Marketplace Renewals: State Efforts to Maximize Enrollment into Affordable Health Plan Options

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INTRODUCTION

The stakes are high for the second year of health coverage enrollment under the Affordable Care Act. Though enrollment in the first year exceeded expectations, with just under 7 million enrolled, most experts predict that the remaining uninsured will be harder to reach and less motivated to sign up for coverage. The Congressional Budget Office has projected that the health insurance marketplaces will have 13 million people enrolled in 2015, but more recent estimates from the U.S. Department of Health and Human Services project only up to 9.9 million people will be enrolled if either target is met, the majority of enrollees will be people who were covered in 2014 and re-enrolled. Though the marketplaces must make a significant investment to reach out to and enroll the uninsured, they must also focus on retaining those already enrolled.

For 2015, marketplaces’ ability to conduct an effective renewal process for current enrollees is constrained by their information technology (IT) capacity, the short time period for open enrollment (November 15, 2014, through February 15, 2015) and limited resources for outreach and consumer assistance. All marketplaces must annually redetermine individuals’ eligibility for enrollment and financial assistance, but that redetermination may take place automatically in the federally facilitated marketplace (FFM) and some state-based marketplaces (SBM) to reduce demands on IT and support infrastructure and maximize retention. Federal law also requires insurance companies to renew policies for enrollees, with few exceptions. Thus, even if a marketplace is unable to conduct an automatic redetermination for marketplace and subsidy eligibility, and the consumer takes no action, many enrollees’ coverage will still be renewed. All marketplaces have communicated with consumers about their options, are ramping up call center and consumer assistance capacity, and are finalizing the testing of IT systems.

The FFM and SBMs are taking different approaches in their efforts to maximize enrollment among current marketplace policyholders, including the use of automatic renewals (auto-renewals). In the federal approach to auto-renewals, the FFM is extending the same absolute dollar amount of an enrollee’s 2014 premium subsidy to their 2015 coverage. Some SBMs are following the federal approach; others are diverging from it. Some SBMs are not using auto-renewals, instead requiring all enrollees to actively update their accounts and select a plan to maintain coverage and premium subsidies in 2015. Others are improving on the federal framework for auto-renewal to help ensure consumers receive a more accurate amount of financial assistance in 2015. In all marketplaces, officials recognize the considerable benefit for consumers that revisit the marketplace, update their account information and shop for new health plan options, as well as the financial risk for enrollees who fail to do so.

In this paper we evaluate six SBMs’ efforts to maximize
enrollment through the redetermination and renewal process. Through a review of federal and state policy decisions we selected six states (California, Colorado, Kentucky, Maryland, Rhode Island and Washington) for an in-depth case study of their approach to re-enrollment. The states were selected because their SBM approaches to re-enrollment differ from the FFM approach. Our case studies include analysis of marketplace policies toward re-enrollment and interviews with marketplace officials, health insurance company representatives and consumer assisters. We conducted 23 interviews from September 2014 to October 2014. We attempt to (1) describe the general consumer experience during the re-enrollment process, (2) understand the role of the SBM in shaping that experience, and (3) share emerging opportunities and challenges for future enrollment periods.

UNDERSTANDING THE RE-ENROLLMENT EXPERIENCE

Consumer Behavior in Insurance Markets

Most health insurance markets that offer a choice of plans, such as the marketplaces created by the Affordable Care Act, involve an annual opportunity for enrollees to change plans. In Medicare (Medicare Advantage and Part D) and most employer-sponsored systems (including the Federal Employees Health Benefits Program), the enrollee’s plan is typically automatically renewed: plan enrollees who take no action retain their current insurance and those who wish to make a change must take proactive steps to do so.

When auto-renewal is available, enrollees tend not to switch plans. In Medicare Part D, about 87 percent of all enrollees in stand-alone drug plans remained in the same plan from one year to the next, even though most had cheaper options available. Over a five-year period, 72 percent of Part D enrollees never made a voluntary switch of plans. This low rate of plan switching is matched in other settings that involve a full array of health services and affiliations to preferred doctors and hospitals. For example, in the Federal Employees Health Benefits Program, about 12 percent of federal employees switched plans annually between 1996 and 2001. A similar rate of switching (13 percent) has been reported for all nonelderly Americans with employer-sponsored health insurance, though that rate includes involuntary switching caused by changes in jobs or employer plan offerings. In some other settings, switching rates have been lower. In Massachusetts’ Commonwealth Care (the Massachusetts Health Connector), no more than 7 percent of enrollees switched plans in any year from 2009 to 2013.

