions**

Assisters contacted the AHRC 37 times with questions about the individual shared responsibility penalty, accounting for 2.67 percent of total call volume. All but two of the calls were about how to obtain an exemption from the penalty, with questions about immigration status, living abroad, having a hardship or having no income.

Under the ACA, all U.S. citizens and lawfully present individuals must have minimum essential coverage or pay a penalty for being uninsured.<sup>23</sup> The ACA, however, provides a number of exemptions to the health insurance requirement including unaffordability of coverage, undocumented status, living out of the country for a consecutive 330 days out of the year, and experiencing a hardship like bankruptcy or homelessness that makes purchasing health insurance difficult.<sup>24</sup> While some of these exemptions can be claimed by individuals through their annual tax filing, other exemptions, such as hardship exemptions, are only available through the Marketplace.<sup>25</sup>

Eight calls sought clarification about exemptions related to immigration status, including three related to Deferred Action Childhood Arrivals (DACA) who are not eligible for Marketplace coverage. Other questions were about whether certain situations qualify for the hardship exemption, how to apply for it, and how long the exemption lasted. There were also a handful of questions about how the individual mandate applied to individuals who did not regularly reside in the United States.

#### *Immigration-related exemptions*

“In-person Assister called to inquire about a consumer deemed ineligible for coverage due to her DACA status. Consumer wanted to know if she should file for exemptions and what form to use to do so.”

#### *Exemption for living abroad*

“The assister states that the consumer has a daughter who has been living abroad for a year. She states that the consumer’s child will be returning after aging out of the parents plan. The family wants to know if they qualify for an exemption for the time frame she has been living outside of the States.”

### **Issues Unique to Young Adults**

The AHRC received 33 questions on issues unique to young adults, representing 2.38 percent of total call volume. Navigators serving families with young adults had questions relating to their status as tax dependents of their parents, their ability to enroll on their parents’ health plan, and residency, particularly for those living in a different state from their parents.

One common question (10 out of 33) came from parents who wanted their son or daughter to enroll in their family plan. The ACA includes a requirement that health plans permit children under age 26 to stay on their parents’ health plan, regardless of whether or not the child is a tax dependent.<sup>26</sup> However, the FFM currently requires adults under age 26 who are not tax dependents to be assessed separately for eligibility for subsidies. Although they can ultimately enroll in the same plan as their parents, the system does not permit them to enroll together as a family if they want to receive subsidies.

This can have significant financial implications. For example, a young adult whose eligibility for subsidies is screened separately from his or her parents may not have sufficient income to meet the 100 percent FPL threshold

for premium tax credits. In a state that hasn't expanded Medicaid, this may mean that the young person falls into the coverage gap. In addition, a young adult child enrolling separately into a QHP must meet a separate deductible and out-of-pocket maximum from the rest of his or her family.

Other questions related to adult children who are tax dependents of their parents but who wish to apply on their own for financial assistance. In a few other cases, the adult children are over age 26, but remain as tax dependents of their parents; these families wanted to include them on their marketplace application.

The AHRC also heard from families whose children live out of state. Questions touched on marketplace residency requirements and how to find a plan with an out-of-state or "national" provider network.

#### *Child who is not a tax dependent*

"Certified Application Counselor has a consumer whose son is 22-years old. He works and files his own taxes and she files her own taxes. The CAC states the consumer would like to get a plan for her and her son and wanted to know if this could be done."

#### *Dependent children aging off parents' coverage*

"CAC is working with a consumer family whose household consists of father, mother, and son. The son is 26 years of age and just been dropped from his father's job coverage. The parents claim him as a dependent. The CAC wants to know if the son would be able to get coverage under the Marketplace as a dependent. The son isn't in school and has no income."

#### *Children living in a different state*

"Navigator is working with a consumer who has a daughter that will be attending college out of state. The consumer is trying to select and compare national plans that will best suit her daughter and her."

### Assister Issues

The AHRC received 33 questions, representing 2.38 percent of total call volume, about issues that assisters faced in training for and fulfilling their responsibilities helping consumers enroll in health insurance. Assistors who called with questions included Navigators, CACs, IPAs, and an insurance broker. Ten callers needed help completing or obtaining training or certification. Five questions related to

obtaining authorization to work on behalf of a consumer, and 2 assisters asked about using translators. Four assisters sought to correct or add information on the "Local Help" section of healthcare.gov, and 5 calls came from assisters looking for their assister ID number. The remaining questions related to reporting requirements, inputting assister information on applications, and technical trouble with the dedicated assister line.

