

Marketplace Assister Essentials



This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.

Course Introduction

Welcome



Welcome to the Marketplace Assister Essentials course!

This course includes an overview of important information that will help you provide consumers in Federally-facilitated Marketplaces (FFMs) with eligibility and enrollment assistance or support them with exemptions and appeals.

For detailed information about topics covered in this course, we encourage you to reference the Assister's [Standard Operating Procedures \(SOP\) Manual](#). Ready? Let's get started!

Welcome to the Marketplace Assister Essentials course!

This course includes an overview of important information that will help you provide consumers in Federally-facilitated Marketplaces (FFMs) with eligibility and enrollment assistance or support them with exemptions and appeals.

For detailed information about topics covered in this course, we encourage you to reference the Assister's [Standard Operating Procedures \(SOP\) Manual](#). Ready? Let's get started!



Before we begin, you need to be aware of these training disclaimers. Select each menu item below to read each disclaimer.

Disclaimers

- ✓ Assister Training Content
- ✓ Coronavirus
- ✓ Standards Related to Essential Health Benefits
- ✓ Remote Application Assistance
- ✓ FFM Navigator Duties

FFM Navigator Duties

Beginning with Navigator grants awarded in 2022, including non-competing continuation awards, Navigators are required to provide information on and assistance with all of the following topics:

- Understanding the process of filing Marketplace eligibility appeals;
- Understanding and applying for hardship and affordability exemptions granted through the Marketplace for consumers age 30 and older seeking to enroll in a Catastrophic plan;
- Marketplace-related components of the premium tax credit reconciliation process, and understanding the availability of IRS resources on this process;
- Understanding basic concepts and rights related to health coverage and how to use it; and
- Referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice related to consumer questions about the Marketplace application and enrollment process and premium tax credit reconciliations.

CMS will continue to provide all assisters with additional information related to these assistance activities through webinars, job aids, and other technical assistance resources.

Before we begin, you need to be aware of these training disclaimers.

Assister Training Content:

The information provided in this training course is not intended to take the place of the statutes, regulations, and formal policy guidance that it is based upon. This course summarizes current policy and operations as of the date it was uploaded to the Marketplace Learning Management System. Links to certain source documents have been provided for your reference. We encourage persons taking the course to refer to the applicable statutes, regulations, CMS assister webinars, and other interpretive materials for complete and current information.

This course includes references and links to nongovernmental third-party websites. CMS offers these links for informational purposes only, and inclusion of these websites shouldn't be construed as an endorsement of any third-party organization's programs or activities.

Coronavirus (COVID-19):

This training does not address COVID-19-related guidance or related requirements for assisters. CMS will communicate applicable information to assisters and assister organizations through separate channels.

- To learn more about how we're responding to coronavirus, visit [HealthCare.gov/coronavirus/](https://www.healthcare.gov/coronavirus/).
- For preventive practices and applicable state/local guidance, visit [CDC.gov/coronavirus](https://www.cdc.gov/coronavirus/).

Standards Related to Essential Health Benefits:

Navigators in FFM(s) must be prepared to inform consumers of the essential health benefits (EHB) that qualified health plans (QHPs) must cover in the FFM(s) they service. For plan years beginning on or after January 1, 2020, states may select which benefits will be EHB in their state. All plans offered in the Marketplace must cover the [10 EHB categories](#), but the specific items and services covered within each benefit category may vary based on state requirements and plan design.

Remote Application Assistance:

Navigators in FFM(s) are not required to maintain a physical presence in their Marketplace service area. In some cases, Navigators may provide remote application assistance (e.g., online or by phone), provided that such assistance is permissible under their organization's contract, grant terms and conditions, or agreement with CMS and/or their organization.

Certified application counselors (CACs) in FFM may also provide remote application assistance if such assistance is permissible with their certified application counselor designated organization (CDO).

For guidance on obtaining consumers' consent remotely over the phone, visit: [Marketplace.cms.gov/technical-assistance-resources/obtain-consumer-authorization.pdf](https://www.marketplace.cms.gov/technical-assistance-resources/obtain-consumer-authorization.pdf).

FFM Navigator Duties:

Beginning with Navigator grants awarded in 2022, including non-competing continuation awards, Navigators are required to provide information on and assistance with all of the following topics:

- Understanding the process of filing Marketplace eligibility appeals;
- Understanding and applying for hardship and affordability exemptions granted through the Marketplace for consumers age 30 and older seeking to enroll in a Catastrophic plan;
- Marketplace-related components of the premium tax credit reconciliation process, and understanding the availability of IRS resources on this process;
- Understanding basic concepts and rights related to health coverage and how to use it; and
- Referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice related to consumer questions about the Marketplace application and enrollment process and premium tax credit reconciliations.

CMS will continue to provide all assisters with additional information related to these assistance activities through webinars, job aids, and other technical assistance resources.

You and Assister

In this course, the terms "you" and "assister" refer to the following types of assisters:



Navigators

in Federally-facilitated Marketplaces



Certified application counselors

in Federally-facilitated Marketplaces

Note: In some cases, "you" is also used to refer to a consumer but it should be clear when this is the intended meaning.

The terms "Federally-facilitated Marketplace" and "FFM," as used in this training course, include FFMs where the state performs plan management functions. The terms "Marketplace" or "Marketplaces," standing alone, often (but not always) refer to FFMs.

In this course, the terms "you" and "assister" refer to the following types of assisters:

Navigators in Federally-facilitated Marketplaces

Certified application counselors in Federally-facilitated Marketplaces

Note: In some cases, "you" is also used to refer to a consumer, but it should be clear when this is the intended meaning.

The terms "Federally-facilitated Marketplace" and "FFM," as used in this training course, include FFMs where the state performs plan management functions. The terms "Marketplace" or "Marketplaces," standing alone, often (but not always) refer to FFMs.

Course Goal

This course has important information that will help you provide consumers in FFMs with eligibility and enrollment assistance or support them with exemptions and appeals.



Goal:

To provide the tools and information needed to help consumers apply for health coverage through the Marketplaces.



Topics:

This course includes information on:

- Consumer consent and PII
- Assessing consumers' needs
- Account creation process
- Identity verification and supporting documents
- Comparing and selecting plans
- Helping consumers enroll in and terminate coverage
- Changes in circumstances
- The individual shared responsibility requirement and exemptions to enroll in Catastrophic coverage for consumers who are age 30 or older
- Marketplace appeals

This course has important information that will help you provide consumers in FFMs with eligibility and enrollment assistance or support them with exemptions and appeals.

Goal:

To provide the tools and information needed to help consumers apply for health coverage through the Marketplaces.

Topics:

This course includes information on:

- Consumer consent and PII
- Assessing consumers' needs
- Account creation process
- Identity verification and supporting documents
- Comparing and selecting plans
- Helping consumers enroll in and terminate coverage
- Changes in circumstances
- The individual shared responsibility requirement and exemptions to enroll in Catastrophic coverage for consumers who are age 30 or older
- Marketplace appeals

Marketplace Overview

The Health Insurance Marketplaces

Consumers can apply for health coverage through the Health Insurance Marketplaces. Those who don't have health insurance through a job, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or another source that provides qualifying health coverage may qualify for financial assistance through a Marketplace.

Each state has a Marketplace for individuals and families and, with the exception of Hawaii, a Small Business Health Options Program (SHOP) Marketplace for small businesses and their employees. States have the option to run their own Marketplaces or to have the Federal Government run them.

This training is addressed to Navigators and CACs in states with FFMs. However, you should understand a few key differences between FFMs and State-based Marketplaces (SBMs).

Select each app to learn more about each [type](#) of Marketplace.



State-based Marketplaces



Federally-facilitated Marketplaces

State-based Marketplaces

States that manage all Marketplace functions have an SBM. Some SBMs rely on a federally-operated information technology platform to manage their eligibility and enrollment functions. These SBMs still hold primary responsibility for managing Marketplace functions.

Consumers can apply for health coverage through the Health Insurance Marketplaces. Those who don't have health insurance through a job, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or another source that provides qualifying health coverage may qualify for financial assistance through a Marketplace.

Each state has a Marketplace for individuals and families and, with the exception of Hawaii, a Small Business Health Options Program (SHOP) Marketplace for small businesses and their employees. States have the option to run their own Marketplaces or to have the Federal Government run them.

This training is addressed to Navigators and CACs in states with FFMs. However, you should understand a few key differences between FFMs and State-based Marketplaces (SBMs).

Different Types

Generally, states are the primary regulators of health insurance companies. States are generally responsible for enforcing statutory requirements for health insurance and provisions of the Affordable Care Act (ACA)—both inside and outside of the Marketplaces.

State-based Marketplaces

States that manage all Marketplace functions have an SBM. Some SBMs rely on a federally-operated information technology platform to manage their eligibility and enrollment functions. These SBMs still hold primary responsibility for managing Marketplace functions.

Federally-facilitated Marketplaces

States that choose to have the Federal Government manage all Marketplace functions have an FFM. In some FFMs, states choose to oversee or regulate plan management functions. Some states with an individual market FFM operate their own SHOP Marketplace. Others have a Federally-facilitated SHOP Marketplace (FF-SHOP). Some states operate a State-based Marketplace on the Federal Platform (SBM-FP) which are like SBMs, but they rely on HHS services to perform certain Marketplace functions, particularly eligibility and enrollment, while still retaining responsibility to perform certain Marketplace functions like QHP certification and consumer outreach and assistance functions. SBM-FPs are required to operate a SHOP; however, some SBM-FPs rely on the FF-SHOP on an interim basis as they transition to full SBMs (e.g., VA).

Note: FF-SHOP Marketplaces and FF-SHOPs using the federal platform no longer offer employee eligibility, premium aggregation, and online enrollment functionality. Instead, qualified employers and employees can enroll in SHOP plans by working with a qualified health plan (QHP) issuer or SHOP-registered agent or broker.

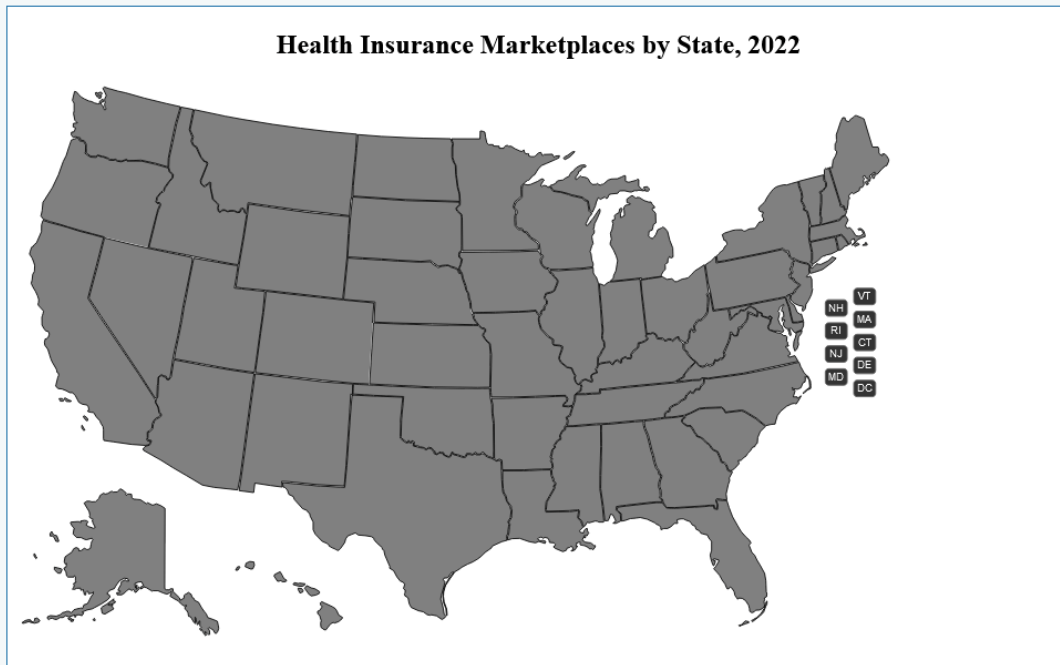
Small employers in states with an FF-SHOP can continue to use the SHOP website to:

- Learn about the benefits of SHOP, including the availability of tax credits for qualified employers;
- Compare available medical and dental plans side by side using the SHOP See Plans and Prices tool; and
- Submit SHOP employer applications and obtain eligibility determinations.

In addition, small employers can contact the SHOP Call Center for any questions or assistance related to submitting employer applications for SHOP coverage.

2023 Marketplace Information by State

You can find important characteristics about your state's Marketplace by selecting your state in the "Marketplaces by State" map. We encourage you to record your state's information and store it for easy access, but you can access this map at any time by selecting the **Map tab** in the course **Menu**.



You can find important characteristics about your state's Marketplace by selecting your state in the "Marketplaces by State" map. We encourage you to record your state's information and store it for easy access, but you can access this map at any time by selecting the **Map tab** in the course **Menu**.

How Consumers Use the Marketplaces

Consumers can use the Marketplaces to find and apply for health coverage that fits their budgets and specific needs.

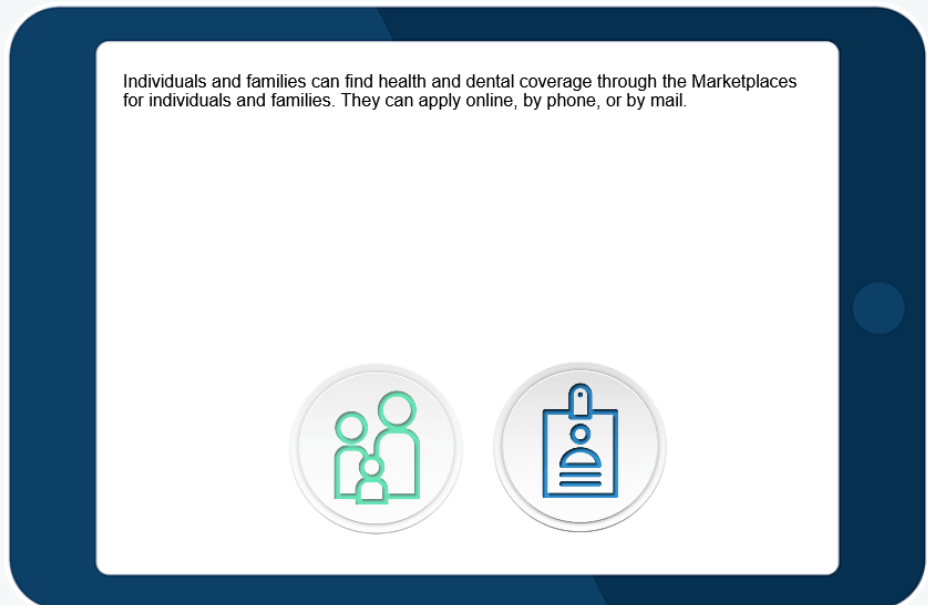
Select each graphic for more information.

Remember, eligible consumers can enroll in [qualified health plans](#) (QHPs) during the annual Open Enrollment Period (OEP) or during a Special Enrollment Period (SEP).

Consumers who experience certain life events at any time during the year, like getting married or having a child, may qualify for an SEP to enroll in or change QHPs.

Consumers can also apply for Medicaid and CHIP at any time during the year and aren't limited to an OEP or SEP. Medicare and other public health coverage options have different annual OEPs. Refer to [Medicare.gov](#) for the Medicare Open Enrollment dates.

No matter how consumers apply and enroll, you can provide in-person help.



Consumers can use the Marketplaces to find and apply for health coverage that fits their budgets and specific needs.

Individuals and families can find health and dental coverage through the Marketplaces for individuals and families. They can apply online, by phone, or by mail.

Remember, eligible consumers can enroll in qualified health plans* (QHPs) during the annual Open Enrollment Period (OEP) or during a Special Enrollment Period (SEP).

Consumers who experience certain life events at any time during the year, like getting married or having a child, may qualify for an SEP to enroll in or change QHPs.

Consumers can also apply for Medicaid and CHIP at any time during the year and aren't limited to an OEP or SEP. Medicare and other public health coverage options have different annual OEPs. Refer to [Medicare.gov](#) for the Medicare Open Enrollment dates.

No matter how consumers apply and enroll, you can provide in-person help.

Individuals and families can find health and dental coverage through the Marketplaces for individuals and families. They can apply online, by phone, or by mail.

Small employers can apply for eligibility determinations to purchase health and dental coverage through the SHOP Marketplaces. Eligible small employers may choose to offer coverage to eligible employees and former employees as well as their spouses and dependents. Employers can apply online or by phone, but the SHOP Marketplaces don't accept applications by mail.

***Qualified Health Plans**

Remember, all health insurance plans sold in the Marketplaces are QHPs. A QHP:

- Provides essential health benefits (EHB), including certain recommended preventive services that are covered at no additional cost to the consumer,
- Follows established limits on cost sharing (e.g., deductibles, copayments, and out-of-pocket maximum amounts),
- Is certified by an Exchange, and
- Meets other requirements.

Differences Between the Individual and SHOP Marketplaces

Although this course generally focuses on the Marketplaces for individuals and families, it is also important for you to know some basic details about [SHOP](#) Marketplaces. You should be able to explain how both types of Marketplaces can function together within a state.

The Marketplaces for individuals and families and the SHOP Marketplaces perform some of the same core functions, like allowing consumers to compare available medical and dental plans side by side. However, there are some key differences.

Marketplaces for Individuals and Families	SHOP Marketplaces
Collect and verify eligibility information from consumers and their families.	Collect eligibility information from small employers.
Consumers and their families may qualify for advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs) to help lower their costs. They can also be assessed or determined eligible for Medicaid and CHIP.	APTC and CSRs aren't available to lower the cost of health coverage to persons enrolled through the SHOP Marketplaces, but certain small employers may qualify for small business health care tax credits.
Verify all consumer information including immigration status.	SHOP Marketplaces don't review or verify citizenship or immigration status since employers are required to determine whether their employees have legal work status.
Consumers can apply for health coverage through the Marketplaces for individuals and families during the individual market OEP. For the 2023 plan year, Open Enrollment starts November 1, 2022, and ends January 15, 2023. To enroll in coverage beginning on January 1, consumers should enroll by December 15, 2022. Outside of the OEP, consumers may qualify for a Special Enrollment Period (SEP) to enroll in a Marketplace plan, or they can apply for free or low-cost coverage through Medicaid and the Children's Health Insurance Program (CHIP) at any time.	Employers can generally purchase SHOP Marketplace small group coverage during any month of the year. Qualified employers and employees can purchase coverage in SHOP plans by working with a qualified health plan (QHP) issuer or SHOP-registered agent or broker. Employers can obtain an eligibility determination from a SHOP Marketplace.
More information about the Marketplaces for individuals and families.	More information about the SHOP Marketplaces.

Although this course generally focuses on the Marketplaces for individuals and families, it is also important for you to know some basic details about SHOP Marketplaces. You should be able to explain how both types of Marketplaces can function together within a state.

The Marketplaces for individuals and families and the SHOP Marketplaces perform some of the same core functions, like allowing consumers to compare available medical and dental plans side by side. However, there are some key differences.

Marketplaces for Individuals and Families

Collect and verify eligibility information from consumers and their families.

Consumers and their families may qualify for advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs) to help lower their costs. They can also be assessed or determined eligible for Medicaid and CHIP.

Verify all consumer information including immigration status.

Consumers can apply for health coverage through the Marketplaces for individuals and families during the individual market OEP. For the 2023 plan year, Open Enrollment starts November 1, 2022, and ends January 15, 2023. To enroll in coverage beginning on January 1, consumers should enroll by December 15, 2022. Outside of the OEP, consumers may qualify for a Special Enrollment Period (SEP) to enroll in a Marketplace plan, or they can apply for free or low-cost coverage through Medicaid and the Children's Health Insurance Program (CHIP) at any time.

[More information about the Marketplaces for individuals and families.](#)

SHOP Marketplaces

Collect eligibility information from small employers.