Most likely, a larger number of people in these programs shopped during the open enrollment periods but did not switch plans. For example, a survey of Medicare beneficiaries found that 60 percent said they review or compare their options at least once a year. But in focus groups, many Medicare beneficiaries reported that they preferred not to switch plans because the initial process of picking a plan was “so frustrating.”

In both Medicare and Federal Employees Health Benefits Program, enrollees were more likely to switch when their current plans were making large premium increases or reducing benefits. But even in these circumstances, switching was infrequent. In Medicare Part D, 28 percent of those facing a premium increase of $20 per month or more made a switch, compared with 7 percent to 8 percent of those with premium decreases or small increases.

The marketplace context and population are different than in these other settings, and the situation is complicated by subsidies. Marketplace enrollees are more likely to have lower incomes, meaning the dollar impact of not shopping for alternative plans may be greater for them. The complexity of returning to the marketplace after the challenges of the 2013-14 experience, however, will be a deterrent.

The Only Constant is Change

In most marketplaces across the country, consumers that enrolled in 2014 are facing a different landscape in 2015. In many areas, new insurance companies are competing for their business. In a few others, insurers have dropped out. Further, many participating insurers have changed the plans they offer. Some are being discontinued; others are being added. Some plans are being continued but with important changes to benefits, networks, or cost-sharing. As one insurer put it, “our
policies have changed so much that they are cancelled, effectively.”

Almost universally, insurers are changing premiums for their 2015 plans. In some markets, premiums are rising; in others they are falling. In markets in which the average premium is unchanged or changed only modestly, there can be considerable premium volatility among plans. The degree of premium changes may also vary considerably among rating areas within a state. Thus, even consumers content with their 2014 plan are likely to learn about plan or premium changes that will affect their finances and potentially their access to care.

Changes in the Value of Premium Tax Credits
Because of premium changes for other plans sold in the marketplace, subsidy-eligible enrollees in plans without a change to their base premium may still face a change in the amount they pay for 2015. Financial assistance through the marketplace comes in the form of premium tax credits (PTCs) that are tied to the price of the second-lowest-cost silver plan available in a given area. This is known as the “benchmark” plan. Consumers receiving PTCs can “buy up” from the benchmark to obtain a more expensive plan. When they do, they pay the difference. Similarly, they can “buy down” from the benchmark by buying a cheaper plan, allowing their PTC to go farther.

Data suggest that the benchmark plan has changed from 2014 to 2015 in most markets. That is, a consumer enrolled in the benchmark plan in 2014 would need to switch to the new benchmark plan to get the maximum value of the premium tax credit. Also, even in markets in which the benchmark plan remains the same from 2014 to 2015, its price relative to other plans in the market is likely to be different. Though notices from the FFM and FFM insurers give enrollees general information about the possibility of a better deal if they return to the marketplace and shop, enrollees are not specifically told when there is a new benchmark plan with a lower price in their area.

Changes in Age and Federal Poverty Level Guidelines
Most enrollees will also face premium increases based on age because insurers are allowed to implement age-related premium increases. These increases may be large or small, according to a standardized age-rating curve. For example, an enrollee who has turned 21 will face a bigger jump in premiums than an enrollee who has turned 27. For those who are automatically renewed into coverage through the FFM, their PTC amount will not be adjusted to reflect this age-based increase in their premium. Also, an enrollee receiving PTCs and cost-sharing subsidies could be affected by the annual update to the federal poverty level (FPL), especially if his or her income crosses one of the income thresholds for reductions in their plan cost-sharing. PTCs and cost-sharing subsidies in 2014 were based on 2013 FPL guidelines. Consumers who actively enroll in a 2015 plan and update their marketplace accounts will have their information updated to reflect the 2014 FPL guidelines, but those whose plans are automatically renewed through the FFM will not. Consequently, they could end up receiving less in PTCs and cost-sharing subsidies than the amount they are entitled to. And though missed PTCs can be recouped when filing taxes in the following year, missed cost-sharing subsidies are never reconciled, so any missed support will never be recouped.