#### *Gaining client authorization*

"CAC has client who has signed an authorization form giving her permission to complete application process on his behalf and she would like to know if that is sufficient documentation."

#### *Access to training*

"The navigator called to ask for assistance with the FFM Assister Training. Her colleague is locked out and has been unable to change his password. Can the AHRC assist him with resetting his password?"

### Enrollment Issues

The AHRC received 32 questions relating to various aspects of enrollment into health plans, representing 2.31 percent of total call volume. These included questions about coverage effective dates, whether and how coverage could be made retroactive, and other challenges effectuating enrollment.

#### Coverage Effective Date

Nineteen of the 32 questions pertained to coverage effective dates. More often than not, these questions came from consumers who were losing MEC – ESI or COBRA, for example – and weren't certain how to enroll into a marketplace plan without a gap in coverage. Consumers seeking to change from one QHP to another during open enrollment had similar questions.

Four assisters called the AHRC because their clients were seeking retroactive coverage effective dates.

#### *Lining up prior coverage with marketplace coverage*

"Certified Application Counselor called in with a consumer who had questions regarding COBRA and Marketplace Coverage. Counselor was wanting to know if the consumer could end COBRA coverage by 12/31/2015 so that she could enroll in a new plan through the Marketplace beginning on 1/1/2016."



*Obtaining retroactive coverage*

“Certified Application Counselor has a consumer and family needing to get insurance. Consumer recently lost his job and his insurance through is set to end in a couple of days (December 4, 2015). Counselor stated that the family has already applied for coverage which is set to begin on 1/1/2016. Spouse is medically needy and is having to go to the doctor every 2 weeks and counselor was wondering if there was a way to have coverage retroactive.”

**Other Enrollment Problems**

The AHRC received 13 additional questions from assisters about various other enrollment problems. These included queries from consumers waiting to receive insurance cards and those that reflected possible breakdowns of communication between the marketplace and the insurance company.

*Obtaining insurance cards*

“Navigator called in stating the consumer had registered for 2016 health coverage. He has selected his plan and paid his premium and has yet to receive his card or any other pertinent information regarding his plan.”

*Communication between marketplace and insurance providers*

“CAC called in for a client that completed the application at the beginning of December. The CAC completed the enrollment with the consumer and suggested that consumer call the insurance carrier to make a payment. The insurance company states that they do not have any information on this consumer.”

**Plan Cancellation/Termination**

Assisters called the AHRC with 21 questions, or 1.52 percent of the total call volume, related to plan cancellation or termination. Under federal rules, plan cancellation and termination are two discrete concepts, but the questions in the AHRC call log often use these terms interchangeably (see below). The FFM defines a cancellation to be a termination that takes place before coverage has been effectuated, whereas a termination would take place after coverage has been effectuated.<sup>27</sup>

Three questions in this category came from assisters helping consumers that had received unexpected termination notices. Three additional questions came from assisters helping people enroll in a 2016 plan when their 2015 coverage had been terminated due to non-payment of premiums. Marketplace consumers that receive premium tax credits are provided a consecutive three month grace period if they fall behind on premium payments, so long as they have paid their initial premium payment. At the end of the three month period, insurers can terminate coverage for consumers who fail to pay all outstanding premium payments.<sup>28</sup>

One question came from a consumer who continued to be billed months after terminating the plan through the Marketplace. Assisters also had problems when the primary subscriber needed to end coverage but wanted to keep other household members on the plan. Questions also arose from consumers with accidental overlapping coverage.

Eight questions involved consumers who were newly eligible for Medicare and wanted to terminate their Marketplace coverage. Many of the Medicare-related questions and others in this category sought advice on when to terminate to ensure seamless coverage, without experiencing a gap in coverage or having to pay back premium tax credits for duplicate coverage. Generally, if Marketplace coverage is being terminated for everyone on the application, whether the application contains one or more individuals, it takes 14 days for the termination to take effect. In such cases, a date can be set more than two weeks in advance to schedule coverage to end. However, if a consumer is ending coverage for only some people on a plan, thereby leaving others enrolled, termination generally takes effect immediately.<sup>29</sup>

*Removing a member from a plan*

“Certified Application Counselor called in with questions on how to remove someone from a Marketplace Application. Certified Application Counselor will be meeting with a family next week. The primary applicant is now eligible for Medicare and needs to cancel his coverage through the Marketplace. His spouse, however, would like to keep her coverage plan through the Marketplace. The Certified Application Counselor wants to know if they should cancel out their current plan and have spouse complete a new application to get coverage.”