APTC and CSRs aren't available to lower the cost of health coverage to persons enrolled through the SHOP Marketplaces, but certain small employers may qualify for small business health care tax credits.

SHOP Marketplaces don't review or verify citizenship or immigration status since employers are required to determine whether their employees have legal work status.

Employers can generally purchase SHOP Marketplace small group coverage during any month of the year.

Qualified employers and employees can purchase coverage in SHOP plans by working with a qualified health plan (QHP)** issuer or SHOP-registered agent or broker. Employers can obtain an eligibility determination from a SHOP Marketplace.

[More information about the SHOP Marketplaces.](#)

***SHOP**

The SHOP Marketplaces are open to eligible small employers. Generally, a small employer is one that:

- Employed 1 to 50 (100 in some states) full-time and full-time-equivalent (FTE) employees, on average, on business days during the preceding calendar year, and
- Employs at least one employee on the first day of the plan year.

Participating employers determine the share of premium costs they will cover for their employees.

You can find more information about small employers and their options at [HealthCare.gov/small-businesses/employers](https://www.healthcare.gov/small-businesses/employers).

****QHP**

An employee with an offer of coverage through a SHOP Marketplace may instead choose to enroll in a QHP through a Marketplace for individuals and families and may also qualify for APTC and CSRs if the following conditions apply:

1. The employee has not enrolled in the SHOP coverage offered by their employer, AND
2. The employer's offer is not affordable for the employee, OR
3. The employer's offer does not meet minimum value.

Eligibility for QHP Coverage in the Marketplaces

To enroll in a QHP in a Marketplace, consumers must:



Be U.S. citizens, U.S. nationals, or lawfully present non-citizens and be reasonably expected to be so for the entire time they plan to have coverage.



Not be [incarcerated](#) (unless pending the disposition of charges).



Live in the U.S. and live in a state served by the Marketplace where they are applying.

To enroll in a QHP in a Marketplace, consumers must:

- Be U.S. citizens, U.S. nationals, or lawfully present non-citizens and be reasonably expected to be so for the entire time they plan to have coverage.
- Not be [incarcerated](#) (unless pending the disposition of charges).
- Live in the U.S. and live in a state served by the Marketplace where they are applying.

Remember, the ACA requires most types of health coverage to offer EHB, including:

- Individual and small group market QHPs that are certified and sold in the Marketplaces.
- Non-grandfathered individual and small group market insurance plans sold outside of the Marketplaces.
- Medicaid plans provided to people newly eligible for Medicaid in states that have expanded the Medicaid program.

[Select](#) to review the 10 EHB.



Remember, the ACA requires most types of health coverage to offer EHB, including:

- Individual and small group market QHPs that are certified and sold in the Marketplaces.
- Non-grandfathered individual and small group market insurance plans sold outside of the Marketplaces.
- Medicaid plans provided to people newly eligible for Medicaid in states that have expanded the Medicaid program.

QHPs must include

There are 10 categories of EHB that all QHPs must include:

1. Ambulatory patient services (e.g., doctor and clinic visits)
2. Emergency services (e.g., ambulance, first aid, and rescue squad)
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices (e.g., therapy sessions, wheelchairs, oxygen)
8. Laboratory services
9. Preventive and wellness services and chronic disease management (e.g., blood pressure screening, immunizations)
10. Pediatric services, including dental and vision care

QHP Dental Coverage Tips

- Routine adult dental coverage isn't considered an essential health benefit, and most QHPs don't offer it; however, consumers may be able to purchase stand-alone dental plans in the FFMs.
- The FFMs must offer pediatric dental care either as part of QHP coverage or through stand-alone dental plans; however, consumers are not required to buy dental insurance for their dependent children.

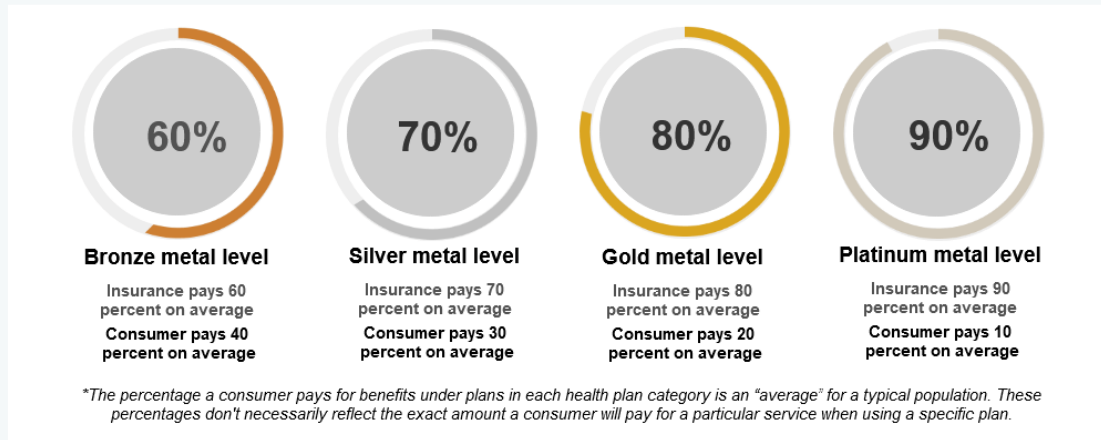
Health Plan Categories

QHPs in the Marketplaces are separated into five health plan categories:

Bronze metal level: 60 percent actuarial value Silver metal level: 70 percent actuarial value Gold metal level: 80 percent actuarial value Platinum metal level: 90 percent actuarial value [Catastrophic](#)

Health plan category metal levels are based on each plan's actuarial value (AV)—that is, the percentage of total average costs for covered benefits that a plan will cover. Health plan categories don't reflect the quality or amount of care the plans provide.

Health insurance companies that sell QHPs in an FFM must offer at least one Silver and one Gold plan; also, they must be licensed and in good standing in the state where the plans are sold. QHPs must meet nondiscrimination and network adequacy requirements and offer the same premiums whether they're sold inside or outside the FFMs. QHPs may also have to meet other state-specific requirements.



QHPs in the Marketplaces are separated into five health plan categories:

- Bronze metal level: 60 percent actuarial value
- Silver metal level: 70 percent actuarial value
- Gold metal level: 80 percent actuarial value
- Platinum metal level: 90 percent actuarial value
- Catastrophic

Health plan category metal levels are based on each plan's actuarial value (AV)—that is, the percentage of total average costs for covered benefits that a plan will cover. Health plan categories don't reflect the quality or amount of care the plans provide.

Health insurance companies that sell QHPs in an FFM must offer at least one Silver and one Gold plan; also, they must be licensed and in good standing in the state where the plans are sold. QHPs must meet nondiscrimination and network adequacy requirements and offer the same premiums whether they're sold inside or outside the FFMs. QHPs may also have to meet other state-specific requirements.

Bronze metal level: 60%

Insurance pays 60 percent on average

Consumer pays 40 percent on average

Silver metal level: 70%

Insurance pays 70 percent on average

Consumer pays 30 percent on average

Gold metal level: 80%

Insurance pays 80 percent on average

Consumer pays 20 percent on average

Platinum metal level: 90%

Insurance pays 90 percent on average

Consumer pays 10 percent on average

*The percentage a consumer pays for benefits under plans in each health plan category is an "average" for a typical population. These percentages don't necessarily reflect the exact amount a consumer will pay for a particular service when using a specific plan.

Catastrophic health insurance plans

Catastrophic plans are only available to individual market consumers under age 30 or consumers age 30 or older who qualify for a hardship or affordability exemption (e.g., a life situation that may prevent them from affording health insurance coverage, like a flood or natural disaster). For Plan Year 2023, individuals can be eligible for an affordability exemption if the amount they would pay for minimum essential coverage exceeds 8.17 percent of their annual household income. Catastrophic plans protect consumers from very high medical costs by only providing coverage when they need a lot of care. However, they do cover certain [preventive services](#) with no cost sharing and also cover at least three primary care visits per year before the deductible is met. Generally, Catastrophic plans have lower premiums than the other health plan categories, but consumers are responsible for higher cost-sharing amounts. Consumers can't use APTC and CSRs to lower the costs of a Catastrophic plan like they can with other health plan categories.

Knowledge Check

This type of plan is only available to individual market consumers and protects them from very high medical costs by providing coverage only when they need a lot of care.

Select **the correct answer** and then select **Check Your Answer**.

- A. Bronze
- B. Platinum
- C. COBRA
- D. Catastrophic

✓ Check Your Answer



Correct!

Catastrophic plans are only available to individual market consumers and protect them from very high medical costs by providing coverage when they require a lot of care. They generally have lower premiums and higher deductibles, copayments, and coinsurance amounts than other plan categories.

This type of plan is only available to individual market consumers and protects them from very high medical costs by providing coverage only when they need a lot of care.

- A. Bronze
- B. Platinum
- C. COBRA
- D. Catastrophic

The correct answer is D. Catastrophic plans are only available to individual market consumers and protect them from very high medical costs by providing coverage when they require a lot of care. They generally have lower premiums and higher deductibles, copayments, and coinsurance amounts than other plan categories.

Key Points



● Marketplaces can be operated by a state, the Federal Government, or a combination of both.

● Individual Marketplaces collect and verify eligibility for consumers and their families.

● SHOP Marketplaces collect information from small employers.

● The ACA requires that most individual and small group health insurance plans must cover EHB.

- Marketplaces can be operated by a state, the Federal Government, or a combination of both.
- Individual Marketplaces collect and verify eligibility for consumers and their families.
- SHOP Marketplaces collect information from small employers.
- The ACA requires that most individual and small group health insurance plans must cover EHB.

Preparing to Apply

Introduction



Before we discuss the application process for individuals and families in FFM's, let's review a few things you should keep in mind when you meet with consumers.

As a Navigator or CAC in an FFM, you must:

- Assist applicants and enrollees submitting Marketplace eligibility applications in an FFM's service area.
- Explain your duties and responsibilities to each consumer you assist and let them know that you can't provide tax or legal advice in your capacity as an assister.
- Provide consumers with fair, accurate, and impartial information about the full range of health coverage options for which they're eligible.
- Clarify distinctions between health coverage options, including QHPs, Medicaid, and CHIP.

Beginning with Navigator grants awarded in 2022, including non-competing continuation awards, Navigators are required to provide information on and assistance with all of the following topics:

- Understanding the process of filing Marketplace eligibility appeals;
- Understanding and applying for hardship and affordability exemptions granted through the Marketplace for consumers age 30 and older seeking to enroll in a Catastrophic plan;
- Marketplace-related components of the premium tax credit reconciliation process and understanding the availability of IRS resources on this process;
- Understanding basic concepts and rights related to health coverage and how to use it; and
- Referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice related to consumer questions about the Marketplace application and enrollment process and premium tax credit reconciliations.

CMS will continue to provide all assisters with additional information related to these assistance activities through webinars, job aids, and other technical assistance resources.

[Here](#) is a reminder about providing appropriate services for consumers with specific needs.

As a Navigator or CAC in an FFM, you must:

- Assist applicants and enrollees submitting Marketplace eligibility applications in an FFM's service area.
- Explain your duties and responsibilities to each consumer you assist and let them know that you can't provide tax or legal advice in your capacity as an assister.
- Provide consumers with fair, accurate, and impartial information about the full range of health coverage options for which they're eligible.
- Clarify distinctions between health coverage options, including QHPs, Medicaid, and CHIP.

Beginning with Navigator grants awarded in 2022, including non-competing continuation awards, Navigators are required to provide information on and assistance with all of the following topics:

- Understanding the process of filing Marketplace eligibility appeals;
- Understanding and applying for hardship and affordability exemptions granted through the Marketplace for consumers age 30 and older seeking to enroll in a Catastrophic plan;
- Marketplace-related components of the premium tax credit reconciliation process and understanding the availability of IRS resources on this process;
- Understanding basic concepts and rights related to health coverage and how to use it; and
- Referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice related to consumer questions about the Marketplace application and enrollment process and premium tax credit reconciliations.

CMS will continue to provide all assisters with additional information related to these assistance activities through webinars, job aids, and other technical assistance resources.

Culturally Appropriate Communication

It's important for you to communicate with consumers in a manner that is culturally appropriate. You should show respect for consumers' cultural diversity and provide information that is relatable and easy to understand, using translated documents when needed.

Navigators must provide information and services in a manner that is accessible to persons with disabilities and persons with Limited English Proficiency (LEP). This may require language interpretation assistance or

other accommodations for consumers with physical, developmental, and/or intellectual disabilities or for consumers with cognitive, hearing, speech, and/or vision impairments. Additionally, this may require language assistance services, like interpreters, for individuals with LEP.

CACs in FFM are expected to provide referrals to Navigators or the FFM Call Center if they are not able to assist consumers with LEP.

For more information, refer to the courses on *Serving Vulnerable and Underserved Populations*, *Cultural Competence and Language Assistance*, and *Working with Consumers with Disabilities*.

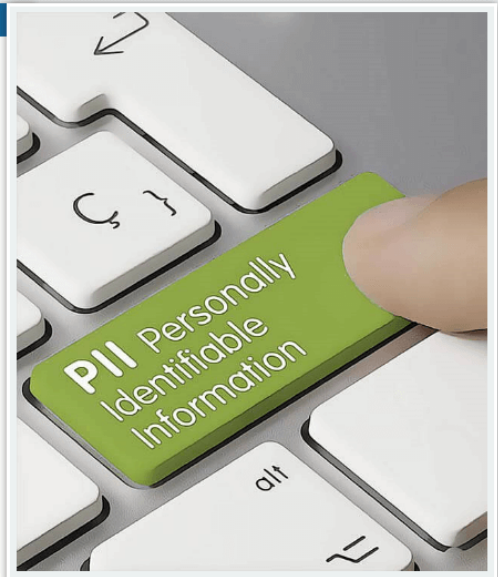
Consumer Consent and PII

One of the first things you should do when helping consumers is obtain consent to access their personally identifiable information (PII) for purposes related to your assister functions. Remember these best practices for handling consumers' PII:

- Always return originals and copies of all documents that contain consumers' PII to them and only make copies for yourself or others if necessary to carry out your required duties. If consumers mistakenly or accidentally leave behind documents containing their PII at your organization's facility or at an enrollment event, you should store them in a safe, locked location and return them to consumers as soon as possible.
- Document consumers' preferred contact information when you obtain their consent per your organization's standard consumer consent procedures. If consumers provide consent for you to follow up with them about applying for or enrolling in coverage as well as their preferred contact information, you may keep their names and contact information to schedule appointments or follow up with them about application or enrollment issues.

PII collected from consumers, including their names, email addresses, telephone numbers, application ID numbers, home addresses, or other notes, must be stored securely.

Remember, you must successfully complete the *Privacy, Security, and Fraud Prevention Standards* course in addition to this course to meet certification requirements.



One of the first things you should do when helping consumers is obtain consent to access their personally identifiable information (PII) for purposes related to your assister functions. Remember these best practices for handling consumers' PII:

- Always return originals and copies of all documents that contain consumers' PII to them and only make copies for yourself or others if necessary to carry out your required duties. If consumers mistakenly or accidentally leave behind documents containing their PII at your organization's facility or at an enrollment event, you should store them in a safe, locked location and return them to consumers as soon as possible.
- Document consumers' preferred contact information when you obtain their consent per your organization's standard consumer consent procedures. If consumers provide consent for you to follow up with them about applying for or enrolling in coverage as well as their preferred contact information, you may keep their names and contact information to schedule appointments or follow up with them about application or enrollment issues.

PII collected from consumers, including their names, email addresses, telephone numbers, application ID numbers, home addresses, or other notes, must be stored securely.

Remember, you must successfully complete the *Privacy, Security, and Fraud Prevention Standards* course in addition to this course to meet certification requirements.

Assess Consumers' Needs



Once you've obtained consumers' consent, you will assess their health coverage needs. Consumers will come to you with different levels of knowledge about health coverage and the Marketplaces. Here are a few questions you can keep in mind when you meet with consumers to make sure they understand their coverage options in the FFM.

- Do they need additional information about the ACA, health coverage, or the FFM?
- Do they currently have health coverage or access to coverage through their employer, even if they aren't currently enrolled?
- If not, have they started the FFM eligibility application process?
- Who needs coverage—an individual, a child, a spouse, or the whole family?
- What health plan features are most important to the applicant(s)? Consumers might be most concerned about affordable premium prices, coverage of certain health care services and prescription drugs, and whether specific doctors are included in their plan's network.

Once you've obtained consumers' consent, you will assess their health coverage needs. Consumers will come to you with different levels of knowledge about health coverage and the Marketplaces. Here are a few questions you can keep in mind when you meet with consumers to make sure they understand their coverage options in the FFM.

- Do they need additional information about the ACA, health coverage, or the FFM?
- Do they currently have health coverage or access to coverage through their employer, even if they aren't currently enrolled?
- If not, have they started the FFM eligibility application process?
- Who needs coverage—an individual, a child, a spouse, or the whole family?
- What health plan features are most important to the applicant(s)? Consumers might be most concerned about affordable premium prices, coverage of certain health care services and prescription drugs, and whether specific doctors are included in their plan's network.



When you meet with consumers, make sure they know that the individual market FFMs provide access to programs that help eligible consumers pay for coverage. Some consumers can save on monthly premiums and additional costs when they enroll in QHPs, while others may qualify for low-cost programs like Medicaid and CHIP.

Consumers who may be eligible for programs to help lower their QHP costs through an individual market FFM include:

- Individuals who don't have affordable health coverage through their jobs or another source.
- Individuals who are not eligible for job-based coverage through a spouse or parent.
- Self-employed consumers (and their families) whose businesses have [no employees](#).

When you meet with consumers, make sure they know that the individual market FFMs provide access to programs that help eligible consumers pay for coverage. Some consumers can save on monthly premiums and additional costs when they enroll in QHPs, while others may qualify for low-cost programs like Medicaid and CHIP.

Consumers who may be eligible for programs to help lower their QHP costs through an individual market FFM include:

- Individuals who don't have affordable health coverage through their jobs or another source.
- Individuals who are not eligible for job-based coverage through a spouse or parent.
- Self-employed consumers (and their families) whose businesses have no employees.

Businesses with No Employees

Generally, self-employed consumers whose businesses have no employees may not purchase group coverage through a SHOP Marketplace.



Some consumers may need your help applying for Medicaid or CHIP coverage. Here are a few reminders.

Consumers can apply for Medicaid and CHIP at any time. There isn't a limited enrollment period for either program.

You can help consumers apply for Medicaid and CHIP in three ways:

- Contact a state Medicaid or CHIP agency
- Submit a Marketplace application online at [HealthCare.gov](https://www.healthcare.gov)
- Contact the FFM Call Center at 1-800-318-2596 (TTY: 1-855-889-4325) 24 hours a day, seven days a week

All states are required to provide Medicaid coverage for certain groups of consumers in certain [mandatory eligibility groups](#).

Continue

Some consumers may need your help applying for Medicaid or CHIP coverage. Here are a few reminders.

Consumers can apply for Medicaid and CHIP at any time. There isn't a limited enrollment period for either program.

You can help consumers apply for Medicaid and CHIP in three ways:

- Contact a state Medicaid or CHIP agency
- Submit a Marketplace application online at [HealthCare.gov](https://www.healthcare.gov)
- Contact the FFM Call Center at 1-800-318-2596 (TTY: 1-855-889-4325) 24 hours a day, seven days a week

All states are required to provide Medicaid coverage for certain groups of consumers in certain mandatory eligibility groups*.

If you help consumers in a state that has not expanded Medicaid to low-income adults and they are not otherwise eligible for Medicaid or other coverage, they may qualify for APTC and CSRs if they enroll in a QHP offered through a Marketplace. Otherwise, they may be eligible to purchase Catastrophic health coverage.

Sometimes, it's faster and more straightforward for consumers to apply for Medicaid and CHIP coverage directly through their state Medicaid or CHIP agency rather than through the individual market FFMs. This is true for individuals who have disabilities and those who are enrolled in other public benefits programs like the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF). Refer to the *Affordable Care Act Basics* course for detailed information about Medicaid and CHIP coverage, including eligibility requirements.