Exhibit 1.
Refresher: How Are Premium Tax Credits Determined?

<table>
<thead>
<tr>
<th>$450</th>
<th>Cost of silver benchmark plan (for age and service area)</th>
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<tbody>
<tr>
<td>-$75</td>
<td>Minus expected “premium contribution” (calculated as a sliding scale percentage of federal poverty level income)</td>
</tr>
<tr>
<td>==375</td>
<td>Equals premium tax credit (the amount a consumer receives to apply towards the cost of coverage he/she selects)</td>
</tr>
</tbody>
</table>

If a higher or lower cost plan is selected, the actual premium will be higher or lower than the expected premium contribution.

Exhibit 2. Plans Offered in Hypothetical Marketplace, Sorted by Premium

- Gold Plan
- Gold Plan
- Silver Plan
- Gold Plan
- Silver Plan
- Gold Plan
- Second-Lowest-Cost Silver Plan
- Bronze Plan
- Silver Plan
- Bronze Plan
- Bronze Plan
- Bronze Plan
- Bronze Plan
- Bronze Plan
- Bronze Plan

Benchmark plan: Basis for amount of premium tax credit

Source: Authors’ analysis
Change in Plan Eligibility
Some enrollees will have other changes that affect their eligibility for certain plans. For example, individuals enrolled in catastrophic plans may no longer be eligible for those plans once they turn 30. Young adults insured under a family plan may no longer be eligible for coverage with that plan if they turn 26 in 2014.

Change in Family or Income Circumstances
Many enrollees will have changes to their projected 2015 income or household composition that will affect their eligibility for financial assistance. Though some will have already reported income or household changes that occurred during 2014 and received a corresponding adjustment to their level of financial assistance, others may not have done so. Reporting the most up-to-date information to the marketplace is important. For those who have not updated their family or income information, the marketplaces will assess income and household information based on the projected income data in their 2014 marketplace application, which many enrollees completed in late 2013. Consequently, these data could be out of date, leading to lower or higher subsidy amounts that would later need to be reconciled when filing tax returns.

Risks and Benefits of Auto-Renewal
The FFM and some SBMs have created auto-renewal processes designed for individuals and families whose income or household circumstances have not changed their eligibility for financial assistance, whose plans are being continued in 2015, and who gave permission to the marketplace to access their tax information for renewal purposes. The benefit of auto-renewal is that eligible individuals will not need to revisit the marketplace to be re-enrolled into their plan. Most of those receiving financial assistance will continue to receive it. Auto-renewal is designed to maximize retention of current enrollees, ensure greater continuity of coverage, and relieve some of the pressure on the marketplace IT and consumer-assistance infrastructure.

However, auto-renewal carries the risks of significant premium increases for some consumers and tax liability for others. For those whose plans are automatically renewed, the FFM will provide the same absolute dollar amount of PTCs they received in 2014, without accounting for changes to the enrollee’s plan, the benchmark plan, income or household size, age of enrollees or FPL. Thus, few people whose plans are automatically renewed through the FFM will receive

Exhibit 3. What happens to the PTC under auto-renewal in two different scenarios?

Mary Scenario 1: Mary's plan premium stays the same; benchmark plan premium decreases in 2015. Mary's income is just below 150 percent of FPL and has not changed from 2014 to 2015. She does not plan to shop for a new plan, so her plan will be automatically renewed by the FFM. Her plan was the benchmark plan in 2014 and has a $400 monthly premium. Mary received $343 of PTC each month in 2014. In 2015, Mary's plan does not change, but a new plan with a $300 monthly premium enters the market and becomes the benchmark plan. Mary is still eligible for a PTC, but this amount is pegged to the new benchmark plan premium, minus her contribution at 4 percent of her income. Her PTC for 2015 should be $243 per month, based on the new lower benchmark. But because her old plan is automatically renewed in the FFM, she will still receive the same 2014 PTC of $343.