*Failure to cancel a plan*

“Navigator is calling in for a consumer who is having an issue with their insurance provider billing them from their policy for 2014. The consumer had insurance in 2014, the consumer called the Marketplace to cancel the coverage in September of 2014. The insurance company did not receive the cancellation request from the Marketplace. The consumer applied for coverage for 2016 and chose a different plan with same insurance provider. The provider is billing the consumer for the 4 months of coverage that the policy should have been cancelled.”

*Unexpected cancellation of a plan*

“IPA has client whose insurance was cancelled in March 2015. IPA states that client wanted insurance to start in March of 2015. IPA stated that client thought she had coverage and wants to know why plan was cancelled so the same thing will not happen this year.”

**Appeals**

The AHRC received 15 calls about appeals of Marketplace determinations, representing 1.08 percent of total call volume. The ACA provides individuals with the right to appeal Marketplace eligibility determinations for coverage including accessing coverage outside of open enrollment (i.e., special enrollment periods), eligibility for financial assistance such as the amount of premium tax credit, and for Marketplace granted exemptions.<sup>30</sup>

In some cases, assisters called because appeal decisions in favor of the consumer were not communicated to the insurance company. Others were generated because paperwork was lost or never received and consumers faced significant consequences as a result (i.e., termination of coverage or financial assistance). A few assisters called because they could not determine the status of an appeal, nor was there clear information about how the appeal would affect their client’s coverage for 2016. There were also a few questions for assistance understanding appeal decisions.

*Managing the appeals process*

“Certified Application Counselor has a consumer who is in the middle of an appeal and she would like to know if the consumer can update her application or if she needs to wait until her appeal is over.”

*Executing an appeal decision*

“Navigator has client that has won an appeal on premium amount that should have been retroactive back to May 2015 and the adjustment still has not been updated. Client has been told by the health plan that they have not made the adjustment because they have not been informed by CMS to do so. Client has made several calls to the marketplace trying to resolve issue and has not been able to do so.”

**Dental Coverage**

The AHRC received 10 questions about dental coverage, representing less than 1 percent of total call volume (.72 percent). Marketplace consumers can purchase dental coverage as part of a health plan or as a stand-alone plan (SADP). Currently the FFM allows consumers to purchase dental insurance only when they are also enrolling into a health plan.<sup>31</sup> All of the AHRC questions focused on the process of enrolling in dental coverage as part of a health plan or as a stand-alone plan.

*Adding dental coverage*

“CAC called because her consumer has completed enrollment in a Marketplace health plan. A couple of days after completing their enrollment the consumer would now like to add dental coverage. How should the CAC go about adding dental coverage to the consumer’s account?”

**Tax Time Reconciliation and 1095 Forms**

The AHRC received 7 questions (or 0.51 percent of total call volume) about the process of filing taxes and reconciling APTCs for the prior coverage year. All but one of these questions came in the final month of OE3.

Five assisters asked how to obtain a 1095-A form or correct mistakes on one that had already been provided. Form 1095-A is the IRS statement required to be filed by the Marketplace that allows consumers who are covered by a Marketplace plan to file an accurate tax return, accounting for any premium tax credit they are owed or reconciling any advance premium tax credits they received.<sup>32</sup> The Marketplace was required to provide the 2015 statements (by mail or electronically) to consumers on or before January 31, 2016.<sup>33</sup> Callers identified mistakes on these forms, such as an adult child included on the form even though the child files taxes separately, as well as forms that did not reflect a reported income change.

One questioner asked how filing for bankruptcy would affect repayment of premium tax credits.

*Correcting 1095-A forms*

“Certified Application Counselor called regarding a consumer who received an incorrect 1095-A form. The form does not include coverage that the consumer had for the months of January – February – March 2015. How can she have the 1095-A form corrected?”

**American Indians/Alaska Natives**

The AHRC received 4 questions about ACA provisions related to American Indians and Alaska Natives (AI/ANs), representing less than 1 percent of total call volume (.29 percent). Under the ACA, American Indians (i.e., members of a federally recognized tribe) and Alaska Natives receive protections and benefits related to Marketplace coverage, including the ability to enroll through the Marketplace at any time during the year and to change plans once a month

under special enrollment periods.<sup>34</sup> AI/ANs can also enroll in health plans with zero or limited cost sharing, depending on their income eligibility.<sup>35</sup> The Marketplace must verify the status of AI/ANs applying for coverage.<sup>36</sup> AI/ANs are also exempt from the requirement to maintain health insurance coverage.<sup>37</sup>

Three of the 4 questions addressed marketplace eligibility for AI/ANs, including the process for verifying AI status. The remaining question was about how the exemption works for married couples when one spouse was an American Indian.