* Mandatory and Optional Eligibility Groups in Medicaid

Under federal law, all states are required to cover certain groups of consumers in Medicaid referred to as **mandatory eligibility groups**. These groups include:

- Pregnant individuals
- Children under age 19
- Parents and other caretaker relatives

- Supplemental Security Income (SSI) beneficiaries
- Some low-income older adults

Some states cover other groups of consumers referred to as **optional eligibility groups**, which federal law provides as options for states to cover under Medicaid. Examples of optional groups include:

- Individuals eligible for family planning services
- Age and disability-related poverty-level group
- Medically needy individuals

Medicaid coverage for optional groups varies from state to state. It's important that you know which groups are covered by Medicaid and the household income requirements for each group in your state.

Note: The American Rescue Plan Act of 2021 gives states a new option to provide 12 months of extended postpartum coverage to pregnant individuals enrolled in Medicaid and CHIP beginning April 1, 2022.

Useful Tools to Help Consumers Get Started



Many individuals and families don't think they can afford coverage and don't realize financial help may be available. Before they begin a Marketplace application, the Savings Estimator Tool and Window Shopping Tool at HealthCare.gov can help them learn about the features and costs of different QHPs in their area. Let's review each one.

The [Savings Estimator Tool](#) provides consumers with a quick view of income levels that qualify for savings. Individuals may qualify at different levels. Remind consumers that they will find out exactly how much they'll save and pay for a plan when they complete a Marketplace eligibility application.

The [Window Shopping Tool](#) lets consumers answer a few quick questions to review available QHP options in their area and provides estimated prices based on their projected income. For example, it can:

- Show consumers whether doctors, medical facilities, and prescription drugs they use are covered by available QHPs in their area.
- Estimate consumers' total costs during a plan's coverage year based on how much care they might use.

Many individuals and families don't think they can afford coverage and don't realize financial help may be available. Before they begin a Marketplace application, the Savings Estimator Tool and Window Shopping Tool at HealthCare.gov can help them learn about the features and costs of different QHPs in their area. Let's review each one.

The [Savings Estimator Tool](#) provides consumers with a quick view of income levels that qualify for savings. Individuals may qualify at different levels. Remind consumers that they will find out exactly how much they'll save and pay for a plan when they complete a Marketplace eligibility application.

The [Window Shopping Tool](#) lets consumers answer a few quick questions to review available QHP options in their area and provides estimated prices based on their projected income. For example, it can:

- Show consumers whether doctors, medical facilities, and prescription drugs they use are covered by available QHPs in their area.
- Estimate consumers' total costs during a plan's coverage year based on how much care they might use.



Let's go over some important reminders about identifying health coverage applicants on a Marketplace application before we review the application process.

Consumers must be U.S. citizens, U.S. nationals, or lawfully present in the U.S. to enroll in a QHP in an FFM. Consumers who aren't lawfully present can still apply for coverage for their family member(s) who are lawfully present.

Those applying for coverage for a family member who is lawfully present can do so without being asked to provide proof of their own citizenship or immigration status.

These best practices can help you talk with consumers who are immigrants and who are seeking health coverage for themselves or on behalf of someone else.

Select each best practice for more information.

[Provide information](#)

[Share information about other resources](#)

[Identify the applicant](#)

[Avoid unnecessary questions](#)

[Allow each consumer to act on their own behalf](#)

Also remember that you can't recommend specific health plans to consumers or make eligibility determinations for consumers.

Let's go over some important reminders about identifying health coverage applicants on a Marketplace application before we review the application process.

Consumers must be U.S. citizens, U.S. nationals, or lawfully present in the U.S. to enroll in a QHP in an FFM. Consumers who aren't lawfully present can still apply for coverage for their family member(s) who are lawfully present.

Those applying for coverage for a family member who is lawfully present can do so without being asked to provide proof of their own citizenship or immigration status.

These best practices can help you talk with consumers who are immigrants and who are seeking health coverage for themselves or on behalf of someone else.

Review each best practice for more information.

Provide information

Share information about other resources

Identify the applicant

Avoid unnecessary questions

Allow each consumer to act on their own behalf

Also remember that you can't recommend specific health plans to consumers or make eligibility determinations for consumers.

Provide information

Provide information about eligible immigration statuses and acceptable immigration documents. Consumers then have the information they need to decide who in their family may have an eligible immigration status to apply for health coverage.

Share information about other resources

Share information with consumers about other resources in the community that might be able to help them:

- Determine whether they have an eligible immigration status, or
- Obtain immigration documents if they don't have them readily available.

Identify the applicant

Be sure to correctly identify the consumer(s) who are applying for health coverage by asking them if they're seeking coverage for themselves or on behalf of someone else.

Avoid unnecessary questions

Avoid unnecessary questions, especially questions about the immigration status of consumers who aren't applying for health coverage and live in mixed immigration status households.

Avoid words like "undocumented," "unauthorized," or "illegal." Instead, use words like "eligible immigrant" and "eligible status."

Allow each consumer to act on their own behalf

Consumers should always input their own information in an online or paper application. If a consumer asks for help typing or using a computer to learn about, apply for, or enroll in coverage in an FFM, an assister may only use the keyboard or mouse to follow the consumer's specific directions.

Knowledge Check

There are many rules you must remember when you are assisting consumers.
Which of the following statements are allowable for you when you are assisting consumers?
Select **the correct answer** and then select **Check Your Answer**.

- A. One of your roles is to help consumers enroll in health coverage. You should be ready to choose a plan for them and explain the benefits that plan covers.
- B. When you assist the same consumer multiple times, you must receive new consent from that consumer each time you access their PII. The older consent the consumer provided is no longer valid.
- C. When using the Savings Estimator Tool, you will be able to tell consumers which plans are best for them. You may offer your advice on which plans they can and can't afford.
- D. If a consumer asks for help typing or using a computer to learn about, apply for, or enroll in coverage through an FFM, you may do so as long as you follow their specific directions.

✓ Check Your Answer



Correct!

When consumers ask you for help inputting information on a paper application or on a computer, you may do so as long as you follow their specific directions.

There are many rules you must remember when you are assisting consumers.

Which of the following statements are allowable for you when you are assisting consumers?

- A. One of your roles is to help consumers enroll in health coverage. You should be ready to choose a plan for them and explain the benefits that plan covers.
- B. When you assist the same consumer multiple times, you must receive new consent from that consumer each time you access their PII. The older consent the consumer provided is no longer valid.
- C. When using the Savings Estimator Tool, you will be able to tell consumers which plans are best for them. You may offer your advice on which plans they can and can't afford.
- D. If a consumer asks for help typing or using a computer to learn about, apply for, or enroll in coverage through an FFM, you may do so as long as you follow their specific directions.

The correct answer choice is D. When consumers ask you for help inputting information on a paper application or on a computer, you may do so as long as you follow their specific directions.

Key Points



- One of the first things you should do when helping consumers is obtain consent to access their PII for purposes related to your assister functions.

- Some consumers can save on monthly premiums and additional costs when they enroll in QHPs, while others may qualify for low-cost programs like Medicaid and CHIP.

- Consumers must be U.S. citizens, U.S. nationals, or lawfully present in the U.S. to enroll in a QHP in an FFM. Consumers who aren't lawfully present can still apply for coverage for their family member(s) who are lawfully present.

- One of the first things you should do when helping consumers is obtain consent to access their PII for purposes related to your assister functions.
- Some consumers can save on monthly premiums and additional costs when they enroll in QHPs, while others may qualify for low-cost programs like Medicaid and CHIP.
- Consumers must be U.S. citizens, U.S. nationals, or lawfully present in the U.S. to enroll in a QHP in an FFM. Consumers who aren't lawfully present can still apply for coverage for their family member(s) who are lawfully present.

Account Creation and Application Completion

Overview of the Account Creation Process

Once you've obtained a consumer's consent, assessed the consumer's needs, and discussed the eligibility and enrollment process, it's time for the consumer to create a Marketplace account at HealthCare.gov.

Let consumers know they can view and compare general health plan information at any time; however, they must create a Marketplace account and complete an application to verify eligibility, plan availability, and prices.

HealthCare.gov

Create an account

Already have an account? [Log in](#)

1 See if your state uses HealthCare.gov

Some states have their own Marketplace. Next, set up your login information.

Pick the state you live in

Alabama

2 Set up your login information

First name

Last name

Email address
Your email address will also be your username when you log in.

Password
Must include:
• 8-20 characters
• Uppercase & lowercase letters
• 1 or more numbers

Show

3 Pick 3 questions only you can answer

These security questions will help you access your account. If you have trouble logging in, you'll need to answer all 3 questions exactly how you entered them here.

Answers must:

- include 1-30 characters
- Start with a letter or number
- Can only contain letters, numbers, spaces and these characters: ' , - .

Question #1

Pick a question

Select a question

Enter an answer

Question #2

Pick a question

Select a question

Enter an answer

Question #3

Pick a question

Select a question

Enter an answer

I understand and agree with the HealthCare.gov [Privacy Policy](#) and [terms and conditions](#).

The Marketplace will send you emails with important enrollment information, updates, and reminders. You can unsubscribe at any time by selecting the 'Unsubscribe' link at the bottom of any Marketplace email.

Create account

Once you've obtained a consumer's consent, assessed the consumer's needs, and discussed the eligibility and enrollment process, it's time for the consumer to create a Marketplace account at HealthCare.gov.

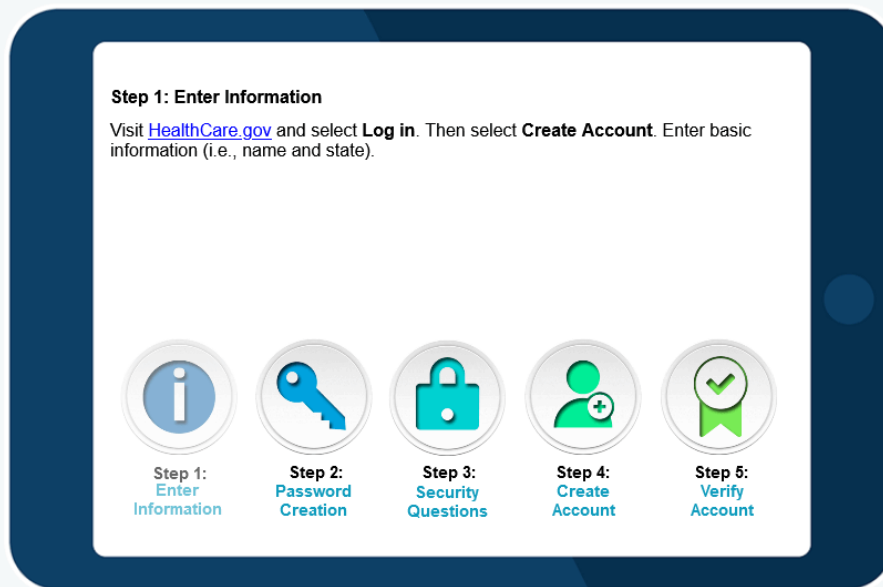
Let consumers know they can view and compare general health plan information at any time; however, they must create a Marketplace account and complete an application to verify eligibility, plan availability, and prices.

Assist Consumers with Creating a Marketplace Account

Here's a quick overview of how the process works.

Consumers should follow five steps to create a Marketplace account at [HealthCare.gov](https://www.healthcare.gov).

Select each step for details.



Here's a quick overview of how the process works.

Consumers should follow five steps to create a Marketplace account at [HealthCare.gov](https://www.healthcare.gov).

Step 1: Enter Information

Visit [HealthCare.gov](https://www.healthcare.gov) and select **Log in**. Then select **Create Account**. Enter basic information (i.e., name and state).

Step 2: Password Creation

Enter a valid email address, which is also used as a consumer's Marketplace account username. Then choose a password. Passwords must contain 8-20 characters, at least one number, and a mix of uppercase and lowercase letters. [How to reset a password*](#).

Step 3: Security Questions

Choose security questions and provide responses. These questions are used for verification purposes if necessary. You should advise consumers to record these and keep them in a secure place.

Step 4: Create Account

Attest to the terms and conditions, then select the **Create Account** radio button.

Step 5: Verify Account

In the last step, consumers verify their identity by answering questions based on information the FFMs gather from trusted data sources (e.g., a consumer's credit report). This prevents other people from creating an account using their name. If a consumer's identity is not verified, they may receive a prompt with instructions and next steps. Additional information about Marketplace identity verification is available at [Marketplace.cms.gov/outreach-and-education/your-marketplace-application.pdf](https://www.marketplace.cms.gov/outreach-and-education/your-marketplace-application.pdf).

*How to reset a password

There are three steps consumers should follow to reset a password:

1. Select **Forgot your password?** from the login page and enter the email address associated with the Marketplace account.
2. The FFM sends a password reset email to this address. Select the link in the password reset email to

verify that the email address is correct. If selecting doesn't work, the consumer should copy and paste the link into an Internet browser.

3. Follow the directions to choose a new password.

Sometimes the FFM's reset consumers' passwords due to security measures. If this happens, consumers won't be able to log in successfully until they reset their password.

If consumers need more help or want to apply by phone, they can contact the FFM Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

The FFM Call Center is open 24 hours a day, seven days a week (except federal holidays).

IMPORTANT: Don't create a second account!

Consumers should never try to create a new account if they already have one. Instead, they should call the FFM Call Center or follow the steps at [HealthCare.gov/tips-and-troubleshooting/logging-in/](https://www.healthcare.gov/tips-and-troubleshooting/logging-in/).

Helping with Identity Verification

After a consumer creates a Marketplace account and logs into HealthCare.gov for the first time, they must answer a few screening questions about their household to begin an application. The FFMs verify specific information about each individual applying for coverage before they can enroll or get help with lowering their costs. Identity (ID) proofing is an important part of this process.

During ID proofing, the FFMs ask questions based on consumers' personal and financial histories that only they are likely to know. You should tell consumers that this process helps prevent someone else from creating a Marketplace account and applying for health coverage in their name without their knowledge.

Consumers should select the **My Profile** button, and then select **Verify Now** to begin. When the "Verify Your Identity" screen appears, they should select the **Get Started** button. The FFMs ask for contact information and other questions about consumers to verify their identity.

Select to zoom

Identity questions

Answer these questions so we can verify your identity.

- Which one of the following retail credit cards do you have? If there is not a matched retail credit card, please select "NONE OF THE ABOVE".
 - S S KRESGE
 - THE TIE BAR
 - THE PARAGON
 - KRESGES
 - NONE OF THE ABOVE/DOES NOT APPLY
- According to our records, you previously lived on (RR). Please choose the city from the following list where this street is located.
 - DICKINSON
 - TURTLE LAKE
 - HAVRE
 - LAUREL
 - NONE OF THE ABOVE/DOES NOT APPLY
- Which of the following is a current or previous employer? If there is not a matched employer name, please select "NONE OF THE ABOVE".
 - KMAY INC DBA KIDS R KID
 - SUNNY MEAD DENTAL GROUP
 - ALEX
 - AT&T
 - NONE OF THE ABOVE/DOES NOT APPLY
- Which of the following is a previous phone number of yours? If there is not a matched phone number, please select "NONE OF THE ABOVE".
 - (202)218-3126
 - (202)203-3431
 - (202)230-8845
 - (202)234-8246
 - NONE OF THE ABOVE/DOES NOT APPLY

CONTINUE

Select to zoom

VERIFY YOUR IDENTITY

- Contact information
- Identity questions

Contact information

Tell us about yourself. Use your complete name, as it appears on legal documents (like your Social Security card).

All fields are required unless they're marked optional. Don't enter any letters with special characters, like accents, tildes, etc.

First name Middle optional

Last name Suffix optional

Date of birth Social Security number optional

Email address

Street address Apt./Ste #, optional

City State ZIP code

Phone number Ext. optional Phone type (Select one.) optional

CONTINUE

After a consumer creates a Marketplace account and logs into HealthCare.gov for the first time, they must answer a few screening questions about their household to begin an application. The FFMs verify specific information about each individual applying for coverage before they can enroll or get help with lowering their costs. Identity (ID) proofing is an important part of this process.

During ID proofing, the FFMs ask questions based on consumers' personal and financial histories that only they are likely to know. You should tell consumers that this process helps prevent someone else from creating a Marketplace account and applying for health coverage in their name without their knowledge.

Consumers should select the **My Profile** button, and then select **Verify Now** to begin. When the "Verify Your Identity" screen appears, they should select the **Get Started** button. The FFMs ask for contact information and other questions about consumers to verify their identity.

If the FFM's can't verify an individual's identity, it means they couldn't match some or all of the information they provided with the information available in records used for this process.

Note: Experian is a contractor that helps the FFM's with ID proofing. The Experian Help Desk can't help consumers with the same things that you and the FFM Call Center can help with. For example, the Experian Help Desk can't help consumers supply supporting documents or resolve Marketplace account issues (e.g., account and password resets).

Select each to learn more.



Single documents



Multiple documents

Single Documents to Verify Identity

When necessary, consumers can upload or mail paper copies of any of the following documents to verify their identities:

- Driver's license issued by a state or territory
- School ID card
- Voter ID card
- U.S. military draft card or draft record
- Military dependent's ID card
- ID card issued by federal, state, or local government
- U.S. passport or U.S. passport card
- Native American tribal document
- Certificate of Naturalization (Form N-550 or N-570) or Certificate of U.S. Citizenship (Form N-560 or N-561)
- Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
- Employment Authorization Document that contains a photograph (Form I-766)
- U.S. Coast Guard Merchant Mariner card
- Foreign passport or ID card issued by a foreign embassy or consulate that contains a photograph

If the FFM's can't verify an individual's identity, it means they couldn't match some or all of the information they provided with the information available in records used for this process.

Note: Experian is a contractor that helps the FFM's with ID proofing. The Experian Help Desk can't help consumers with the same things that you and the FFM Call Center can help with. For example, the Experian Help Desk can't help consumers supply supporting documents or resolve Marketplace account issues (e.g., account and password resets).

Single Documents to Verify Identity

When necessary, consumers can upload or mail paper copies of any of the following documents to verify their identities:

- Driver's license issued by a state or territory
- School ID card
- Voter ID card
- U.S. military draft card or draft record
- Military dependent's ID card
- ID card issued by federal, state, or local government
- U.S. passport or U.S. passport card
- Native American tribal document
- Certificate of Naturalization (Form N-550 or N-570) or Certificate of U.S. Citizenship (Form N-560 or N-561)
- Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
- Employment Authorization Document that contains a photograph (Form I-766)
- U.S. Coast Guard Merchant Mariner card
- Foreign passport or ID card issued by a foreign embassy or consulate that contains a photograph

Multiple Documents to Verify Identity

If consumers can't provide a copy of one of the documents above, they can submit copies of two of these documents:

- Birth certificate
- Social Security card
- Marriage certificate
- Divorce decree
- Employer ID card
- High school or college diploma, including high school equivalency diploma
- Property deed or title

Identity Verification Failure

An FFM will indicate whether a consumer's identify has been verified successfully. If the FFM can't verify certain consumers' citizenship or immigration status, it will make a second attempt using the Systematic Alien Verification Entitlement Program (SAVE) database. This process can take three to five days.

If Experian can verify a consumer's identity over the phone, the consumer can select the **Resubmit** button to complete the ID proofing process. If their identity was not verified after a third attempt, the consumer will be directed to submit updated contact information and to upload documents that verify their identity by selecting the **Upload Documents** button.

Consumers have to upload documents electronically if the system is unable to verify their identity right away—even if they verify their identity over the phone with Experian. While consumers can also mail documents to the FFMs, remind them that this method takes more time to process. If consumers mail documents, they should mail copies and keep the original documents. They should include their name, date of birth, and Social Security Number with their copies and send them to the following address:

Health Insurance Marketplace®
465 Industrial Blvd.
London, KY 40750-0001

Information is typically processed within seven to 10 business days after documents are received. If a consumer's identity still isn't verified, they may need to provide additional information.