Mary Scenario 2: Mary's plan premium stays the same; benchmark plan premium increases in 2015. Mary's income and other circumstances are the same as in Scenario 1. But her plan is now the lowest-cost plan instead of the second lowest, and the new benchmark is a plan with a $450 monthly premium. Mary's 2015 PTC should be $393 a month, based on the higher benchmark. But if her plan is automatically renewed in the FFM, she will receive her 2014 monthly PTC of $343, or $50 less per month than she is eligible for in 2015. She will thus pay $57 each month for her plan, though she should be paying just $7. Though she can recover the difference during next year’s tax reconciliation, she will face higher costs in 2015 unless she goes to the marketplace to get an eligibility redetermination.

Table 1. Mary’s PTCs and Premium Payments Under Two Scenarios

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015: Scenario 1</th>
<th>2015: Scenario 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary's monthly income</td>
<td>$1,425</td>
<td>$1,425</td>
<td>$1,425</td>
</tr>
<tr>
<td>Mary's expected monthly premium (4 percent of income)</td>
<td>$57</td>
<td>$57</td>
<td>$57</td>
</tr>
<tr>
<td>Mary's PTC based on a 2014 benchmark premium of $400 a month (FFM approach)</td>
<td>$343</td>
<td>$343</td>
<td>$343</td>
</tr>
<tr>
<td>Mary's PTC based on the 2015 benchmark premium of $300 in Scenario 1 and $450 in Scenario 2</td>
<td>N/A</td>
<td>$243</td>
<td>$393</td>
</tr>
<tr>
<td>Mary's total premium for her current plan if it is automatically renewed with 2014 PTC</td>
<td>$57</td>
<td>$57</td>
<td>$57</td>
</tr>
<tr>
<td>Mary's total premium for her current plan, redetermined with 2015 information</td>
<td>$57</td>
<td>$157</td>
<td>$7</td>
</tr>
</tbody>
</table>

Note: N/A = not applicable.
the correct level of PTCs or cost-sharing reductions in 2015, as illustrated in Exhibit 3. Even those enrollees who have no personal changes in circumstances are likely to live in areas in which there have been premium increases or decreases and a change in the benchmark plan. The FFM approach also does not consider changes in enrollees’ age and annual changes to the FPL guidelines. Individuals who receive less in PTCs than they are eligible for (and must thus pay commensurately more in premiums) may be unable to afford their 2015 premium, and some may therefore drop coverage. Those who receive more PTCs than they are eligible for will be required to pay the extra amount back during the tax reconciliation process. In some cases, these amounts could be significant.

For the marketplaces, auto-renewal is a double-edged sword. It is attractive because it can help maintain overall enrollment numbers and reduce strain on marketplace and insurer customer support capacity (such as IT, call centers and in-person assistance). Many consumers, however, are likely to be re-enrolled in a plan that is suboptimal for them; this may be financially risky. As described, other health insurance programs’ auto-renewals have implicitly discouraged shopping and caused most people to stay in the same plan they had in the previous year.

Further, there is potential for error with auto-renewal because the marketplace draws on old income and household information that may not reflect enrollees’ current status. Consumers that do shop for a new plan are likely to find one that offers a better overall value; in each market there will always be at least one plan a subsidy-eligible consumer can purchase to keep their net premium the same. As one insurance company official put it, “The cynical part of me likes [auto-renewal] and the crusader part of me says that you have to get into the best coverage that you and your family need.”

RE-ENROLLMENT: STATE AND FEDERAL APPROACHES

SBMs have flexibility, within federally set boundaries, to develop their own processes for renewing enrollees. Even as they exercised that flexibility, however, SBMs faced uncertainty over the capability of their IT systems, the number and variety of plans insurers would offer and final approved premiums for the 2015 benchmark plans. This uncertainty made decision-making about the renewal process more difficult.

The FFM will renew enrollees into their current plan if it is available and if they do not take action to review their account information and select a plan. The FFM will apply enrollees’ 2014 PTC dollar amount to their 2015 coverage. Several SBMs have adopted this federal approach; others are able to adjust PTCs for auto-renewals to reflect 2015 plan prices, changes in age and the new FPL guidelines. But other SBMs are requiring all enrollees to return to the marketplace to update their account and select a plan. For some SBMs in this latter category, failure to return to the marketplace will lead to enrollees being re-enrolled in their plan without PTCs and cost-sharing reductions. In other SBMs, an enrollee’s failure to act will lead to the loss of both financial assistance and health insurance coverage. Of our six study states, all are pursuing an alternative process to the one the FFM uses.