*Mixed status families*

“Navigator is working with a married couple. One individual is a member of a federal recognized tribe and the other is not a member. The navigator wanted to know if they both get the American Indian exemption.”

## Conclusion

Most of the early technical challenges facing the health insurance marketplaces have subsided, and millions of consumers now have dramatically improved access to comprehensive health coverage, often with financial assistance. But the rules governing eligibility for and enrollment into that coverage are complex and evolving, and are often challenging to apply to the myriad ways in which households are formed, income is gained, and coverage is obtained. Without doubt, one-on-one assistance is and will continue to be essential for many consumers, a large proportion of whom would not ultimately enroll into coverage without the guidance assisters provide. At the same time, marketplace assisters face a very steep learning curve, and no amount of training can prepare them for all of the different consumer interactions they are likely to have.

In response, federal and state officials have dramatically expanded the resources and support available to assisters.

These include manuals, on-line educational materials, and the AHRC call center. There will be a long-term need for this support as assisters cycle in and out and marketplace rules continue to evolve.

At the same time, assisters are an important source of information for the marketplace about consumers' experiences applying to and enrolling in coverage. Monitoring and analyzing the questions posed to and by assisters can help marketplace officials identify and address systemic or policy-related problems as they arise.

Supporting assisters with policy and technical expertise and monitoring their interactions with consumers are both important marketplace functions. Yet the resources for performing these functions are not infinite, and officials will need to prioritize areas of the greatest need. The authors therefore hope that reports such as this one can help officials identify such areas and target resources appropriately.

## Acknowledgments

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## Appendix

Category	November	December	January	Total	Percent of Total
Eligibility for financial assistance	228	208	110	546	39.45%
General	10	11	3	24	1.73%
Tax filing status	17	14	8	39	2.82%
Counting income/MAGI	79	77	47	203	14.67%
Counting household size	31	24	12	67	4.84%
Minimum essential coverage	3	2	3	8	0.58%
ESI/family glitch	42	29	15	86	6.21%
COBRA	4	6	3	13	0.94%
Medicaid/CHIP interaction	25	31	12	68	4.91%
Medicare interaction	9	9	4	22	1.59%
Reconciling 2014 APTCs	8	5	3	16	1.16%
Point of entry	94	100	29	223	16.11%
Account creation/password problems/ duplicate accounts	72	69	18	159	11.49%
Identity verification	19	31	11	61	4.41%
Tobacco	3	0	0	3	0.22%
Other issues related to applications	39	48	6	93	6.72%
Data inconsistencies	23	13	17	53	3.83%
General	3	2	4	9	0.65%
Income	17	9	11	37	2.67%
Documented status	3	2	2	7	0.51%
Eligibility for Marketplace	14	20	16	50	3.61%
Immigration	10	15	14	39	2.82%
Incarceration	1	3	1	5	0.36%
Residency	3	2	1	6	0.43%
Change in circumstance	38	22	17	77	5.56%
Redeterminations and renewals	15	25	8	48	3.47%
Plan selection	14	13	10	37	2.67%
Individual shared responsibility	10	10	17	37	2.67%
Young adult issues	10	15	8	33	2.38%
Assister issues	19	11	3	33	2.38%
Enrollment issues	8	17	7	32	2.31%
Coverage effective date	6	10	3	19	1.37%
Other enrollment problems	2	7	4	13	0.94%
Plan cancellation/termination	12	5	4	21	1.52%
Appeals	4	10	1	15	1.08%
Miscellaneous	9	6	8	23	1.66%
Dental	4	5	1	10	0.72%
Tax Time Reconciliation	0	1	6	7	0.51%
American Indians/Alaska natives	3	0	1	4	0.29%
SHOP	2	0	0	2	0.14%
N/A	-	-	-	63	4.55%