Health Insurance Marketplace® is a registered service mark of HHS.

Your identity wasn't verified.

You need to submit documents to prove your identity. You won't be able to submit your application for health coverage until your identity is verified.

Once you upload your documents, they'll be reviewed. The results of your identity verification will be emailed to you at ebr81277@mzico.com.

UPLOAD DOCUMENTS

If you aren't able to upload your documents now, [return to My Profile](#).

Your identity wasn't verified.

To verify your identity, call the Experian help desk at (866) 578-5409 and give them your code below.

Your code: 03A-4C4-S3M-505-L21
Be sure to write down this code now, because you won't be able to see it again if you leave this page.

If your identity is verified over the phone, you may be asked about changes on the call (like using your legal name instead of a nickname). You'll need to make the same changes to your application, and you may need to answer the challenge questions again. Select "Resubmit" to continue.

If your identity isn't verified over the phone, select "Resubmit" to continue. Then, select "Resubmit information." You'll then be asked to upload documents to help verify your identity.

RESUBMIT

If you aren't able to call now, [return to My Profile](#).

An FFM will indicate whether a consumer's identify has been verified successfully. If the FFM can't verify certain consumers' citizenship or immigration status, it will make a second attempt using the Systematic Alien Verification Entitlement Program (SAVE) database. This process can take three to five days.

If Experian can verify a consumer's identity over the phone, the consumer can select the **Resubmit** button to complete the ID proofing process. If their identity was not verified after a third attempt, the consumer will be directed to submit updated contact information and to upload documents that verify their identity by selecting the **Upload Documents** button.

Consumers have to upload documents electronically if the system is unable to verify their identity right away—even if they verify their identity over the phone with Experian. While consumers can also mail documents to the FFMs, remind them that this method takes more time to process. If consumers mail documents, they should mail copies and keep the original documents. They should include their name, date of birth, and Social Security Number with their copies and send them to the following address:

Health Insurance Marketplace®
465 Industrial Blvd.
London, KY 40750-0001

Information is typically processed within seven to 10 business days after documents are received. If a consumer's identity still isn't verified, they may need to provide additional information.

Health Insurance Marketplace® is a registered service mark of HHS.

Upload Documents to Verify Identity

Account Creation and Application Completion
Upload Documents to Verify Identity

Text Only

Module 4 / 6
Page 7 / 19

To upload documents online, consumers should:

- Select the **Upload Documents** button.
- Select the type of document(s) from the drop-down list.
- Attach a copy of the document(s).

Earlier we listed single and multiple documents that consumers can use to verify their identity.

For example, if a consumer provides a copy of a photo ID like a driver's license, the consumer may only need to submit that one document. If a consumer submits a Social Security card or similar document that is not a photo ID, the consumer may need to submit additional documents.

The application provides a list of acceptable documents or combinations of documents consumers can provide under different circumstances. Consumers can check the status of documents they've submitted in their Marketplace account profile.

Submit documents that prove your identity.

What type of document do you want to upload?

Select

- Select
- Driver's license issued by state or territory
- School identification card
- Voter registration card
- U.S. military card or draft record
- Identification card issued by the federal, state, or local government
- U.S. passport or U.S. passport card
- Certificate of Naturalization (Form N-550 or N-570) or Certificate of U.S. Citizenship (Form N-560 or N-561)
- Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
- Employment Authorization Document that contains a photograph (Form I-766)
- Military dependent's identification card
- Native American Tribal document
- U.S. Coast Guard Merchant Mariner card
- Foreign passport, or identification card issued by a foreign embassy or consulate that contains a photograph
- Birth certificate
- Social Security card
- Marriage certificate
- Divorce decree
- Employer identification card
- High school or college diploma (including high school equivalency diplomas)

To upload documents online, consumers should:

- Select the **Upload Documents** button.
- Select the type of document(s) from the drop-down list.
- Attach a copy of the document(s).

Earlier we listed single and multiple documents that consumers can use to verify their identity.

For example, if a consumer provides a copy of a photo ID like a driver's license, the consumer may only need to submit that one document. If a consumer submits a Social Security card or similar document that is not a photo ID, the consumer may need to submit additional documents.

The application provides a list of acceptable documents or combinations of documents consumers can provide under different circumstances. Consumers can check the status of documents they've submitted in their Marketplace account profile.

Who to Include on an Application



Remember, individuals and families only need to complete one Marketplace application per tax household.

How do you know who is included in a tax household?

Select the text for the answer.

Remember, individuals and families only need to complete one Marketplace application per tax household.

How do you know who is included in a tax household?

If consumers plan to file federal income taxes together using the same federal income tax return, they're considered part of the same tax household, and they generally should submit one Marketplace application with all applicants listed together. If consumers are part of separate tax households—that is, they will file separate federal income tax returns—they should complete separate Marketplace applications.

Which household members should consumers include on a Marketplace application?

If consumers are only applying for QHP coverage in an FFM (without any help paying for it), they should only include those household members who want coverage on their applications.

If consumers choose to apply for help paying for coverage, they may need to include other household members—even if those household members don't need or want coverage. The application will ask consumers to provide information about these non-applicant household members if needed.

Individuals Included on Applications for Coverage

For adults who are applying for help paying for coverage, the Marketplace application may ask for information about the following individuals, even individuals who aren't applying for coverage themselves:

- All people who are on the same federal income tax return, including spouses and dependents
- Any spouse who lives with the consumer, even if they aren't on the same tax return
- Any children under 21, including stepchildren who live with them, even if they aren't on the same tax return

For children who are applying for help paying for coverage, the Marketplace application may ask for information about the following individuals, even if these individuals aren't applying for coverage themselves:

- All people who are on the same federal income tax return, including parents and siblings
- Any parent, including step-parents, who lives with them, even if they're not on the same tax return

- Any siblings (including step-siblings and half-siblings) who live with them, even if they're not on the same tax return

Note: Members of the same household may need to complete separate applications if they won't file taxes together and they want to apply for help paying for coverage. For more information, refer to the *Advanced Marketplace Issues and Technical Support* course.

Individuals NOT Included on Applications for Coverage

The following individuals may need to submit separate applications:

- Unmarried domestic partners
 - Domestic partners may have to file separate applications. Unmarried domestic partners should submit one application only if they have a child together or one partner will claim the other partner as a tax dependent. For more information, refer to the *Advanced Marketplace Issues and Technical Support* course.

Family members who live together but who file separate tax returns Note: The Marketplace application asks applicants whether they are married. Consumers should select No if they are:

- Unmarried for tax-filing purposes
- Legally married but filing federal income taxes separately due to domestic violence or spousal abandonment

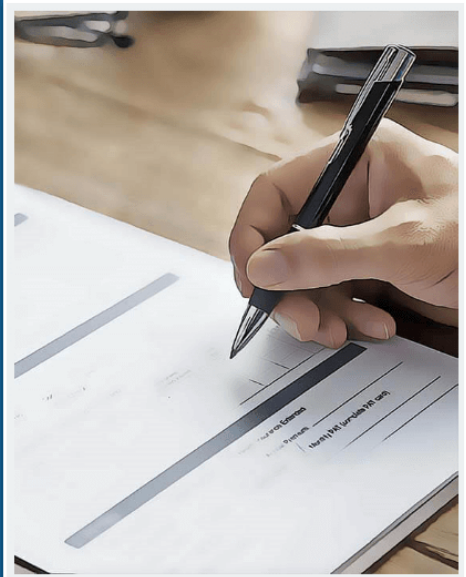
Information Collected During the Application Process

Remember, consumers need to provide the following information to the FFMs when they apply:

- ✓ Contact information
- ✓ Who's applying for coverage
- ✓ Whether they'd like to check their eligibility for APTC and CSRs or other coverage programs (e.g., Medicaid and CHIP)
- ✓ Personal information for each applicant (e.g., name, date of birth, relationship to consumers filing the application)
- ✓ Citizenship or immigration status for each applicant (but not for non-applicants)
- ✓ Information about life events that may qualify consumers for a Special Enrollment Period

If applying for help paying for coverage:

- Tax filing information
- Household income information
- Information regarding access to other coverage (e.g., job-based coverage)



Remember, consumers need to provide the following information to the FFMs when they apply:

- Contact information
- Who's applying for coverage
- Whether they'd like to check their eligibility for APTC and CSRs or other coverage programs (e.g., Medicaid and CHIP)
- Personal information for each applicant (e.g., name, date of birth, relationship to consumers filing the application)
- Citizenship or immigration status for each applicant (but not for non-applicants)
- Information about life events that may qualify consumers for a Special Enrollment Period

If applying for help paying for coverage:

- Tax filing information
- Information regarding access to other coverage (e.g., job-based coverage)

Knowledge Check

Which of the following pieces of information will this consumer need to know to complete his Marketplace application?

Select **all that apply** and then select **Check Your Answer**.

- A. Which household members are applying for coverage
- B. Personal information for each applicant (e.g., name, date of birth, relationship to the consumer filing the application)
- C. Explanation of pre-existing conditions for all applicants
- D. Income information

Check Your Answer



Correct!

This consumer should complete the application, and the FFM will help determine whether they or members of their family are eligible for other programs to help lower their costs. However, the consumer needs to know which household members are applying for coverage, personal information for each applicant, and whether each applicant can get coverage through an employer. You don't need to explain pre-existing conditions to all applicants. All Marketplace insurance plans are prohibited from excluding coverage for treatment based on pre-existing medical conditions.

Hi, I have created a Marketplace account and I am ready to begin the application process. I really want to apply for help paying for coverage.

Which of the following pieces of information will this consumer need to know to complete his Marketplace application?


- A. Whom to include on the application
- B. Personal information for each applicant (e.g., name, date of birth, relationship to the consumer filing the application)
- C. Explanation of pre-existing conditions for all applicants
- D. Income information

The correct answers are A, B, and D. This consumer should complete the application, and the FFM will help determine whether they or members of their family are eligible for other programs to help lower their costs. However, the consumer needs to know which household members are applying for coverage, personal information for each applicant, and whether each applicant can get coverage through an employer. You don't need to explain pre-existing conditions to all applicants. All Marketplace insurance plans are prohibited from excluding coverage for treatment based on pre-existing medical conditions.

Application Inconsistencies

In some cases, application inconsistencies called data matching issues (DMIs) may occur if an FFM's trusted data sources don't confirm the consumers' attested information.

Consumers who encounter a DMI can enroll in coverage during a temporary "inconsistency period;" however, they must provide documents to the FFM that support what they put on their application. If they don't, they may lose their coverage as well as any APTC and CSR amounts they were determined eligible for during the inconsistency period.



For example, if a consumer had a recent name change due to marriage, the FFM may flag the consumer's information as potentially inaccurate. In this case, the consumer could receive a notice from the FFM asking for documents to prove the recent name change.

In some cases, application inconsistencies called data matching issues (DMIs) may occur if an FFM's trusted data sources don't confirm the consumers' attested information.

Consumers who encounter a DMI can enroll in coverage during a temporary "inconsistency period;" however, they must provide documents to the FFM that support what they put on their application. If they don't, they may lose their coverage as well as any APTC and CSR amounts they were determined eligible for during the inconsistency period.

For example, if a consumer had a recent name change due to marriage, the FFM may flag the consumer's information as potentially inaccurate. In this case, the consumer could receive a notice from the FFM asking for documents to prove the recent name change.

Provide Supporting Documents

If a consumer receives a notice asking for additional supporting documents to resolve an application inconsistency, the notice will indicate how long the consumer has to submit them and receive a final eligibility determination.

If a consumer fails to submit necessary documents on time, an FFM may:

- Determine the consumer ineligible for APTC and CSRs
- Terminate the consumer's enrollment through the Marketplace

If consumers enroll and use any APTC amount during an inconsistency period, they must acknowledge that those payments are subject to reconciliation when they file taxes. You should help consumers understand this and help them gather the documents they need to resolve application inconsistencies.

For more information, refer to the *Fact Sheet on Submitting Supporting Documents* in the **Resources** section.

Note: Consumers usually have either 90 or 95 days depending on the inconsistency type, to submit supporting documents when they encounter a DMI. For more information about how DMIs affect consumers, refer to the tip sheet *5 Things Assistants Should Know about Data Matching Terminations* at [Marketplace.cms.gov/technical-assistance-resources/data-matching-terminations.pdf](https://marketplace.cms.gov/technical-assistance-resources/data-matching-terminations.pdf).



If a consumer receives a notice asking for additional supporting documents to resolve an application inconsistency, the notice will indicate how long the consumer has to submit them and receive a final eligibility determination.

If a consumer fails to submit necessary documents on time, an FFM may:

- Determine the consumer ineligible for APTC and CSRs
- Terminate the consumer's enrollment through the Marketplace

If consumers enroll and use any APTC amount during an inconsistency period, they must acknowledge that those payments are subject to reconciliation when they file taxes. You should help consumers understand this and help them gather the documents they need to resolve application inconsistencies.

Note: Consumers usually have either 90 or 95 days depending on the inconsistency type, to submit supporting documents when they encounter a DMI. For more information about how DMIs affect consumers, refer to the tip sheet *5 Things Assistants Should Know about Data Matching Terminations* at HHS.gov/guidance/document/job-aid-5-things-assisters-should-know-about-data-matching-terminations.

Best Practices for Submitting Supporting Documents

You are responsible for helping consumers verify their information in the event of a DMI.

Select the folder to open a PDF with best practices for submitting supporting documents to an FFM.



You are responsible for helping consumers verify their information in the event of a DMI.

Uploading documents at HealthCare.gov is the fastest way to resolve a DMI. When consumers are ready, you should remind them to:

- Include the application ID number associated with the DMI on each page they submit.
- Choose the "Other" option from the drop-down list if they need to upload documents that do not fall into a specific document type category.
- Upload a .pdf, .jpeg, .jpg, .gif, .xml, .png, .tiff, or .bmp file.
- Upload a file no larger than 10 MB.

Don't include any of the following characters in the file name:

- Forward slash
- Back slash
- Colon
- Asterisk
- Quotation marks
- Angle brackets
- Vertical bar
- Question mark

If consumers have trouble uploading documents or don't have the option to upload, they can also mail paper copies; however, they can't fax documents to an FFM. Here are some helpful tips:

- Keep the original versions of any documents and only send copies. Consumers can send documents that say "do not copy" on them. These shouldn't be treated as original documents—the FFMs just need copies to verify consumers' information.
- Include the bar code page from the initial eligibility notice the FFM mailed to them.

- Write their legal names and application ID numbers on each page that they submit if they don't have a bar code page. This makes it easier for the FFMs to match the documents to consumers' application records. Consumers can find their application ID numbers on the letters they received about their DMIs. You can also help them look up their application ID numbers for them online.

Send all documents to:

Health Insurance Marketplace

Attn: Coverage Processing

465 Industrial Blvd.

London, KY 40750-0001

Key Tip: Once consumers' documents are reviewed and processed, they are securely shredded and destroyed.

Remember

There is no need to send documents through FedEx, UPS, or United States Postal Service certified mail or to send documents with a confirmation. If consumers do use these services, the documents will still reach the processing center and will fall within the federal requirements for document retention.

How the Marketplaces Calculate Consumers' Income

If consumers choose to apply for insurance affordability programs when they submit a Marketplace application, it's important that they provide accurate income information for each household member once their identity is verified.

Can a consumer list alimony or child support as income?

Select each image to learn what counts and does not count as income.



Counts as income



Does NOT count as income

What Counts as Income

Some examples of countable income under MAGI are:

- Job
- Self-employment
- Social Security benefits
- Unemployment
- Retirement
- Pension
- Capital gains
- Investment income
- Rental or royalty income
- Farming or fishing income
- [Alimony received](#) (for divorces or separations finalized before January 1, 2019)
- Other taxable income like prizes, gambling winnings, etc.
- [Taxable scholarships, awards, or fellowship grants](#) used for educational purposes (note this income is not counted for Medicaid or CHIP)

Note: Some states determine certain consumers' eligibility for Medicaid and CHIP based on their adjusted gross income (AGI). Some states that don't determine consumer's eligibility for Medicaid and CHIP based on AGI count certain types of income differently from others when determining consumers' eligibility for Medicaid or CHIP.

If consumers choose to apply for insurance affordability programs when they submit a Marketplace application, it's important that they provide accurate income information for each household member once their identity is verified.

Can a consumer list alimony or child support as income?

What Counts as Income

Some examples of countable income under MAGI are:

- Job
- Self-employment
- Social Security benefits
- Unemployment
- Retirement
- Pension
- Capital gains
- Investment income
- Rental or royalty income
- Farming or fishing income
- Alimony received (for divorces or separations finalized before January 1, 2019)
- Other taxable income like prizes, gambling winnings, etc.
- Taxable scholarships, awards, or fellowship grants used for educational purposes (note this income is not counted for Medicaid or CHIP)*

Note: Some states determine certain consumers' eligibility for Medicaid and CHIP based on their adjusted gross income (AGI). Some states that don't determine consumer's eligibility for Medicaid and CHIP based on AGI count certain types of income differently from others when determining consumers' eligibility for Medicaid or CHIP.

* Key Tip: Taxable scholarships, awards, or fellowship grants used for education purposes count as income in the FFMs and consumers should enter them on a Marketplace application. However, they don't count as income when determining consumers' eligibility for Medicaid and CHIP.

What Does NOT Count as Income

Some examples of excluded income under MAGI are:

- Alimony received (for divorces or separations finalized on or after January 1, 2019)
- Child support
- Gifts
- Supplemental Security Income (SSI)
- Veterans' disability payments
- Workers' compensation
- Proceeds from loans like student, home equity, or bank loan

Alimony received

The Tax Cuts and Jobs Act made important changes to how consumers should treat alimony when reporting their income:

For divorces and separations finalized on or after January 1, 2019, alimony should not be reported on the Marketplace application as income or as a deduction.

For divorces and separations finalized before January 1, 2019, alimony should be reported on the Marketplace application as income or as a deduction.

- This means that alimony payments to a former spouse will continue to be tax deductible and alimony payments received from a former spouse will continue to be reported as income.
- If a divorce or separation is modified on or after January 1, 2019, and the modification expressly provides that the alimony rule in the Tax Cuts and Jobs Act's amendment applies to this modification, then alimony shouldn't be reported on the Marketplace application as income or a deduction.

The FFMs use consumers' modified adjusted gross income (MAGI) to determine whether they meet income requirements for financial assistance for enrollment in a QHP. MAGI is adjusted gross income (AGI) as reported on a consumer's federal income tax return plus these, if any: untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest. MAGI is generally very close to consumers' AGI. However, it does not appear as a line on federal income tax returns and does not include SSI.

Tax Returns

It's a good idea to advise consumers who file federal income tax returns to have their tax returns from the previous year available when they complete a Marketplace application. That's because:

- Income reported on a federal income tax return from a previous year can help a consumer estimate their household's MAGI.
- Both Marketplace applications and tax returns should have similar information about a consumer's household size.

Key Tip: If a consumer is married and files a joint tax return with a spouse, their Marketplace application should reflect the spouse and spousal income, as applicable. Dependent(s) information may also be included on a Marketplace application if it is included on a tax return.

Remember, the Marketplaces [calculate MAGI differently](#) from state Medicaid and CHIP agencies. Refer to the *Affordable Care Act Basics* course for more information.

Notice

CMS is offering this link for informational purposes only and this fact shouldn't be construed as an endorsement of the host organization's programs or activities.



The FFMs use consumers' modified adjusted gross income (MAGI) to determine whether they meet income requirements for financial assistance for enrollment in a QHP. MAGI is adjusted gross income (AGI) as reported on a consumer's federal income tax return plus these, if any: untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest. MAGI is generally very close to consumers' AGI. However, it does not appear as a line on federal income tax returns and does not include SSI.

Tax Returns

It's a good idea to advise consumers who file federal income tax returns to have their tax returns from the previous year available when they complete a Marketplace application. That's because:

- Income reported on a federal income tax return from a previous year can help a consumer estimate their household's MAGI.
- Both Marketplace applications and tax returns should have similar information about a consumer's household size.