States Requiring Active Re-Enrollment

Among our six study states, Maryland and Rhode Island both require current enrollees to return to the marketplace to review their information, check their eligibility, and actively re-enroll in a health plan. The consequences of inaction, however, are different. In Maryland, enrollees who take no action will still be renewed into health coverage but will not receive PTCs or cost-sharing reductions in 2015; they can receive these if they re-enroll. If Rhode Island enrollees do not return to the marketplace, however, their coverage stops after December 31, 2014.

In Maryland, which experienced significant IT problems in the marketplace’s first year and is switching to a new IT system, auto-renewal is not feasible. The marketplace was not able to transfer enrollees’ data from the old IT system to the new one. In Rhode Island, the marketplace is not able to implement auto-renewal because it did not obtain consent from applicants to allow access to enrollees’ income information for the 2015 redetermination process. But Rhode Island officials and stakeholders alike assert that given dramatic changes in plans and prices offered through the Rhode Island marketplace, requiring active renewals may be optimal.
For Rhode Island consumers. For example, premiums for some plans fell significantly, but the premium for the 2014 benchmark plan went up. Consequently, there is now a new benchmark plan available at a lower price than the 2014 benchmark plan. One insurer respondent told us that their data show that a subsidy-eligible enrollee remaining in the 2014 benchmark plan “could experience [as much as] a 100 percent premium increase” if he or she stayed in the same plan and did not shop for new coverage. Similarly, Maryland officials noted significant rate competition among participating insurers in 2015 and a resulting change in the benchmark plan. They concluded that by requiring renewing individuals to return to the marketplace for redetermination, “folks may be better off because they’ll get accurate eligibility [determinations].”

Officials and stakeholders in both states recognize that requiring active renewals could lower overall enrollment numbers. National studies have shown that Medicaid programs, including the Medicare Savings Programs, in which Medicaid provides supplemental assistance to low-income Medicare beneficiaries, experience reduced participation when they require enrollees to take an active step to renew eligibility. Consequently, the marketplaces in Maryland and Rhode Island are conducting proactive outreach to enrollees using email, telephone, regular mail and social media. By the end of the open enrollment period, enrollees will have received several rounds of communications from the marketplace and their insurance companies, urging them to return to the marketplace to ensure they continue receiving subsidies. But even repeated notices may not reach everyone.

Further, Maryland officials are concerned that consumers will be discouraged from taking steps to complete an active renewal because of user experience and IT system problems experienced during the last open enrollment period. “The biggest issue is changing perceptions of the…experience… [We] don’t want people to not come into the system because it was so bad last year.” Stakeholders confirmed this, reporting that the biggest obstacle to maximizing re-enrollment is concerns about system proficiency among Marylanders who used the marketplace last year. Consequently, the marketplace has planned an aggressive, multiphase communications campaign for current enrollees:

- July-August: work with insurers to build a database of enrollees’ contact information.
- September: contact enrollees via email, mail and phone about the redetermination process.
- October: begin media campaign to supplement direct outreach.
- November: insurers send enrollees a renewal notice; brokers and assisters initiate contacts with enrollees to encourage renewal.
- December: enrollees receive a reminder and “call to action” regarding the deadline to enroll in coverage effective January 1; additional outreach for those who have not yet obtained a redetermination.
- January–February: begin additional outreach to people that have not yet received a redetermination and chosen a new plan.

Maryland officials recognize that even with an extensive outreach effort, their requirement of an active redetermination for financial assistance will likely lead to a cohort of enrollees without PTCs in 2015. As one official put it, some enrollees will get “their first bill in January and ask, ‘What happened?’” after they are renewed into a plan without the PTCs they had received in 2014. Many of these individuals are likely to experience significant “sticker shock” when asked to pay their premium without a PTC. Though they can visit the marketplace and gain a redetermination of eligibility for PTCs, they may have to pay one or two months’ premiums without financial assistance.