## Endnotes

- 1 Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Health Insurance Coverage and the Affordable Care Act, 2010-2016, Mar. 2016, <https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf> (last accessed Mar. 21, 2016).
- 2 Kaiser Family Foundation, 2015 Survey of Health Insurance Marketplace Assister Programs, Jul. 2014, <http://kff.org/health-reform/report/survey-of-health-insurance-marketplace-assister-programs/> (last accessed Mar. 2016).
- 3 Each call was assigned to one category label. In a few cases, we either over- or under-counted. Specifically, a few calls covered more than one substantive issue. When that occurred, the call was categorized according to the issue that appeared to be the primary concern of the consumer. Conversely, there were also a few calls in which more than one call was needed to resolve an issue. Each of these calls was separately tagged. On balance, however, we believe this tally is an accurate representation of the range of issues assisters brought to the AHRC during the open enrollment period.
- 4 26 U.S.C. § 36B(c)(1)(C).
- 5 26 C.F.R. § 1.36B-2T(a)(2).
- 6 “Affordable” in this context means that the employee’s annual premiums for a self-only plan do not exceed 9.66 percent of household income. 26 C.F.R. § 1.36B-2(c)(3)(v).
- 7 “Adequate” refers to the concept of “minimum value,” which means that the plan must cover at least 60 percent of covered services for an average population. 26 C.F.R. § 1.36B-6.
- 8 26 C.F.R. §1.36B-2(c)(3)(iv). Note however that if someone becomes eligible for COBRA because their hours were reduced at work and they are no longer eligible for their employer-based plan, then they will have to show that their COBRA coverage is unaffordable or doesn’t meet minimum value standard.
- 9 Medicare Rights Center, People with Medicare Can Ignore Marketplace Enrollment Deadline but Those with Marketplace Coverage Nearing Medicare Eligibility Must Act, News Release, Jan. 2016, <https://www.medicarerights.org/newsroom/press-releases/12816-2> (last accessed May 2, 2016).
- 10 Centers for Medicare and Medicaid Services, Tips for Submitting Supporting Documents to the Health Insurance Marketplace, March 20, 2015, <https://marketplace.cms.gov/technical-assistance-resources/submitting-supporting-documents.pdf> (last accessed Feb. 24, 2016).
- 11 45 C.F.R. § 147.102(a)(1).
- 12 45 C.F.R. § 155.310.
- 13 Data matching issues can also occur when verifying American Indian/Alaskan Native status or access to other types of coverage.
- 14 Health Insurance Marketplace, Consumer Guide for Annual Household Income Data Matching Issues, CMS Product 11954, Oct. 2015, <https://marketplace.cms.gov/outreach-and-education/household-income-data-matching-issues.pdf> (last accessed Feb. 24, 2016).
- 15 Centers for Medicare and Medicaid Services, Tips to Resolve Outstanding Data Matching Issues (Inconsistencies), Dec. 2015, <https://marketplace.cms.gov/technical-assistance-resources/resolve-data-match-issues.pdf> (last accessed Feb. 24, 2016). The Marketplace provides a special enrollment period to individuals whose coverage was terminated because of a citizenship or immigration related data matching inconsistency if an individual misses the timeframe to resolve the inconsistency, but later provides verifying documentation.
- 16 45 C.F.R. § 155.305.
- 17 See Health Insurance Marketplace, Serving Special Populations: Immigrants Fast Facts for Assisters.
- 18 45 C.F.R. § 155.330.
- 19 45 C.F.R. § 155.420.
- 20 45 C.F.R. § 155.355; Centers for Medicare and Medicaid Services, Helping Consumers with the Eligibility Redetermination and Reenrollment Process for 2016, Nov. 2015.
- 21 Centers for Medicare and Medicaid Services, Helping Consumers with the Eligibility Redetermination and Reenrollment Process for 2016.
- 22 The Multi-State Plan (MSP) Program, established under the Affordable Care Act, directs the U.S. Office of Personnel Management to contract with private health insurers to offer Multi-State Plans. Some may offer access to an out-of-state network of providers, but, despite the name, many do not. See U.S. Office of Personnel Management, Multi-state Plan Program and the Health Insurance Marketplace, <https://www.opm.gov/healthcare-insurance/multi-state-plan-program/>.
- 23 26 U.S.C. § 5000A.
- 24 26 U.S.C. § 5000A(e).
- 25 45 C.F.R. § 155.605.
- 26 45 C.F.R. §147.120.
- 27 45 C.F.R. § 155.430.
- 28 45 C.F.R. § 156.270.
- 29 See Healthcare.gov, Cancel Your Marketplace Plan, <https://www.healthcare.gov/reporting-changes/cancel-plan/>.
- 30 45 C.F.R. § 155.355.
- 31 See Healthcare.gov, Dental Coverage in the Marketplace, <https://www.healthcare.gov/coverage/dental-coverage/> (last accessed Mar. 15, 2016).
- 32 Internal Revenue Service, 2015 Instructions for Form 1095-A, <https://www.irs.gov/pub/irs-pdf/i1095a.pdf> (last accessed March 15, 2016).
- 33 Ibid.
- 34 45 C.F.R. §§ 155.350 and 155.420.
- 35 45 C.F.R. § 156.420.
- 36 45 C.F.R. § 155.350.
- 37 26 U.S.C. § 5000A(e)(3) and 45 C.F.R. § 155.605.



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