Key Tip: If a consumer is married and files a joint tax return with a spouse, their Marketplace application should reflect the spouse and spousal income, as applicable. Dependent(s) information may also be included on a Marketplace application if it is included on a tax return.

Remember, the Marketplaces [calculate MAGI differently](#) from state Medicaid and CHIP agencies. Refer to the *Affordable Care Act Basics* course for more information.

Notice

CMS is offering this link for informational purposes only and this fact shouldn't be construed as an endorsement of the host organization's programs or activities.

Knowledge Check

Roberta is a divorced waitress with a seven-year-old son. She separated from her ex-husband in 2017 and receives alimony and child support payments from him. Roberta comes to you for advice on what income she should include when applying for programs to help lower her costs.

Which of the following sources of income should Roberta **NOT** include when estimating her income?

Select **the correct answer** and then select **Check Your Answer**.

- A. Wages
- B. Tips
- C. Alimony
- D. Child Support

✓ Check Your Answer



Correct!

Roberta shouldn't include child support when estimating her household income. However, she should include wages, tips, and alimony.

Note: If Roberta's separation from her ex-husband was finalized on or after January 1, 2019, then she **shouldn't include child support and alimony** when estimating her household income.

Roberta is a divorced waitress with a seven-year-old son. She separated from her ex-husband in 2017 and receives alimony and child support payments from him. Roberta comes to you for advice on what income she should include when applying for programs to help lower her costs.

Which of the following sources of income should Roberta NOT include when estimating her income?

- A. Wages
- B. Tips
- C. Alimony
- D. Child Support

The correct answer is D. Roberta shouldn't include child support when estimating her household income. However, she should include wages, tips, and alimony.

Note: If Roberta's separation from her ex-husband was finalized on or after January 1, 2019, then she **shouldn't include child support and alimony** when estimating her household income.

Explaining Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions

You are responsible for explaining how APTC and CSRs work when consumers apply for coverage in an FFM. You should describe these insurance affordability programs before a consumer chooses whether to apply for them.

Select each for a reminder.



APTC

To be eligible for APTC, a consumer must:

- Be a non-incarcerated U.S. citizen, U.S. national, or legal U.S. resident.
- Have a household income which qualifies the tax filer as an applicable taxpayer according to IRS income thresholds. Currently, the income threshold is between 100 percent and 400 percent of the Federal Poverty Level (FPL)*.
- Have no other minimum essential coverage (MEC)** and not be considered eligible for MEC, including job-based coverage that is affordable (a premium less than 9.61 percent of household income) and meets the minimum value standard.
- File a federal income tax return for the benefit year the consumer enrolled in a QHP and reconcile prior APTC.
- File a joint tax return, if married, unless the consumer is a victim of domestic abuse or spousal abandonment.
- Not be claimed as a dependent on another taxpayer's federal income tax return.

*Under the American Rescue Plan Act of 2021:

- **For Plan Years 2021 and 2022**, premium tax credit (PTC) is available to taxpayers with household income above 400 percent of the FPL and caps how much of a family's household income the family will pay towards the premiums for a benchmark plan at 8.5 percent. However, these expanded benefits are no longer available for PY 2023.

**MEC is any health coverage that meets the Affordable Care Act requirement for having health coverage. Types of coverage that meet MEC requirements include: individual Marketplace policies, certain job-based coverage, Medicare Part A or C, CHIP (including CHIP buy-in programs that provide identical coverage to the state's Title XXI CHIP program), Peace Corps, most Medicaid, TRICARE, VA health care program plans, and certain other coverage designated by the Secretary of HHS.

You are responsible for explaining how APTC and CSRs work when consumers apply for coverage in an FFM. You should describe these insurance affordability programs before a consumer chooses whether to apply for them.

APTC

To be eligible for APTC, a consumer must:

- Be a non-incarcerated U.S. citizen, U.S. national, or legal U.S. resident.
- Have a household income which qualifies the tax filer as an applicable taxpayer according to IRS income thresholds. Currently, the income threshold is between 100 percent and 400 percent of the Federal Poverty Level (FPL)*.
- Have no other minimum essential coverage (MEC)** and not be considered eligible for MEC, including job-based coverage that is affordable (a premium less than 9.61 percent of household income) and meets the minimum value standard.
- File a federal income tax return for the benefit year the consumer enrolled in a QHP and reconcile prior APTC.
- File a joint tax return, if married, unless the consumer is a victim of domestic abuse or spousal abandonment.
- Not be claimed as a dependent on another taxpayer's federal income tax return.

*Under the American Rescue Plan Act of 2021:

For Plan Years 2021 and 2022, premium tax credit (PTC) is available to taxpayers with household income above 400 percent of the FPL and caps how much of a family's household income the family will pay towards the premiums for a benchmark plan at 8.5 percent. However, these expanded benefits are no longer available for PY 2023.

**MEC is any health coverage that meets the Affordable Care Act requirement for having health coverage. Types of coverage that meet MEC requirements include: individual Marketplace policies, certain job-based coverage, Medicare Part A or C, CHIP (including CHIP buy-in programs that provide identical coverage to the state's Title XXI CHIP program), Peace Corps, most Medicaid, TRICARE, VA health care program plans, and certain other coverage designated by the Secretary of HHS.

**MEC is any health coverage that meets the Affordable Care Act requirement for having health coverage. Types of coverage that meet MEC requirements include: individual Marketplace policies, certain job-based coverage, Medicare Part A or C, CHIP (including CHIP buy-in programs that provide identical coverage to the state's Title XXI CHIP program), Peace Corps, most Medicaid, TRICARE, Veterans Affairs (VA) health care program plans, and certain other coverage designated by the Secretary of HHS.

CSRs

Consumers who qualify for APTC may also qualify for CSRs. CSR payments are advanced directly to insurance companies for eligible consumers. To qualify for CSRs, consumers* must:

- Meet the eligibility criteria for APTC.
- Enroll in a Silver plan in a Marketplace.
- Have a household income between 100 percent and 250 percent of the FPL.

Key Tip: Use the tool available at [HealthCare.gov/see-plans](https://www.healthcare.gov/see-plans) to search for Silver plans available in a consumer's area.

Eligible consumers with incomes in lower FPL ranges (e.g., from 100 percent to 150 percent) generally receive greater savings on additional costs in the form of CSRs.

*American Indians and Alaska Natives (AI/ANs) or members of Federally-recognized Indian tribes with household incomes up to 300 percent of the FPL qualify for CSRs regardless of which metal level health plan category they choose. They can also continue to receive health services from the following:

- Indian Health Service (IHS)
- Tribes and tribal organizations
- Urban Indian Health Organizations (UIHO)
- Medicare, Medicaid, and CHIP, if eligible.

Knowledge Check

Generally, consumers must have a household income between ____ percent and ____ percent of the FPL to be eligible for APTC.

Select **the correct answer** and then select **Check Your Answer**.

- A. 100 percent and 400 percent
- B. 200 percent and 400 percent
- C. 100 percent and 500 percent
- D. 200 percent and 500 percent

✓ Check Your Answer



Correct!

Consumers must generally have a household income between 100 percent and 400 percent of the FPL to be eligible for APTC.

Generally, consumers must have a household income between ____ percent and ____ percent of the FPL to be eligible for APTC.

- A. 100 percent and 400 percent
- B. 200 percent and 400 percent
- C. 100 percent and 500 percent
- D. 200 percent and 500 percent

The correct answer is A. Consumers must generally have a household income between 100 percent and 400 percent of the FPL to be eligible for APTC. For Plan Years 2021 and 2022, premium tax credit is available to taxpayers with household income above 400.

Key Points



- You should know how to guide consumers through each step of creating a Marketplace account, completing an application, and resolving any DMIs that may occur.

- Consumers need to provide identifying information and answer questions about their citizenship or immigration status as part of the application process.

- You should provide accurate information about insurance affordability programs in the FFMs and help consumers accurately report their income if they choose to apply for them.

- You should know how to guide consumers through each step of creating a Marketplace account, completing an application, and resolving any DMIs that may occur.
- Consumers need to provide identifying information and answer questions about their citizenship or immigration status as part of the application process.
- You should provide accurate information about insurance affordability programs in the FFMs and help consumers accurately report their income if they choose to apply for them.

Interpreting Eligibility and Enrolling in Coverage

Eligibility Results

After consumers submit a Marketplace application, the individual market FFMs verify information about each household applicant and assess or determine their eligibility for:

- An [SEP](#) (Consumers applying for an SEP may have to submit supporting documents to an FFM to prove their eligibility for certain SEP qualifying events before the FFM sends their information to a QHP issuer for processing.)
- Medicaid
- CHIP
- QHP coverage with APTC and CSRs
- QHP coverage without APTC and CSRs—either because they haven't applied for them or are ineligible

You should be able to explain consumers' eligibility determination notice (EDN) results to them and describe each program they are eligible for. Sometimes this will be a simple conversation, and an applicant will quickly move to the next step of shopping for a QHP. Other times, applicants may encounter a DMI or wish to appeal a decision in their EDN. If the information on a consumer's Marketplace application doesn't match Marketplace records, the EDN will explain that the consumer must provide additional documents and list any next steps for resolving outstanding DMIs.

Step 2 : View Your "Eligibility Results"

Your "Eligibility Results" contain important information about your Marketplace coverage, including your eligibility for coverage, costs, deadlines, and next steps. If you're eligible for coverage through a Marketplace plan, you'll continue to Step 3 to enroll in coverage after you review your results.

[VIEW ELIGIBILITY RESULTS \(PDF\)](#)

For detailed information on reviewing eligibility results with consumers, refer to SOP 6 in the [Assister's SOP Manual](#).

After consumers submit a Marketplace application, the individual market FFMs verify information about each household applicant and assess or determine their eligibility for:

- An SEP (Consumers applying for an SEP may have to submit supporting documents to an FFM to prove their eligibility for certain SEP qualifying events before the FFM sends their information to a QHP issuer for processing.)
- Medicaid
- CHIP
- QHP coverage with APTC and CSRs
- QHP coverage without APTC and CSRs—either because they haven't applied for them or are ineligible

You should be able to explain consumers' eligibility determination notice (EDN) results to them and describe each program they are eligible for. Sometimes this will be a simple conversation, and an applicant will quickly move to the next step of shopping for a QHP. Other times, applicants may encounter a DMI or wish to appeal a decision in their EDN. If the information on a consumer's Marketplace application doesn't match Marketplace records, the EDN will explain that the consumer must provide additional documents and list any next steps for resolving outstanding DMIs.

For detailed information on reviewing eligibility results with consumers, refer to SOP 6 in the [Assister's SOP Manual](#).



Remember, the FFM assesses or determines consumers' eligibility for Medicaid and CHIP if the applicant applies for help paying for coverage. You should be able to explain how the FFM in your state determines consumers' final eligibility for these programs.

- An FFM in a Medicaid assessment state uses Medicaid rules and any applicable state-specific rules to evaluate a consumer's MAGI and then transfers a consumer's information to the state's Medicaid or CHIP agency for a final determination if the FFM believes the consumer may be eligible for Medicaid or CHIP on the basis of MAGI.
- An FFM in a Medicaid determination state has been delegated authority by the state Medicaid agency to make a final Medicaid/CHIP eligibility determination. Therefore, these FFMs use Medicaid rules and any applicable state-specific rules to evaluate a consumer's MAGI and then makes a final determination about whether the consumer is eligible for Medicaid or CHIP on the basis of MAGI.

If consumers are [assessed](#) eligible for Medicaid or CHIP by an FFM, the FFM transfers the consumer's information to the appropriate state Medicaid or CHIP agency for a final eligibility determination.

If consumers are [determined](#) eligible for Medicaid or CHIP by an FFM, the FFM will transfer the consumer's information to the appropriate state Medicaid or CHIP agency to process their enrollment. The Medicaid or CHIP agency accepts the FFM's determination of eligibility as final and enrolls the consumer in coverage.

Even if consumers are not assessed or determined eligible for Medicaid or CHIP based on MAGI, they will be referred to the state Medicaid or CHIP agency if they appear potentially eligible for Medicaid on a [non-MAGI basis](#), based on their responses to certain questions on the application.

In addition, a consumer has the opportunity in the FFM application to request a "full determination," or a determination of eligibility on all bases. If this is requested by a consumer:

- In an assessment state, the state Medicaid or CHIP agency will then make a determination of the applicant's eligibility on all bases, including on a MAGI basis for applicants whom the FFM didn't already assess as potentially MAGI-eligible.
- In a determination state, the state Medicaid or CHIP agency will determine the applicant's eligibility only on non-MAGI bases, as the FFM has already made a final determination on the basis of MAGI.

Consumers may contact their state Medicaid or CHIP agency directly for more information or to appeal a determination.

[Additional Information](#)

Remember, the FFMs assess or determine consumers' eligibility for Medicaid and CHIP if the applicant applies for help paying for coverage. You should be able to explain how the FFM in your state determines consumers' final eligibility for these programs.

- An FFM in a Medicaid assessment state uses Medicaid rules and any applicable state-specific rules to evaluate a consumer's MAGI and then transfers a consumer's information to the state's Medicaid or CHIP agency for a final determination if the FFM believes the consumer may be eligible for Medicaid or CHIP on the basis of MAGI.
- An FFM in a Medicaid determination state has been delegated authority by the state Medicaid agency to make a final Medicaid/CHIP eligibility determination. Therefore, these FFMs use Medicaid rules and any applicable state-specific rules to evaluate a consumer's MAGI and then makes a final determination about whether the consumer is eligible for Medicaid or CHIP on the basis of MAGI.

If consumers are [assessed*](#) eligible for Medicaid or CHIP by an FFM, the FFM transfers the consumer's information to the appropriate state Medicaid or CHIP agency for a final eligibility determination.

If consumers are [determined**](#) eligible for Medicaid or CHIP by an FFM, the FFM will transfer the consumer's information to the appropriate state Medicaid or CHIP agency to process their enrollment. The Medicaid or CHIP agency accepts the FFM's determination of eligibility as final and enrolls the consumer in coverage.

Even if consumers are not assessed or determined eligible for Medicaid or CHIP based on MAGI, they will be referred to the state Medicaid or CHIP agency if they appear potentially eligible for Medicaid on a non-MAGI basis, based on their responses to certain questions on the application.

In addition, a consumer has the opportunity in the FFM application to request a "full determination," or a determination of eligibility on all bases. If this is requested by a consumer:

- In an assessment state, the state Medicaid or CHIP agency will then make a determination of the applicant's eligibility on all bases, including on a MAGI basis for applicants whom the FFM didn't already assess as potentially MAGI-eligible.
- In a determination state, the state Medicaid or CHIP agency will determine the applicant's eligibility only on non-MAGI bases, as the FFM has already made a final determination on the basis of MAGI.

Consumers may contact their state Medicaid or CHIP agency directly for more information or to appeal a determination.

***Medicaid Assessment**

In a Medicaid assessment state, the FFM makes an initial decision that a consumer is potentially eligible for Medicaid or CHIP based on their household's MAGI and other eligibility criteria. In these states, the FFM transfers the consumer's application to the state Medicaid or CHIP agency for a final eligibility determination. The agency then sends a notice to the consumer with a final eligibility determination or requests additional information if necessary.

****Medicaid Determination**

In a Medicaid determination state, the FFM makes a final determination about a consumer's eligibility for Medicaid or CHIP based on the basis of their household's MAGI and sends the consumer's information to the state Medicaid or CHIP agency for enrollment. If consumers are potentially eligible on a non-MAGI basis, the FFM will send the consumer's information to the state Medicaid or CHIP agency, which will conduct a final determination on the appropriate bases.

Additional Information

Remember, you can use the **Map tab** in the course **Menu** to determine whether your state or other states make an assessment or determination for Medicaid and CHIP eligibility.

Key Tip: If an individual is assessed or determined **ineligible** for Medicaid and CHIP, their EDN will state whether that individual can enroll in a QHP and receive APTC and CSRs.

You can find more detailed information about assisting consumers with Medicaid and CHIP eligibility in the *Medicaid and CHIP Overview* tip sheet at [Marketplace.cms.gov/technical-assistance-resources/fast-facts-medicaid-chip.pdf](https://marketplace.cms.gov/technical-assistance-resources/fast-facts-medicaid-chip.pdf).



Remember, some states have expanded their Medicaid programs to cover low-income adults. Others haven't.

- **In all states:** Consumers can qualify for Medicaid based on income, household size, disability, family status, and other factors. Eligibility rules differ between states.
- **In states that have expanded Medicaid coverage:** Certain low-income consumers ages 19-64 can qualify under the ACA Medicaid expansion to the adult group. If consumers' household income is below 133 percent of the FPL, they qualify under the adult group. [In practice](#), however, consumers whose household income is below 138 percent of the FPL qualify for this group.

Be sure you know whether the state you are working in has expanded Medicaid eligibility for adults and the applicable FPL.

For the latest FPL information and guidelines, visit aspe.hhs.gov/poverty-guidelines.

Remember, some states have expanded their Medicaid programs to cover low-income adults. Others haven't.

- **In all states:** Consumers can qualify for Medicaid based on income, household size, disability, family status, and other factors. Eligibility rules differ between states.
- **In states that have expanded Medicaid coverage:** Certain low-income consumers ages 19-64 can qualify under the ACA Medicaid expansion to the adult group. If consumers' household income is below 133 percent of the FPL, they qualify under the adult group. In practice, however, consumers whose household income is below 138 percent of the FPL qualify for this group.

Be sure you know whether the state you are working in has expanded Medicaid eligibility for adults and the applicable FPL.

For the latest FPL information and guidelines, visit aspe.hhs.gov/poverty-guidelines.

*In practice

The ACA's MAGI calculation is generally based on taxable income as defined in the Internal Revenue Code. For Medicaid and CHIP, the MAGI-based methodology includes a disregard equivalent to five percent of the FPL. With this five percent disregard, the Medicaid adult group eligibility threshold is effectively 138 percent of the FPL.

CHIP Eligibility and the FFMs

If a child is eligible for both QHP coverage and CHIP coverage, remind consumers that CHIP qualifies as MEC. Children who are eligible for CHIP are not eligible for APTC or CSRs in a Marketplace; however, they may still enroll in a QHP without APTC and CSRs. If they choose to enroll in Marketplace coverage without APTCs and CSRs, they should tell their state CHIP agency that they're still enrolled in Marketplace coverage without financial help, as they may no longer be eligible for CHIP



If a child is eligible for both QHP coverage and CHIP coverage, remind consumers that CHIP qualifies as MEC. Children who are eligible for CHIP are not eligible for APTC or CSRs in a Marketplace; however, they may still enroll in a QHP without APTC and CSRs. If they choose to enroll in Marketplace coverage without APTCs and CSRs, they should tell their state CHIP agency that they're still enrolled in Marketplace coverage without financial help, as they may no longer be eligible for CHIP.

You should be prepared to explain consumers' options if their eligibility determinations show that they qualify for a PTC and CSRs.

Eligible individuals and families can use all, some, or none of the premium tax credit amount they qualify for in advance to lower their monthly premiums when they enroll in a QHP. You should help consumers make informed decisions about the amount of premium tax credit they want to use in advance. Eligible consumers can:

- Distribute the amount equally for each month during the year as APTC.
- Receive a smaller amount of APTC during the year.
- Use none.

Explain to consumers that the amount of APTC they use could affect the amount of taxes they owe the Internal Revenue Service (IRS) or the amount they get back when they file federal income tax returns for the year.

APTC Reconciliation

You should always make sure consumers understand the importance of reporting changes in household income and other eligibility factors during the year. When consumers file federal income tax returns, they will need to use Form 8962 to calculate the amount of premium tax credit they were eligible for during the year and reconcile that amount with any APTC they received. You can learn more about APTC reconciliation in the *Assister Standard Operating Procedures* course.

Select to zoom

HealthCare.gov

Step 1 of 6. Decide how much tax credit to use to lower your premium. [View steps](#)

Use your tax credit to lower your monthly premium

You qualify for a premium tax credit of \$604 a month. You can decide how much of this amount you want to use to save on your monthly premium.