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Table 2. State and Federal Approaches to Auto-Renewal*

<table>
<thead>
<tr>
<th>Automatic Renewal</th>
<th>Financial Assistance</th>
<th>Marketplaces in Our Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>PTC adjusted for 2015 with available premium, age and FPL guideline data</td>
<td>CA, CO, KY, WA</td>
</tr>
<tr>
<td>Yes</td>
<td>2014 PTCs applied unless consumer updates account and selects plan</td>
<td>FFM</td>
</tr>
<tr>
<td>Yes</td>
<td>No PTCs unless consumer updates account and selects plan</td>
<td>MD</td>
</tr>
<tr>
<td>No</td>
<td>Not provided unless consumer re-enrolls</td>
<td>RI</td>
</tr>
</tbody>
</table>

*Source: Authors’ review of FFM and SBM published materials.
in mid-October 2014. Openly renewed a month early, approach are not able to do this year. California also consumers PTCs to reflect changes in 2015 premiums, not actively re-enroll. Further, all four states can adjust redeterminations and renewals for enrollees who do not take action within the open enrollment period, consistent with federal and state regulations.

Auto-Renewal: State Efforts to Maximize Renewals and Improve the Renewal Process

Four of the six study states—California, Colorado, Kentucky, and Washington—can offer automatic redeterminations and renewals for enrollees who do not actively re-enroll. Further, all four states can adjust consumers’ PTCs to reflect changes in 2015 premiums, something the FFM and several states following the FFM approach are not able to do this year. California also opened its marketplace up for renewals a month early, in mid-October 2014. As one respondent noted, with 1.4 million people enrolled through their marketplace, the state needed to “smooth out the volume” and avoid “straining the back end of customer service and distribution capacity.”

All four states are investing heavily in marketing and outreach campaigns to educate consumers about the open enrollment opportunity. The California marketplace, for example, will spend more on outreach during this open enrollment period than it did during the first one. The Kentucky marketplace launched a mobile tour; has a shopping mall storefront; and is advertising on radio, TV, and social media. But the states are emphasizing somewhat different messages.

Some California respondents minimized the potential risks of auto-renewal, asserting that because rates are stable in the state and because the marketplace will adjust PTCs to reflect 2015 prices, most consumers will be content if their plan is automatically renewed. However, marketplace officials say that notices and marketing materials sent to enrollees encourage them to return, shop and compare plans.

Colorado, Kentucky and Washington are also, to varying degrees, encouraging enrollees to come back to the marketplace and shop for a new plan, even if they are eligible for auto-renewal. Officials in Kentucky report that they are encouraging consumers eligible for auto-renewal to shop because they have two new insurers and want consumers to see the new plans. Officials there also acknowledge that even though the state will adjust consumers’ PTCs to reflect the cost of the 2015 benchmark plan, some enrollees whose plans are automatically renewed could still face premium changes because their current plan may have a higher cost relative to the 2015 benchmark plan. Shopping for alternative plans will allow them to save money.

The marketplaces in Colorado and Washington shifted their messaging strategy around renewals after they gained better information about changes to plans and plan premiums for 2015. Early on, Washington reported they were not “going so strong on the shop around message,” but were providing a “softball pitch” of checking out other options and shopping. But after receiving an internal analysis of premium and benchmark plan changes, Washington officials adjusted their messaging to include a stronger push for consumers to return, review their account information and shop. Similarly, Colorado officials initially reported that they hoped to maximize the number of people who auto-renewed to reduce demands on their IT and customer support capacity. “For the population that’s eligible for the [auto-renewal] option, we’ll be pushing it,” officials said. However, shortly before the start of open enrollment, the marketplace received a rate and PTC impact analysis showing that almost all of their enrollees live in an area where the premium for the benchmark plan is decreasing, substantially for most of those enrollees. With this new information, the marketplace adjusted its messaging to enrollees to emphasize shopping and the new, lower-priced plan options available.
Washington may be unique among our six states in that marketplace officials estimate 20 percent of enrollees did not provide consent for the marketplace to access their income information for renewals. One respondent pointed out that some in this category have incomes well beyond subsidy eligibility, so renewal could have been done without income verification. Further, the plans of another 20 percent of enrollees are being discontinued because of changes to benefits and other factors.35 Most of these enrollees, however, will be transitioned into similarly structured plans; this is part of the auto-renewal process in Washington. The state’s Office of the Insurance Commissioner worked closely with participating insurers to smooth this process. Nevertheless, insurer respondents in Washington predict “lots of chaos” because of well-intentioned but perhaps confusing communications from the marketplace and their health plan. Individuals are receiving notices from their plan, the content of which is prescribed the Office of the Insurance Commissioner. The letter informs them of their 2015 plan information, such as the plan name and ID, but does not include information about their estimated premium or 2015 PTC. Consumers will receive separate letters from the marketplace, referred to as “open enrollment renewal letters” by marketplace officials, that inform them of the amount of their PTC. Insurer respondents believe this is a recipe for “total confusion” on the part of consumers. Other marketplaces, such as those in California, Colorado and Kentucky, are “co-branding” their notices with participating insurers so consumers receive the same messages from both entities.

Barriers to Re-Enrollment

Information Technology

All six states identified IT capacity and functionality as a top barrier to maximizing re-enrollment for 2015. Insurer respondents noted that many SBMs were behind on testing important components of the renewal system and worried about readiness for launch on November 15, 2014. One plan respondent reported that testing had not been possible as late as 20 days before the start of open enrollment. Further, stakeholders in Washington and Colorado noted that the marketplaces are still resolving billing and reconciliation problems from 2014, leaving them skeptical of system capacity for another round of open enrollment. As one insurer put it, “If we enroll people with bad data, then the reconciliation process will be a hole we don’t ever come out of.”

Stakeholders also identified a technical glitch that could anger consumers who change their plan selection during the renewal process. According to insurer respondents, the FFM does not have the technical capability to notify an enrollee’s previous insurer when they switch to a new insurer.36 Consequently, enrollees will have to proactively disenroll themselves from their old plan to avoid duplicate coverage (and therefore extra premium payments). Some states, such as Washington and California, report that they are able to send termination notices to insurers, but insurers say those notices are not always timely.

Insufficient Consumer Support Infrastructure

Another challenge is the limited amount of resources for marketplace consumer support, including call centers, Navigators and in-person assisters. “[T]he biggest challenge is spreading out the workforce for renewing customers,” one marketplace official told us; another reported she was primarily concerned with call centers’ ability to handle an expected high volume of consumer questions. An assister noted that because consumers “will wait for the very end” to either renew or enroll into coverage, the workforce’s capacity will be stretched to help renewing and newly enrolling customers. Another barrier that many assisters are up against is their inability to contact enrollees they helped during the last open enrollment period: assisters were prohibited from keeping records of their clients’ contact information.

Messaging

Other stakeholders identified communications and messaging to enrollees as a primary barrier; they are concerned that different messages are coming from different actors and creating confusion about deadlines. A Rhode Island assister told us: “We are fully expecting people to come through the door, confused by these notice letters [from their insurers and the marketplace].” Many respondents across the six study states also remarked that the volume of notices is adding to consumer confusion regarding what to do and when to do it. One assister noted that letters telling consumers to take action arrived two weeks before those consumers could take any action; consequently, “they’ll forget to do something.” The confusion about what to do, when to do it, and why they should do it could lead some enrollees to choose inaction, even if it is financially disadvantageous. In California, assisters report that enrollees “call and ask, ‘Do I have to come in?’ When I tell them they can be automatically enrolled, they are happy about that and take the path of least resistance.” Insurers expect widespread confusion, and some report they have prepared their own call center operators to answer questions arising because of the notices.

Marketplace officials and those working directly with consumers also cited concerns about their ability to
effectively explain how changes in plans and premiums, including changes to the benchmark plan, could affect enrollees. Because these changes could leave enrollees with higher premiums or potential tax liabilities and thus lead to frustrated and angry customers, conveying this information correctly and clearly is important.

**Short Time Frame**
Enrollees who want to actively renew their coverage and implement a plan change by January 1, 2015, for continuous coverage have a short window in which to do so: just 30 days, from November 15, 2014 to December 15, 2014. Most respondents are concerned about this tight time frame. “This is a daunting task,” said one insurance company observer. “Even if every state did what California did [opened early for renewals] and we staffed 24/7, we’d have to process 7,000 [renewals] per day [if everyone decided to get actively renewed].”