You can lower your monthly premium up to
\$604 per month

The amount is based on:

- Expected yearly income
- Where you live
- Tax household size

If any of these things change over the year, the tax credit amount you qualify for can change. For example, if your income goes up during the year, you'll likely qualify for a lower tax credit. If you take more tax credit than you're eligible for, you may have to pay money back when you file your federal taxes at the end of the year.

If your income or household changes, it's very important to update your Marketplace application as soon as possible to avoid paying money back on your federal taxes.

If you choose not to use any of your tax credit, you'll claim the full amount on your federal taxes.

How much of your \$604 monthly tax credit do you want to use to lower your premium?

ALL of the tax credit each month.
Good choice if you're pretty sure your final 2022 income will be about the same as your estimate.

SOME of the tax credit each month.
Good choice if it's likely your final 2022 income will be higher than your estimate.

NONE of the tax credit each month.
Good choice if you don't want to risk having to pay money back on your federal taxes if anything changes.

Important: If things change – like you get a raise, gain or lose a dependent, or work more or less hours, update your Marketplace application right away.

[Save & Continue](#)

You should be prepared to explain consumers' options if their eligibility determinations show that they qualify for a PTC and CSRs.

Eligible individuals and families can use all, some, or none of the premium tax credit amount they qualify for in advance to lower their monthly premiums when they enroll in a QHP. You should help consumers make informed decisions about the amount of premium tax credit they want to use in advance. Eligible consumers can:

- Distribute the amount equally for each month during the year as APTC.
- Receive a smaller amount of APTC during the year.
- Use none.

Explain to consumers that the amount of APTC they use could affect the amount of taxes they owe the Internal Revenue Service (IRS) or the amount they get back when they file federal income tax returns for the year.

APTC Reconciliation

You should always make sure consumers understand the importance of reporting changes in household income and other eligibility factors during the year. When consumers file federal income tax returns, they will need to use Form 8962 to calculate the amount of premium tax credit they were eligible for during the year and reconcile that amount with any APTC they received. You can learn more about APTC reconciliation in the *Assister Standard Operating Procedures* course.

Helping Consumers Compare and Select Plans

After you help consumers who qualify for a premium tax credit set the APTC amount they'd like to use, they'll set their health insurance preferences, compare plans, and choose a QHP that meets their needs.

The "Enroll To-Do List" in a Marketplace application includes six steps consumers should complete:

1. Choose how much premium tax credit to apply to their monthly premiums in advance.
2. Report tobacco use.
3. Determine if QHPs cover their doctors, hospitals, and prescription drugs.
4. Choose a QHP.
5. If desired, compare and select dental coverage.
6. Review and confirm health and dental coverage choices before signing the application.

Select to zoom

The screenshot shows the HealthCare.gov website interface. At the top, it says "You're eligible to enroll in Marketplace coverage". Below this, there's a blue banner that says "Choose a plan by December 31, 2022 to get coverage." and "Select your health plan and complete the steps below by December 31, 2022." There are two input fields: "For coverage to start on:" with "January 1, 2023" and "Confirm your plan by:" with "December 31, 2022". A red box highlights the first three steps of the enrollment process: 1. "Decide how much tax credit to use to lower your premium" with a "Start" button; 2. "Report tobacco use"; 3. "See if plans cover your doctors, hospitals & prescription drugs" with a "Start" button. Below these are steps 4, 5, and 6, and an optional step: "Optional: Get an estimate of your total yearly costs" with a "Start" button. At the bottom, there's a link to "Enter an Exemption Certificate Number (ECN)".

After you help consumers who qualify for a premium tax credit set the APTC amount they'd like to use, they'll set their health insurance preferences, compare plans, and choose a QHP that meets their needs.

The "Enroll To-Do List" in a Marketplace application includes six steps consumers should complete:

1. Choose how much premium tax credit to apply to their monthly premiums in advance.
2. Report tobacco use.
3. Determine if QHPs cover their doctors, hospitals, and prescription drugs.
4. Choose a QHP.
5. If desired, compare and select dental coverage.
6. Review and confirm health and dental coverage choices before signing the application.

Plan Comparison

When you help consumers compare QHPs, remember to show them all of the QHP options they're eligible for. You should never provide recommendations about which plan or plans consumers should select.

Consumers can filter QHPs based on factors like:

- Premium price range
- Yearly deductible
- Health plan type (e.g., Health Maintenance Organization (HMO), Preferred-Provider Organization (PPO))
- Marketplace health plan category (i.e., Bronze, Silver, Gold, Platinum, or Catastrophic)
- Dental coverage
- Estimated yearly costs
- Health Savings Account (HSA)-eligible plans

Key Tip: Remember, QHP premium amounts shown in Plan Compare are discounted by the APTC amount an eligible consumer selects. Remind consumers that they can change this amount later if desired.

The screenshot shows a plan comparison interface for the Proton Health Network Proton Bronze HMO 3400. The monthly premium is \$141.66, including a \$500.00 tax credit (was \$141.66). The deductible is \$16,000 (Family Total) and the out-of-pocket maximum is \$16,300 (Family Total). The interface also displays copayments/coinsurance for emergency room care, generic drugs, primary doctor, and specialist doctor. Plan features include Adult Dental and Child Dental. There are buttons for 'Plan Details', 'Enroll', 'Add Your Medical Providers', and 'Add Your Prescription Drugs'. A 'Compare' button is also visible.

When you help consumers compare QHPs, remember to show them all of the QHP options they're eligible for. You should never provide recommendations about which plan or plans consumers should select.

Consumers can filter QHPs based on factors like:

- Premium price range
- Yearly deductible
- Health plan type (e.g., Health Maintenance Organization (HMO), Preferred-Provider Organization (PPO))
- Marketplace health plan category (i.e., Bronze, Silver, Gold, Platinum, or Catastrophic)
- Dental coverage
- Estimated yearly costs
- Health Savings Account (HSA)-eligible plans

Key Tip: Remember, QHP premium amounts shown in Plan Compare are discounted by the APTC amount an eligible consumer selects. Remind consumers that they can change this amount later if desired.

Side-by-side Comparison Tool



Compare plans

Proton Health Network Proton Bronze HMO 3400 Enroll	P. One Healthcare One Care Silver 2.150 Enroll	Next Step Health System Next Care Gold 14 Enroll
--	--	--

Highlights

Monthly premium	\$141.66 Including a \$500.00 tax credit Was \$641.66	\$283.80 Including a \$500.00 tax credit Was \$783.80	\$375.58 Including a \$500.00 tax credit Was \$875.58
Deductible	\$8,000 Individual total \$16,000 Family Total	\$0 Individual total \$0 Family Total	\$2,925 Individual total \$5,850 Family Total
Out-of-pocket maximum	\$8,150 Individual total \$16,300 Family Total	\$2,700 Individual total \$5,400 Family Total	\$6,000 Individual total \$12,000 Family Total
Estimated total yearly costs	Add	Add	Add
Plan metal level	Bronze	Silver	Gold
Plan type	HMO	HMO	HMO
Plan ID	40047MI0090002	40047MI0090001	40047MI0010001
Medical Providers in-network	Add Your Medical Providers	Add Your Medical Providers	Add Your Medical Providers
Drugs covered/Not covered	Add Your Prescription Drugs	Add Your Prescription Drugs	Add Your Prescription Drugs
Star rating	▼		
Plan documents	▼		

Select to zoom 🔍

Consumers can use the side-by-side comparison tool to explore different QHP features and compare how plans differ in categories like costs for medical care, prescription drug coverage, and in-network providers. Consumers can also use the tool to check for medical management programs that are important to them (e.g., pain management, diabetes care, and psychiatric care for depression).

Consumers can refer to a QHP's Summary of Benefits and Coverage (SBC) for more detailed information. You can learn more about the SBC in the *Coverage to Care Assistance course*.

Consumers can use the side-by-side comparison tool to explore different QHP features and compare how plans differ in categories like costs for medical care, prescription drug coverage, and in-network providers. Consumers can also use the tool to check for medical management programs that are important to them (e.g., pain management, diabetes care, and psychiatric care for depression).

Consumers can refer to a QHP's Summary of Benefits and Coverage (SBC) for more detailed information. You can learn more about the SBC in the *Coverage to Care Assistance course*.



Once consumers select a QHP, you can help them complete their enrollment.

When consumers select a QHP, remind them that their QHP enrollment generally isn't complete unless their health insurance company receives their first month's premium payment in full before the due date. If consumers don't pay their first month's premium, their QHP enrollment won't be effectuated. If consumers miss any premium payments after the first month's premium, the Marketplace may cancel their enrollment unless a [grace period](#) for nonpayment of premiums applies.

Generally, you shouldn't enter consumers' payment information into a QHP provider's website (e.g., credit card numbers or bank account numbers). You should encourage consumers to carefully enter all application and enrollment information themselves. Under limited circumstances, if a consumer asks for help typing or using a computer to learn about, apply for, and enroll in Marketplace coverage, you may use the keyboard or mouse, but only to follow consumer's specific directions.

Continue

Once consumers select a QHP, you can help them complete their enrollment.

When consumers select a QHP, remind them that their QHP enrollment generally isn't complete unless their health insurance company receives their first month's premium payment in full before the due date. If consumers don't pay their first month's premium, their QHP enrollment won't be effectuated. If consumers miss any premium payments after the first month's premium, the Marketplace may cancel their enrollment unless a grace period for nonpayment of premiums applies.

Generally, you shouldn't enter consumers' payment information into a QHP provider's website (e.g., credit card numbers or bank account numbers). You should encourage consumers to carefully enter all application and enrollment information themselves. Under limited circumstances, if a consumer asks for help typing or using a computer to learn about, apply for, and enroll in Marketplace coverage, you may use the keyboard or mouse, but only to follow consumer's specific directions.

Effective Date of Coverage

In most cases, the earliest date consumers' coverage can start – that is, their "effective date of coverage"—is:

- For the OEP for 2023 coverage, January 1 for consumers who enroll between November 1, 2022, and December 15, 2022, or February 1 if they enroll between December 16, 2022, and January 15, 2023; or
- For Special Enrollment Periods, the first day of the month following plan selection, unless a special effective date applies.

Remember to tell consumers that their effective date of coverage is based on when they choose a plan and the type of SEP they qualify for, not the first date on which they actually use the coverage to get care.

Key Tip: The individual market OEP for 2023 coverage begins on November 1, 2022, and ends January 15, 2023. . Consumers generally must pay their first month's premium for new coverage by the deadline noted by the health insurance issuer in the enrollment materials. If there are questions about the deadline for payment, the consumer should call their issuer directly.

Grace Period

There's a three-month grace period for consumers who are receiving APTC when they fail to pay their premiums by the due date noted in the issuer's enrollment materials. A QHP must continue to pay claims

during the first month of the grace period; however, it may delay payments for any claims made in the second and third months until consumers pay any overdue premiums. If consumers still haven't paid their premiums in full after the third month, their QHP is terminated retroactively to the end of the first month of the grace period. This means the consumer may have to pay any claims made on their behalf during the second and third months of the grace period.

Redetermination, Re-enrollment, and Changes in Circumstances



Consumers who are already enrolled in a QHP through an FFM generally don't need to complete a new application for the following coverage year. Remember to tell consumers they are required to report changes that affect their eligibility for a QHP, as well as any APTC or CSRs they receive, within 30 days of the change.

Even if consumers believe they have no changes to report, it's strongly recommended that they contact the FFM to make sure their eligibility information is up to date.

Select each number to learn more.



Consumers who are already enrolled in a QHP through an FFM generally don't need to complete a new application for the following coverage year. Remember to tell consumers they are required to report changes that affect their eligibility for a QHP, as well as any APTC or CSRs they receive, within 30 days of the change.

Even if consumers believe they have no changes to report, it's strongly recommended that they contact the FFM to make sure their eligibility information is up to date.

Asking consumers the following questions will help you understand how to assist them:

- Do you currently have a Marketplace plan?
- Do you use it?
- What was your experience like?
- What questions do you have about using your current plan?
- Was the plan sufficient for your needs? Why or why not?

Before each OEP, the FFMs send a notice to all current enrollees that summarizes their eligibility for the coming year (unless they have terminated their coverage and the FFM has a cancellation request on file).

There are four variations of this eligibility notice:

- Standard eligibility notice
- Income-based outreach notice
- Failure to File and Reconcile (FTR) notice
- Special notice

The eligibility notice will also state:

- Whether the consumer's plan will be available for the next plan year.
- Any changes to the plan.
- If the plan won't be available, what plan the consumer will be enrolled in for the next plan year if the consumer doesn't actively choose a different plan.

You should advise consumers to review the notice and contact the FFM if anything is incorrect. If the FFM found that a consumer's household income has changed, the notice will advise the consumer to report the change and obtain updated eligibility results. This is very important for consumers who receive financial assistance. If a consumer's household is no longer eligible for financial assistance, the FFM will discontinue their eligibility for APTC and CSRs at the end of the coverage year and re-enroll them in a QHP without financial assistance.

Consumers who meet any of the following criteria must also contact the FFM to obtain updated eligibility results:

- No updated tax return information is provided by the IRS in response to the Marketplace's request; or
- The IRS provides updated household income information from tax data that, when evaluated together with the family size used for the enrollee's most recent eligibility results for the current plan year, reflects:
 - Household income in excess of 350 percent of the FPL
 - An increase or decrease in household income of greater than 50 percent when compared to the household income from the most recent FFM eligibility results;
 - Household income under 100 percent of the FPL; or
 - Household income that meets other criteria established by the FFM.
- IRS indicates in response to Marketplace's request for updated tax return information that APTC was provided to the tax filer but the tax filer didn't comply with the requirement to file a federal income tax return for the year APTC was provided and reconcile APTC.

Existing QHP enrollees will also receive a notice from their health insurance company indicating whether their current plan has changed or can be renewed for the following coverage year.

Changes in circumstance may also affect consumers' eligibility and enrollment (e.g., a move or a change in access to job-based health coverage). Consumers should report changes to the FFMs within 30 days of the change occurring.

Before Open Enrollment, the FFMs request updated tax return information from the IRS for all consumers who have agreed to allow the Marketplaces to recheck their information. If these consumers are currently enrolled in QHPs, the FFMs will determine whether they are eligible to receive APTC and CSRs. Any changes in coverage or eligibility as a result of the redetermination process are effective on January 1 of the following coverage year.

If consumers requested help paying for health coverage on their Marketplace application but didn't agree to allow the FFM to recheck their federal tax data on an annual basis, they will receive a notice asking them to contact the FFM to get updated eligibility results. If they don't do this by December 15 of the current coverage year, the enrollees' APTC and CSRs will end on December 31. The FFM will still renew consumers' QHP coverage without APTC and CSRs for the following year if the coverage is available unless the FFM determines they are no longer eligible to purchase a QHP.

Some changes in circumstances are "qualifying events," meaning consumers are eligible for an SEP to newly enroll in or change QHPs. SEPs typically last 60 days and can provide an opportunity for consumers to enroll in coverage outside of the individual market OEP.

Examples of qualifying events include the loss of MEC, gaining or becoming a dependent due to the birth of a child or getting married, or a permanent move.

If consumers qualify for certain common SEPs, they may be required to submit supporting documents to an FFM so it can [verify their eligibility](#). Once their eligibility is verified, the FFM can transfer their information to an issuer if they selected a QHP. Consumers who are eligible to change to a different QHP during an SEP may be limited in the type of QHP they can choose. For example, a consumer may be able to select a new plan, but that plan may need to be within the same metal level (e.g., Bronze, Silver, Gold, Platinum) as the consumer's current QHP coverage.

If consumers do not qualify for an SEP and the annual OEP for the current coverage year has already passed, they must wait for the next OEP to enroll in or change QHPs or experience a different SEP life event. Remember, consumers do NOT qualify for an SEP if their coverage is terminated because they didn't pay their premiums.

Effective dates of coverage for most SEPs is the first day of the month following plan selection.

There are a few exceptions, including but not limited to:

- In the case of gaining or becoming a dependent through birth, adoption, placement for adoption, placement in foster care or due to a child support or other court order, coverage is effective on the date of the event. If they prefer, consumers have the option to call the FFM Call Center to request that coverage instead take effect on the first day of the month following the date of plan selection.

[Policy Updates](#)

Some changes in circumstances are "qualifying events," meaning consumers are eligible for an SEP to newly enroll in or change QHPs. SEPs typically last 60 days and can provide an opportunity for consumers to enroll in coverage outside of the individual market OEP.

Examples of qualifying events include the loss of MEC, gaining or becoming a dependent due to the birth of a child or getting married, or a permanent move.

If consumers qualify for certain common SEPs, they may be required to submit supporting documents to an FFM so it can verify their eligibility. Once their eligibility is verified, the FFM can transfer their information to an issuer if they selected a QHP. Consumers who are eligible to change to a different QHP during an SEP may be limited in the type of QHP they can choose. For example, a consumer may be able to select a new plan, but that plan may need to be within the same metal level (e.g., Bronze, Silver, Gold, Platinum) as the consumer's current QHP coverage.

If consumers do not qualify for an SEP and the annual OEP for the current coverage year has already passed, they must wait for the next OEP to enroll in or change QHPs or experience a different SEP life event. Remember, consumers do NOT qualify for an SEP if their coverage is terminated because they didn't pay their premiums.

Effective dates of coverage for most SEPs is the first day of the month following plan selection.

There are a few exceptions, including but not limited to:

- In the case of gaining or becoming a dependent through birth, adoption, placement for adoption, placement in foster care or due to a child support or other court order, coverage is effective on the date of the event. If they prefer, consumers have the option to call the FFM Call Center to request that coverage instead take effect on the first day of the month following the date of plan selection.

***Verify their eligibility**

Consumers who are newly enrolling in Marketplace coverage during an SEP due to loss of MEC may be required, at the option of the Exchanges using the Federal platform, to verify their eligibility by submitting supporting documents showing their loss of coverage.

Consumers generally have 60 days from the date of their qualifying life event to enroll, change plans, or add new dependents to their current plan. The submission of required documents to verify their SEP eligibility also takes place during the 60-day window.

For all other SEP types consumers don't need to submit documents before they can start using their new coverage.

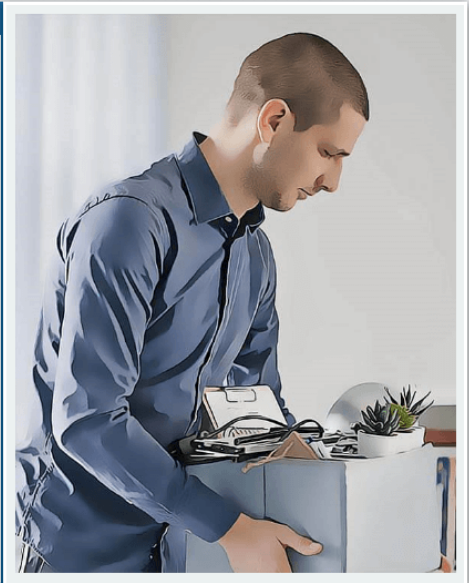
Policy Updates

In 2022, a new SEP is available to lower-income consumers allowing them to enroll in Marketplace coverage or change their Marketplace coverage once per month, if they so choose. Consumers who qualify for this SEP may also qualify for more savings. Consumers who have an estimated annual household income at or below 150 percent of the FPL in their state and are APTC-eligible are eligible for this SEP. The annual household income at or below 150 percent of the FPL varies by state and household size. This SEP will continue to be available during any period of time when these individuals are expected to contribute zero percent of their annual household income towards premiums, such as due to changes introduced in the American Rescue Plan Act of 2021 (ARP).

Loss of Job-based Coverage and COBRA Eligibility

When consumers lose job-based insurance, their former employer may offer COBRA continuation coverage. Consumers who leave a job and are eligible for COBRA continuation coverage must be given an election period of at least 60 days to choose whether or not to elect COBRA continuation coverage (starting on the date they are furnished the election notice or the date they would lose coverage, whichever is later).