**CONCLUSION**

The eligibility redetermination and renewal process for current marketplace enrollees is a significant technical and policy hurdle to a successful enrollment season for health insurance marketplaces. Marketplaces are under pressure to boost their enrollment numbers and make the process as simple and streamlined as possible to limit the number of consumers who fail to renew their coverage. Experience in the Medicare program has demonstrated that when auto-renewal is available, most consumers will not take active steps to shop for a new plan, even if it is in their financial interest to do so. The FFM and many SBMs will help ensure continuity of coverage for consumers and maximize re-enrollment by allowing many consumers who take no action to automatically renew into the same or a similar plan. The auto-renewal option, however, will likely leave many consumers with ongoing insurance coverage but in a suboptimal situation. Some will be paying higher premiums than they should, some will be enrolled in a suboptimal plan, and some will face tax liability because they will have received more in financial assistance than the amount for which they are eligible. For many, the financial costs could be significant.

To help mitigate these problems, four SBMs we studied used their flexibility to improve on the FFM’s auto-renewal process by adjusting enrollees’ financial assistance to reflect the updated cost of the 2015 benchmark plan in each enrollee’s area, enrollees’ current age and updated FPL guidelines. Consequently, enrollees in these states will have a more accurate determination of their PTCs and cost-sharing subsidies than many residents of FFM states. But these enrollees still need to consider the potential value of shopping for a plan that better fits their needs, particularly because subsidy amounts may be a function of premium changes in other plans offered in the enrollee’s area. All six states we studied, and particularly the two SBM states that are not offering auto-renewal, are investing heavily in outreach and communication to enrollees to ensure they understand what they need to do and when they need to do it. At least two marketplaces, Colorado and Washington, changed their messaging strategy to de-emphasize auto-renewal and encourage enrollees to return to the marketplace and shop; these changes came after those states received data on changes to 2015 plans and prices. In all states, communications about renewals present a significant challenge: they require consumers to wade through many pages of technical and legal notices to understand the benefits and risks associated with re-enrolling through the marketplace.

Marketplaces will not know whether their plan-renewal processes have been successful in both maximizing coverage and enrolling consumers in optimal coverage until later in 2015. Either way, the policy, technical, and communication choices they have made will likely provide important lessons for state and federal officials responsible for future open enrollment periods.

*Consequently, enrollees in these states will have a more accurate determination of their PTCs and cost-sharing subsidies than many residents of FFM states.*
1. Tavenner, M. Letter to the Honorable Darrell Issa, Chairman, Committee on Oversight and Government Reform, U.S. House of Representa-


4. 79 Fed. Reg. 37262 at 37263 (July 1, 2014).

5. 45 C.F.R. § 147.106.


12. Hoadley et al., To Switch or Not to Switch.


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17. Although enrollees can choose to receive their PTCs as a lump sum pay-
ment at the end of the year (as part of a tax refund), the majority of enrol-
lees receive their PTCs in advance to defray their premium each month. When provided this way, they are referred to as “advanced premium tax credits.” For this report, we refer generally to both PTCs and advanced premium tax credits as PTCs.

18. The authors thank Tricia Brooks of Georgetown University’s Center for Children and Families for providing this example of the PTC at work.


22. Though the effect of changes to the FPL guidelines on PTCs may be modest, the effect on people eligible for cost-sharing subsidies could be significant. For example, an individual earning $23,000 in 2014 would be considered above 200 percent of FPL. This would make him or her eligible for cost-sharing reductions that increase the actuarial value of their silver plan to 87 percent. However, if his or her income did not change, he or she would drop below 200 percent of FPL in 2015, based on the recent update to the FPL tables. This would make him or her eligible for cost-sharing reductions that increase the actuarial value of their silver plan to 87 percent.

23. 45 C.F.R. § 156.155.

24. 45 C.F.R. § 147.120.

25. There is no tax reconciliation process for cost-sharing reductions. Eligible individuals who receive more in cost-sharing reductions than they are entitled to (based on actual income) will not be required to pay the
difference when filing taxes; individuals who receive less in cost-sharing reductions than what they are entitled to will not be able to recover those.


27. All enrollees receiving PTCs will go through the tax reconciliation process when they file their 2015 tax returns. Based on their actual 2015 income, those receiving too little in PTCs will be paid back via a tax refund and those receiving too much will be required to pay that assistance back.


29. 45 C.F.R. § 155.335(a).