- Consumers eligible to enroll in COBRA can generally choose to enroll in a QHP through an FFM instead. Remember, consumers who lose job-based coverage qualify for a 60-day SEP and may be eligible for APTC and CSRs that wouldn't be available to them if they enrolled in COBRA continuation coverage.
- Consumers may also be eligible for a 60-day SEP to enroll in a QHP through an FFM if their former employer ceases all employer contributions for COBRA continuation coverage.
- Consumers who lose job-based insurance may also be eligible for Medicaid/CHIP.



When consumers lose job-based insurance, their former employer may offer COBRA continuation coverage. Consumers who leave a job and are eligible for COBRA continuation coverage must be given an election period of at least 60 days to choose whether or not to elect COBRA continuation coverage (starting on the date they are furnished the election notice or the date they would lose coverage, whichever is later).

- Consumers eligible to enroll in COBRA can generally choose to enroll in a QHP through an FFM instead. Remember, consumers who lose job-based coverage qualify for a 60-day SEP and may be eligible for APTC and CSRs that wouldn't be available to them if they enrolled in COBRA continuation coverage.
- Consumers may also be eligible for a 60-day SEP to enroll in a QHP through an FFM if their former employer ceases all employer contributions for COBRA continuation coverage.
- Consumers who lose job-based insurance may also be eligible for Medicaid/CHIP.

Loss of Job-based Coverage and COBRA Eligibility (cont'd)

Typically, consumers have until the later of 60 days after losing eligibility for their employer's group health coverage or 60 days after receiving their COBRA election notice to elect COBRA continuation coverage. However, due to the COVID-19 Public Health Emergency, these deadlines have been temporarily extended. Instead of employees being required to elect COBRA coverage within 60 days of losing group health coverage, plans are now required to "disregard" the period between March 1, 2020, and 60 days after the end of the COVID-19 Public Health Emergency. Therefore, employees who have experienced a COBRA continuation coverage qualifying event have until the earlier of one year from the date they were first eligible for relief or 60 days after the announced end of the COVID-19 National Emergency, which is ongoing.

For more information about COBRA continuation coverage and the FFMs, visit [HealthCare.gov/unemployed/cobra-coverage/](https://www.healthcare.gov/unemployed/cobra-coverage/).

Typically, consumers have until the later of 60 days after losing eligibility for their employer's group health coverage or 60 days after receiving their COBRA election notice to elect COBRA continuation coverage. However, due to the COVID-19 Public Health Emergency, these deadlines have been temporarily extended. Instead of employees being required to elect COBRA coverage within 60 days of losing group health coverage, plans are now required to "disregard" the period between March 1, 2020, and 60 days after the end of the COVID-19 Public Health Emergency. Therefore, employees who have experienced a COBRA continuation coverage qualifying event have until the earlier of one year from the date they were first eligible for relief or 60 days after the announced end of the COVID-19 National Emergency, which is ongoing.

For more information about COBRA continuation coverage and the FFMs, visit [HealthCare.gov/unemployed/cobra-coverage/](https://www.healthcare.gov/unemployed/cobra-coverage/).

Termination of Coverage

Consumers who wish to end coverage through an FFM can generally terminate it at any time. They don't need to wait for an individual market OEP or qualify for an SEP. Enrollee-initiated terminations are effective on the date an enrollee requests to terminate coverage or on another prospective date the enrollee selects.

Consumers can terminate coverage in an FFM by logging into their Marketplace account and selecting **End (Terminate) All Coverage** on the "My Plans and Programs" page. Consumers will receive a termination notice from their health plan issuer. Consumers enrolled in a stand-alone dental plan (SADP) can terminate this coverage while remaining enrolled in their Marketplace health plan.

Consumers who wish to end coverage through an FFM can generally terminate it at any time. They don't need to wait for an individual market OEP or qualify for an SEP. Enrollee-initiated terminations are effective on the date an enrollee requests to terminate coverage or on another prospective date the enrollee selects.

Consumers can terminate coverage in an FFM by logging into their Marketplace account and selecting **End (Terminate) All Coverage** on the "My Plans and Programs" page. Consumers will receive a termination notice from their health plan issuer. Consumers enrolled in a stand-alone dental plan (SADP) can terminate this coverage while remaining enrolled in their Marketplace health plan.

Assisting Consumers Who Want to Switch to a Different QHP

Consumers can also switch from one QHP to another during an OEP or during certain types of SEPs. Consumers can re-enroll into a different plan by logging into their Marketplace account and selecting the **Change Plan** button on the "My Plans and Programs" page. Consumers can then select and confirm new health and dental insurance selections, if desired.

Consumers who are eligible to change to a different QHP during an SEP may be limited in the type of QHP they can choose.

Consumers can also switch from one QHP to another during an OEP or during certain types of SEPs. Consumers can re-enroll into a different plan by logging into their Marketplace account and selecting the **Change Plan** button on the "My Plans and Programs" page. Consumers can then select and confirm new health and dental insurance selections, if desired.

Consumers who are eligible to change to a different QHP during an SEP may be limited in the type of QHP they can choose.

Low-income Consumers Who Don't Qualify for Public Coverage and Can't Afford QHP Coverage in an FFM

The Coverage Gap

In states that have not expanded Medicaid to low-income adults, many adults with incomes below 100 percent of the FPL fall into what is known as a coverage gap. Their incomes are too high to receive Medicaid or other public health coverage under their state's current rules and are too low to qualify for help paying for coverage in a Marketplace. Some consumers who may fall into the coverage gap include jobless parents, working parents, and non-disabled, non-elderly childless adults.

Coverage Exemptions

For tax year 2019 and later, consumers who don't have MEC for part or all of the tax year don't need to file for an exemption from the individual shared responsibility payment with their tax returns because the Tax Cuts and Jobs Act reduced the individual shared responsibility payment to zero beginning with tax year 2019.

However, individuals age 30 and above must continue to apply for, obtain, and report an ECN for a Marketplace affordability or hardship exemption if they wish to purchase Catastrophic health coverage.

Remember, you can show consumers where to access tax forms, but you can't help them fill out tax forms in your role as an assister.

The Coverage Gap

In states that have not expanded Medicaid to low-income adults, many adults with incomes below 100 percent of the FPL fall into what is known as a coverage gap. Their incomes are too high to receive Medicaid or other public health coverage under their state's current rules and are too low to qualify for help paying for coverage in a Marketplace. Some consumers who may fall into the coverage gap include jobless parents, working parents, and non-disabled, non-elderly childless adults.

Coverage Exemptions

For tax year 2019 and later, consumers who don't have MEC for part or all of the tax year don't need to file for an exemption from the individual shared responsibility payment with their tax returns because the Tax Cuts and Jobs Act reduced the individual shared responsibility payment to zero beginning with tax year 2019.

However, individuals age 30 and above must continue to apply for, obtain, and report an ECN for a Marketplace affordability or hardship exemption if they wish to purchase Catastrophic health coverage.

Remember, you can show consumers where to access tax forms, but you can't help them fill out tax forms in your role as an assister.

Options for Consumers that Fall into a Coverage Gap

It might also be helpful to refer consumers who fall into a coverage gap to other programs or organizations. Here are some options you should discuss with them:

- **Obtain health care services at Federally Qualified Health Centers (FQHCs).** These community health centers provide services on a sliding fee scale depending on a consumer's income. Use the following tool to find a community health center near the consumer: [HealthCare.gov/community-health-centers](https://www.healthcare.gov/community-health-centers).
- **Purchase Catastrophic coverage.** Catastrophic health insurance plans have low monthly premiums and very high deductibles. They may be an affordable way for consumers to protect themselves from worst-case scenarios, like getting seriously sick or injured. But consumers pay most routine medical expenses themselves. Catastrophic plans are available through the FFMs for consumers under 30 years old and consumers age 30 and above who apply for, obtain, and report an ECN for a Marketplace affordability or hardship exemption. For more information, visit [HealthCare.gov/choose-a-plan/catastrophic-health-plans](https://www.healthcare.gov/choose-a-plan/catastrophic-health-plans).
- **Find out what pharmaceutical assistance programs may be available.** Some pharmaceutical companies offer assistance programs for the drugs they manufacture. You can help consumers find out if assistance is available for the medications they take by visiting [Medicare.gov/Pharmaceutical-Assistance-Program](https://www.Medicare.gov/Pharmaceutical-Assistance-Program).

You should always follow [CMS guidance](#) when working with or referring consumers to organizations that are not other FFM assister organizations or HHS entities.

It might also be helpful to refer consumers who fall into a coverage gap to other programs or organizations. Here are some options you should discuss with them:

- **Obtain health care services at Federally Qualified Health Centers (FQHCs).** These community health centers provide services on a sliding fee scale depending on a consumer's income. Use the following tool to find a community health center near the consumer: [HealthCare.gov/community-health-centers/](https://www.healthcare.gov/community-health-centers/).
- **Purchase Catastrophic coverage.** Catastrophic health insurance plans have low monthly premiums and very high deductibles. They may be an affordable way for consumers to protect themselves from worst-case scenarios, like getting seriously sick or injured. But consumers pay most routine medical expenses themselves. Catastrophic plans are available through the FFMs for consumers under 30 years old and consumers age 30 and above who apply for, obtain, and report an ECN for a Marketplace affordability or hardship exemption. For more information, visit: [HealthCare.gov/choose-a-plan/catastrophic-health-plans/](https://www.healthcare.gov/choose-a-plan/catastrophic-health-plans/).
- **Find out what pharmaceutical assistance programs may be available.** Some pharmaceutical companies offer assistance programs for the drugs they manufacture. You can help consumers find out if assistance is available for the medications they take by visiting [Medicare.gov/Pharmaceutical-Assistance-Program](https://www.Medicare.gov/Pharmaceutical-Assistance-Program).

You should always follow [CMS guidance](#) when working with or referring consumers to organizations that are not other FFM assister organizations or HHS entities.

Key Points



- Eligible consumers can set the amount of premium tax credit they would like to use in advance to lower their premium costs when they apply for or renew QHP coverage in an FFM. Consumers must reconcile the difference between any APTC they received during the year and the actual premium tax credit amount they qualified for based on their final income and household size.

- When helping consumers with plan comparison, show them all the QHP options they're eligible for and never provide recommendations about which plan or plans they should select.

- Some changes in circumstances are considered "qualifying life events" and may allow consumers to enroll in or change QHPs during an SEP.

- Eligible consumers can set the amount of premium tax credit they would like to use in advance to lower their premium costs when they apply for or renew QHP coverage in an FFM. Consumers must reconcile the difference between any APTC they received during the year and the actual premium tax credit amount they qualified for based on their final income and household size.
- When helping consumers with plan comparison, show them all the QHP options they're eligible for and never provide recommendations about which plan or plans they should select.
- Some changes in circumstances are considered "qualifying life events" and may allow consumers to enroll in or change QHPs during an SEP.

Exemptions and Appeals Assistance

Introduction



Taxpayers are still required by law to have MEC or qualify for a health coverage exemption. However, consumers who don't maintain MEC or qualify for a health coverage exemption no longer need to make an individual shared responsibility payment because the Tax Cuts and Jobs Act reduced the individual shared responsibility payment to zero beginning with tax year 2019. Let's review what this means for consumers you will assist in 2023.

Consumers only need to request a Marketplace hardship or affordability exemption if they are age 30 or above and wish to purchase Catastrophic health coverage. Consumers under age 30 can apply for Catastrophic health coverage without obtaining an exemption.

Continue

Taxpayers are still required by law to have MEC or qualify for a health coverage exemption. However, consumers who don't maintain MEC or qualify for a health coverage exemption no longer need to make an individual shared responsibility payment because the Tax Cuts and Jobs Act reduced the individual shared responsibility payment to zero beginning with tax year 2019. Let's review what this means for consumers you will assist in 2023.

Consumers only need to request a Marketplace hardship or affordability exemption if they are age 30 or above and wish to purchase Catastrophic health coverage. Consumers under age 30 can apply for Catastrophic health coverage without obtaining an exemption.

In this training module, we will review important policies and procedures that are in place in all states for which CMS is performing exemption determinations and eligibility appeals. As of the date this training was uploaded to the Marketplace Learning Management System, CMS is making exemption determinations in all states except California, Connecticut, Maryland, and the District of Columbia.

What counts as MEC?

- Any QHP sold in a Marketplace
- Individual health plans sold outside the Marketplaces
- Any "grandfathered" individual insurance plan the consumer has had since March 23, 2010, or earlier
- [Any job-based plan](#), including [retiree plans](#) and [COBRA continuation coverage, other than excepted benefits](#)
- [Medicare Part A or Part C](#) (but Part B coverage by itself doesn't qualify)
- [Most Medicaid coverage](#) except for certain [limited coverage plans](#)
- CHIP, including coverage under CHIP buy-in programs
- [Coverage under a parent's plan that is MEC](#)

- [Most student health plans](#) (consumers should check with the school to find out if the plan counts as qualifying health coverage)
- Health coverage for Peace Corps volunteers
- [Certain types of veterans' health coverage through the Department of Veterans Affairs](#)
- [Most TRICARE plans](#)
- [Department of Defense Nonappropriated Fund Health Benefits Program](#)
- [Refugee Medical Assistance](#)
- [State high-risk pools](#) for plan or policy years that started on or before December 31, 2014 (check with your high-risk pool plan to see if it counts as qualifying health coverage)

What does not count as MEC?

Some products that help consumers pay for medical services don't qualify as MEC.

Examples include:

- Coverage only for vision care or dental care
- Workers' compensation
- Coverage only for a specific disease or condition
- Plans that offer only discounts on medical services
- Short-term, limited-duration insurance policies designed for people who experience a temporary gap in health coverage

Consumers age 30 and older must apply for a hardship or affordability exemption through the Marketplace and obtain an ECN if they wish to purchase Catastrophic coverage. Consumers under the age of 30 don't need to claim an exemption or obtain an ECN if they wish to purchase Catastrophic coverage; if the consumer is otherwise eligible, Catastrophic health plan options will display when the consumer shops for coverage through the Marketplace.

Consumers age 30 and older must apply for a hardship or affordability exemption through the Marketplace and obtain an ECN if they wish to purchase Catastrophic coverage. Consumers under the age of 30 don't need to claim an exemption or obtain an ECN if they wish to purchase Catastrophic coverage; if the consumer is otherwise eligible, Catastrophic health plan options will display when the consumer shops for coverage through the Marketplace.

Let's review the hardship and affordability exemptions. Select each exemption type to read the description.

Exemptions

Hardship

Marketplace Affordability

Job-based Affordability

Hardship

This exemption applies to consumers facing life situations that keep them from obtaining health insurance, including:

- Homelessness;
- Eviction or foreclosure;
- Receiving a utility shut-off notice;
- Fire, flood, or other disaster;
- Bankruptcy;
- Being a victim of domestic violence;
- Death of a family member;
- Having medical expenses they couldn't pay;
- Experiencing unexpected increases in necessary expenses due to caring for a family member who is ill or aging or who has a disability;
- Claiming a child as a tax dependent who's been denied coverage for Medicaid and CHIP and another person is required by court order to give medical support to the child;
- Not having health coverage while waiting for a Marketplace appeal decision about coverage eligibility or savings; or
- Not being eligible for Medicaid because their state didn't expand Medicaid and the household income was below 138 percent of the FPL. For more information about this exemption, visit [HealthCare.gov](https://www.healthcare.gov).

To claim most hardship exemptions, consumers must fill out a paper application and mail it to the FFMs. [Instructions are here.](#)

Let's review the hardship and affordability exemptions.

- Hardship
- Marketplace affordability
- Job-based affordability

Hardship

This exemption applies to consumers facing life situations that keep them from obtaining health insurance, including:

- Homelessness;
- Eviction or foreclosure;
- Receiving a utility shut-off notice;
- Fire, flood, or other disaster;
- Bankruptcy;
- Being a victim of domestic violence;
- Death of a family member;
- Having medical expenses they couldn't pay;
- Experiencing unexpected increases in necessary expenses due to caring for a family member who is ill or aging or who has a disability;
- Claiming a child as a tax dependent who's been denied coverage for Medicaid and CHIP and another person is required by court order to give medical support to the child;
- Not having health coverage while waiting for a Marketplace appeal decision about coverage eligibility or savings; or
- Not being eligible for Medicaid because their state didn't expand Medicaid and the household income was below 138 percent of the FPL. For more information about this exemption, visit [HealthCare.gov](https://www.healthcare.gov).

To claim most hardship exemptions, consumers must fill out a paper application and mail it to the FFMs. [Instructions are here.](#)

Marketplace Affordability

Consumers age 30 or over who wish to enroll in Catastrophic coverage apply for this exemption through the Marketplace based on their projected annual household income at the beginning of a plan year. They qualify for the exemption if the lowest-price Bronze-level plan available through a Marketplace would cost more than 8.17 percent (2023) of the consumer's projected household income.

[You can find affordability exemption application information here.](#)

Job-based affordability

Job-based health insurance is considered unaffordable in different ways depending on how the coverage is offered:

- For an employee: If the annual premium for the lowest-cost self-only plan is more than 8.17 percent (2023) of their annual household income.
- For the employee's spouse and dependents: If the annual premium for the lowest-cost family plan is more than 8.17 percent (2023) of their annual household income.

Notes:

It's possible that an employee won't be eligible for this exemption because the self-only plan available to them is affordable. But other members of the household could be eligible for this exemption if family coverage offered to them is unaffordable.

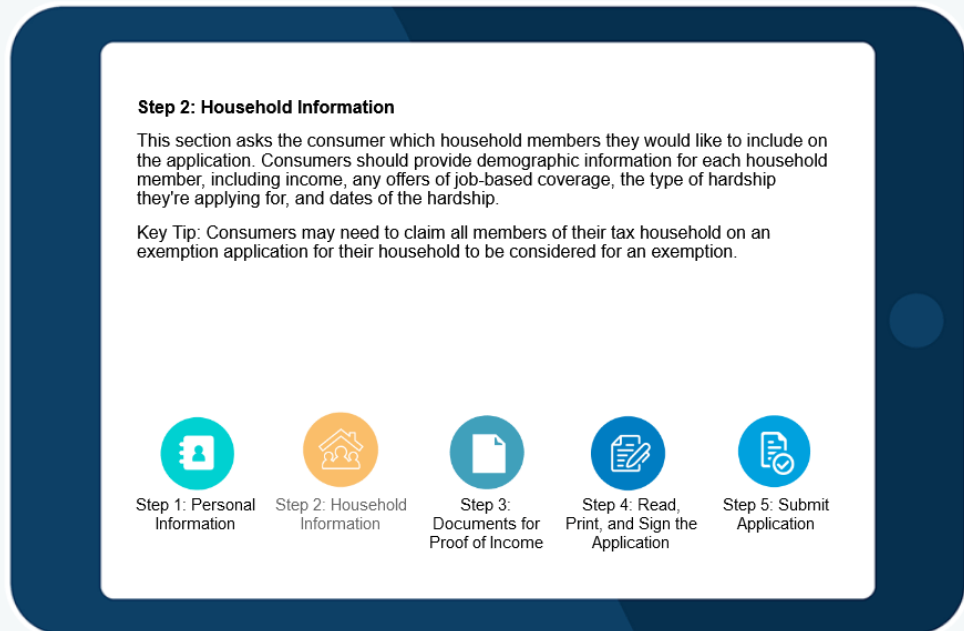
If the lowest-price self-only plan an employer offers costs more than 9.61 percent (2022) of an employee's total household income, the employee may be eligible for a premium tax credit if they buy a Marketplace insurance plan.

Remember, consumers under the age of 30 don't need to claim an exemption or obtain an ECN, and Catastrophic health plan options will display when the consumer shops for coverage through the Marketplace.

Consumers age 30 and older must apply for a hardship or affordability exemption through the Marketplace and obtain an ECN if they wish to view and enroll in Catastrophic coverage.

You should help these consumers identify and complete the appropriate hardship or affordability exemption application through the Marketplace. The applications are available at [HealthCare.gov/exemption-form-instructions/](https://www.healthcare.gov/exemption-form-instructions/).

Select each step to review the Marketplace exemption application process.



Remember, consumers under the age of 30 don't need to claim an exemption or obtain an ECN, and Catastrophic health plan options will display when the consumer shops for coverage through the Marketplace. Consumers age 30 and older must apply for a hardship or affordability exemption through the Marketplace and obtain an ECN if they wish to view and enroll in Catastrophic coverage.

You should help these consumers identify and complete the appropriate hardship or affordability exemption application through the Marketplace. The applications are available at [HealthCare.gov/exemption-form-instructions/](https://www.healthcare.gov/exemption-form-instructions/).

Review the Marketplace exemption application process.

- Step 1: Personal Information
- Step 2: Household Information
- Step 3: Documents for Proof of Income
- Step 4: Read, Print, and Sign
- Step 5: Submit Application

Step 1: Personal Information

The application asks the consumer to fill out their personal information, including name, address, phone number, and whether the consumer wants to receive information by email. If a consumer has a preferred spoken or written language other than English, the consumer should indicate that as well.

Step 2: Household Information

This section asks the consumer which household members they would like to include on the application. Consumers should provide demographic information for each household member, including income, any offers of job-based coverage, the type of hardship they're applying for, and dates of the hardship.

Key Tip: Consumers may need to claim all members of their tax household on an exemption application for their household to be considered for an exemption. .

Step 3: Documents for Proof of Income

To claim an affordability exemption, "proof of income" documents are needed, like a recent pay stub and/or a letter from the consumer's employer verifying the consumer's income. Consumers may need to submit different documents depending on the type of exemption they're applying for.

Even if a consumer doesn't have all the required documents, you can encourage the consumer to start filling out the exemption application and identifying the documents they will need to gather and submit with the application.

Step 4: Read, Print, and Sign the Application

Remind the consumer to sign the application and confirm that all the information provided is accurate.

Step 5: Submit Application

Mail the completed application with supporting documents. Remember, the Marketplaces don't accept online or telephone exemption applications at this time. Consumers must mail all exemption applications to the Marketplaces with copies of their supporting documents to following address:

Health Insurance Marketplace®

Attn: Exemption Processing

465 Industrial Blvd.

London, KY 40741

Health Insurance Marketplace® is a registered service mark of HHS.

Obtaining an Exemption Certificate Number from a Marketplace to Purchase Catastrophic Coverage

When consumers submit Marketplace exemption applications, the Marketplaces review them and determine their eligibility for an exemption. Response times may vary depending on:

- How complicated a request is,
- How complete an application is, or
- Whether a consumer needs to submit additional supporting documents after applying.

Depending on their communication preferences, consumers who qualify for exemptions through an FFM receive exemption notices by mail or email. Exemption notices include a six- or seven-digit ECN in the "Eligibility Results" column. Consumers can also find this number online in their Marketplace account profile.

Additional Information:

If multiple individuals in a household qualify for exemptions granted by a Marketplace, each will receive a separate ECN.

Remind consumers to keep their ECNs and approval notices in a safe place. Consumers should also keep a copy of their submitted exemption applications and supporting documents in case they need to follow up later.

HealthCare.gov Individuals & Families Small Businesses

Exemption Certificate Number (ECN)

A number the Marketplace provides when you qualify for a health insurance exemption. When you fill out an exemption application, the Marketplace will review it and determine if you qualify. The Marketplace will mail you a notice of your eligibility result. If you qualify for an exemption, the notice will include your unique identifier, called the exemption number (ECN). Each member of your household who qualifies for the exemption will get their own ECN. You'll need it when you file your federal taxes for the year you don't have coverage.

Use these numbers to complete [IRS Form 8965 — Health Coverage Exemptions \(PDF\)](#).

Related content

- [Exemptions from the fee for not having health coverage](#)
- [If you didn't have health coverage last year](#)

Health coverage exemptions: Forms & how to apply

After you apply for a health coverage exemption

- Exemptions from the requirement to have health insurance
- Health coverage exemptions, forms & how to apply
- Hardship exemptions, forms & how to apply
- After you apply for a health coverage exemption

After you mail an exemption application to the Health Insurance Marketplace, it and determine if you qualify.

- ▶ [How you can help us respond faster](#)
- ▶ [How you'll find out if you qualify for an exemption](#)
- ▼ [How to claim an exemption you qualify for](#)
 - If you qualify for an exemption, the notice you get from the Marketplace includes your unique Exemption Certificate Number (ECN).
 - You'll use your ECN when you file your federal taxes for the year you don't have coverage. You'll use it to complete [IRS Form 8965—Health Coverage Exemptions](#). Each member of your household who qualifies for an exemption will get their own ECN.

When consumers submit Marketplace exemption applications, the Marketplaces review them and determine their eligibility for an exemption. Response times may vary depending on:

- How complicated a request is,
- How complete an application is, or
- Whether a consumer needs to submit additional supporting documents after applying.

Depending on their communication preferences, consumers who qualify for exemptions through an FFM receive exemption notices by mail or email. Exemption notices include a six- or seven-digit ECN in the "Eligibility Results" column. Consumers can also find this number online in their Marketplace account profile.

Additional Information:

If multiple individuals in a household qualify for exemptions granted by a Marketplace, each will receive a separate ECN.

Remind consumers to keep their ECNs and approval notices in a safe place. Consumers should also keep a copy of their submitted exemption applications and supporting documents in case they need to follow up later.

Providing ECNs When Purchasing Catastrophic Coverage

Exemptions and Appeals Assistance
Providing ECNs When Purchasing Catastrophic Coverage

Text Only Module 6 / 6 Page 7 / 15

To enroll in a Catastrophic plan, consumers age 30 and above should log into their Marketplace account and select **Exemption** at the left of the **Application Status** page. They must enter an ECN for each person in their household who qualifies for an exemption on this page so they can proceed with enrolling in a Catastrophic plan.

Remind consumers to keep their ECNs and approval notices in a safe place. Consumers should also keep a copy of their submitted exemption applications and supporting documents in case they need to follow up later.

Select here for more information about applying for [Catastrophic](#) plans.

Report an exemption

If you requested a Marketplace hardship exemption and got an ECN, select "Add Exemption." Then, enter the ECN, complete your application, and shop for Catastrophic plans, if you or someone on your application qualifies.

ADD EXEMPTION

Add an exemption

Enter information for each person on your coverage application with an Exemption Certificate Number (ECN).

First name	Last name	Date of birth
<input type="text"/>	<input type="text"/>	<input type="text"/>

Enter the Exemption Certificate Number (ECN), which has 6 or 7 letters and numbers.

XXXXXXXX

[Where do I find the Exemption Certificate Number?](#)

CANCEL **SUBMIT EXEMPTION**

To enroll in a Catastrophic plan, consumers age 30 and above should log into their Marketplace account and select Exemption at the left of the Application Status page. They must enter an ECN for each person in their household who qualifies for an exemption on this page so they can proceed with enrolling in a Catastrophic plan.

Remind consumers to keep their ECNs and approval notices in a safe place. Consumers should also keep a copy of their submitted exemption applications and supporting documents in case they need to follow up later.

Select here for more information about applying for [Catastrophic](#) plans.

Tips for Helping Consumers Apply for Exemptions

- Be familiar with the different exemption types so you can help consumers determine which exemptions best fit their situation. If consumers choose the wrong exemption type or submit the wrong exemption application, they'll have to submit a new exemption application.
- Make sure consumers who seek exemptions on behalf of other people are designated authorized representatives. Otherwise, they must be qualified to seek exemptions on behalf of others.
- Help consumers determine who is in their tax household. Consumers can use one application per exemption for multiple members of their tax household.
- Remind consumers to complete all of the questions on the application for every adult in the tax household and any dependent child who also needs the exemption. If consumers skip questions, the Marketplaces will contact them for the missing information. This will slow the exemption application process down.
- Encourage consumers to submit all supporting documents requested on the application.
- Remind consumers that missing information may delay processing since the Marketplaces can't process exemption applications until they receive consumers' supporting documents.
- Remind consumers that they shouldn't send original documents to the Marketplaces (other than the application itself).
- Advise consumers to keep copies of their exemption application, the original documents submitted with them, proof of mailing, and their exemption certificates (if an exemption was granted).
- Make sure you return any hard copies of consumers' records when you assist them. If consumers leave their information with you by accident, take immediate measures to return the information and be sure to follow your organization's procedures.

Tips for Helping Consumers Apply for Exemptions

- Be familiar with the different exemption types so you can help consumers determine which exemptions best fit their situation. If consumers choose the wrong exemption type or submit the wrong exemption application, they'll have to submit a new exemption application.
- Make sure consumers who seek exemptions on behalf of other people are designated authorized representatives. Otherwise, they must be qualified to seek exemptions on behalf of others.
- Help consumers determine who is in their tax household. Consumers can use one application per exemption for multiple members of their tax household.
- Remind consumers to complete all of the questions on the application for every adult in the tax household and any dependent child who also needs the exemption. If consumers skip questions, the Marketplaces will contact them for the missing information. This will slow the exemption application process down.
- Encourage consumers to submit all supporting documents requested on the application.
- Remind consumers that missing information may delay processing since the Marketplaces can't process exemption applications until they receive consumers' supporting documents.
- Remind consumers that they shouldn't send original documents to the Marketplaces (other than the application itself).
- Advise consumers to keep copies of their exemption application, the original documents submitted with them, proof of mailing, and their exemption certificates (if an exemption was granted).
- Make sure you return any hard copies of consumers' records when you assist them. If consumers leave their information with you by accident, take immediate measures to return the information and be sure to follow your organization's procedures.

Assisting Consumers with Eligibility Appeals

If consumers don't agree with a decision made by a Marketplace, they may be able to file an appeal. All eligibility determination notices, regardless of whether consumers are determined eligible or ineligible for a particular program, will tell consumers how they can appeal a decision if they're dissatisfied with the outcome.

Consumers have 90 days from the date they receive an eligibility determination notice to start an appeal. Consumers can also request an appeal if they didn't receive an eligibility determination notice in a timely manner.

Consumers can appeal the following kinds of Marketplace decisions, whether in connection with an initial eligibility determination or a redetermination:

- Eligibility to enroll in a QHP in a Marketplace
- Denial of an SEP
- Denial of premium tax credit or CSRs
- Level of premium tax credit and CSRs
- Eligibility for Medicaid or CHIP (in some Marketplaces)
- Eligibility for an exemption to enroll in a Catastrophic plan
- Failure to provide a timely notice of eligibility determination

The screenshot shows the HealthCare.gov website interface. At the top, there's a navigation bar with 'Get Coverage', 'Keep or Update Your Plan', 'See Topics', and 'Get Answers'. A search bar is on the right. Below the navigation bar, the main content area is titled 'How to appeal a Marketplace decision'. The sub-heading is 'When can you appeal?'. On the left, there's a sidebar with a table of contents: 'When can you appeal?', 'How to file an appeal', 'Appeal forms', 'After you file an appeal', 'Expediting your appeal', 'Getting help with your appeal', 'Decisions employers can appeal', and 'How to appeal a SHOP Marketplace decision'. The main content area explains that if you don't agree with a decision, you have 90 days to file an appeal. It lists 'Marketplace decisions you can appeal': not eligible for advance payments of the premium tax credit (APTC), eligible for APTC but the amount is wrong, not eligible for a Special Enrollment Period, not eligible to buy a Marketplace plan, not eligible to choose a Catastrophic plan, not eligible for an exemption from the requirement to have health insurance, and if you live in Alabama, Alaska, Louisiana, Montana, New Jersey, Virginia, West Virginia, or Wyoming, you can also appeal a denial of Medicaid or CHIP eligibility. A note at the bottom states you can't file an appeal until you get an Eligibility Determination Notice.

If consumers don't agree with a decision made by a Marketplace, they may be able to file an appeal. All eligibility determination notices, regardless of whether consumers are determined eligible or ineligible for a particular program, will tell consumers how they can appeal a decision if they're dissatisfied with the outcome.

Consumers have 90 days from the date they receive an eligibility determination notice to start an appeal. Consumers can also request an appeal if they didn't receive an eligibility determination notice in a timely manner.

Consumers can appeal the following kinds of Marketplace decisions, whether in connection with an initial eligibility determination or a redetermination:

- Eligibility to enroll in a QHP in a Marketplace
- Denial of an SEP
- Denial of premium tax credit or CSRs
- Level of premium tax credit and CSRs
- Eligibility for Medicaid or CHIP (in some Marketplaces)
- Eligibility for an exemption to enroll in a Catastrophic plan
- Failure to provide a timely notice of eligibility determination

Filing an Appeal

Consumers can file appeals in four ways. All eligibility determination notices explain the process for how to file an appeal. Consumers can generally appeal their eligibility results by:



Submitting the Marketplace Eligibility Appeal Request Form at HealthCare.gov online.



Writing a letter to:
Health Insurance Marketplace®
Attn: Appeals
465 Industrial Blvd.
London, KY 40750-0061



Mailing an appeal request form using the proper form for their states. Appeal request forms are available at HealthCare.gov.



Faxing their appeal request to a secure fax line: 1-877-369-0130.

Health Insurance Marketplace is a registered service mark of HHS.

Marketplace Appeal Request Form A (07/2021) Page 1 of 6

Health Insurance Marketplace

Marketplace Eligibility Appeal Request

- Submit this form within 90 days of the date on the Marketplace Eligibility Notice you're appealing.
- Include any documents you have to help your appeal (Step 6).
- Have the tax filer on the Marketplace application sign the form (Step 7).

Person filling out this form:

* First name: * Last name:

STEP 1 Whose eligibility is being appealed?

Include ONLY the people on your Marketplace application whose eligibility is being appealed.

Person 1 appealing

* Person 1's First name: * Person 1's Last name:

* Date of birth: * Email:

* Daytime phone number:

* Street address: * Apartment or suite number:

* City: * State: * ZIP code:

Consumers can file appeals in four ways. All eligibility determination notices explain the process for how to file an appeal. Consumers can generally appeal their eligibility results by:

- Submitting the Marketplace Eligibility Appeal Request Form at HealthCare.gov online.
- Writing a letter to:
Health Insurance Marketplace®
Attn: Appeals
465 Industrial Blvd.
London, KY 40750-0061
- Mailing an appeal request form using the proper form for their states. Appeal request forms are available at HealthCare.gov.
- Faxing their appeal request to a secure fax line: 1-877-369-0130.

Health Insurance Marketplace is a registered service mark of HHS.

After you file an appeal

[When can you appeal?](#)

The Marketplace Appeals C
your appeal and giving mor
days.

[How to file an appeal](#)

[Appeal forms](#)

If your appeal request is ac
appeal. If the letter says yo
actions to get your request
[your Marketplace appeal is](#)

[After you file an appeal](#)

[Expediting your appeal](#)

How your appeal

[Getting help with your appeal](#)

In general, the Marketplace
How long it takes for a deci
the Marketplace needs mor

[Decisions employers can appeal](#)

[How to appeal a SHOP
Marketplace decision](#)

- The Marketplace Appe
Marketplace uses to d
- You may get a letter a
passport. Sending the
Marketplace Appeals

After consumers file an appeal, they receive a letter that:

- States their appeal request was received
- Provides a description of the appeals process
- Includes instructions for submitting additional material for consideration, if applicable

After consumers file an appeal, they receive a letter that:

- States their appeal request was received
- Provides a description of the appeals process
- Includes instructions for submitting additional material for consideration, if applicable

Here is a summary of the process for resolving eligibility appeals in a Marketplace.

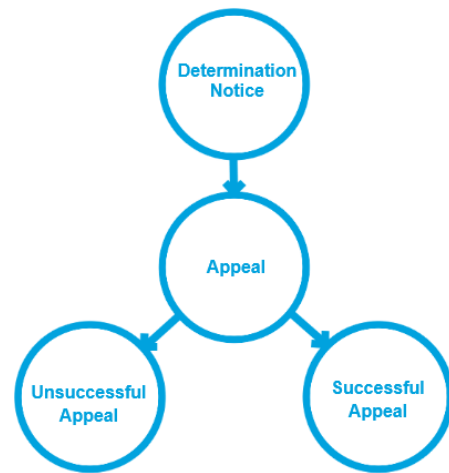
Select each step in the image for more information about the appeals process

1. A consumer disagrees with an eligibility determination.
2. The consumer submits a complete appeal request.
3. An informal resolution is attempted.
4. The consumer decides whether or not to accept the informal resolution decision.
 - a. If the consumer accepts, the appeal is closed, and the decision is communicated through a notice.
 - b. If the consumer doesn't accept, a formal hearing is scheduled and then conducted.
5. After the hearing, the appeal is closed and the decision is communicated to the consumer through a notice.
6. If the consumer is still dissatisfied, the consumer can seek review in court to the extent it's available by law.

If a consumer didn't enroll in a QHP and the consumer's initial eligibility determination turned out to be incorrect, the consumer qualifies for an SEP to enroll in coverage through a Marketplace.

If an initial eligibility determination was correct, a consumer generally can't enroll in or change QHPs through a Marketplace if the original enrollment period in which they applied has ended.

It's important to remind consumers that an appeal decision may result in a change in eligibility for other members of their household as well as for themselves.



Here is a summary of the process for resolving eligibility appeals in a Marketplace.

1. A consumer disagrees with an eligibility determination.
2. The consumer submits a complete appeal request.
3. An informal resolution is attempted.
4. The consumer decides whether or not to accept the informal resolution decision.
 - a. If the consumer accepts, the appeal is closed, and the decision is communicated through a notice.
 - b. If the consumer doesn't accept, a formal hearing is scheduled and then conducted.
5. After the hearing, the appeal is closed and the decision is communicated to the consumer through a notice.
6. If the consumer is still dissatisfied, the consumer can seek review in court to the extent it's available by law.

If a consumer didn't enroll in a QHP and the consumer's initial eligibility determination turned out to be incorrect, the consumer qualifies for an SEP to enroll in coverage through a Marketplace.

If an initial eligibility determination was correct, a consumer generally can't enroll in or change QHPs through a Marketplace if the original enrollment period in which they applied has ended.

It's important to remind consumers that an appeal decision may result in a change in eligibility for other members of their household as well as for themselves.

Medicaid Determination Notice

Consumers in states that delegated authority to the Marketplace to make final Medicaid and CHIP eligibility determinations may receive eligibility determination notices from the Marketplace that indicate they're eligible to enroll in Marketplace plans but not eligible to enroll in Medicaid or CHIP. If consumers believe they should have qualified for Medicaid or CHIP, they may wish to file an appeal. All Marketplace eligibility determination notices state that consumers who think there's a mistake in their final eligibility notice can file an appeal.

Medicaid Assessment States

Some states don't allow the Marketplaces to make final eligibility determinations for Medicaid and CHIP. In these states, the Marketplaces assess whether consumers are eligible for Medicaid or CHIP. If consumers in assessment states apply for help paying for coverage, they receive a notice from the Marketplace that states whether they are eligible to enroll in a QHP and receive APTC/CSRs. The notice includes an initial assessment from the Marketplace of their eligibility for Medicaid or CHIP. However, consumers who are assessed eligible receive final Medicaid or CHIP eligibility determination notices from their state Medicaid or CHIP agency.

If consumers are determined ineligible by their state Medicaid or CHIP agency, they may wish to file an appeal, and they should follow the instructions in their eligibility determination notice from the state agency for filing an appeal with the state. Consumers in Medicaid assessment states can't file Medicaid or CHIP appeals with the Marketplace.

Appeal

Consumers in Medicaid assessment states should follow the instructions on their Medicaid or CHIP eligibility determination notice if they wish to appeal determinations indicating that they are not eligible for Medicaid or CHIP.

Unsuccessful Appeal

If the appeal process results in a decision that the initial eligibility determination was correct, that determination applies, and the consumer is not eligible for Medicaid or CHIP. That concludes the administrative process, but the appeal decision explaining this outcome includes information about any available judicial reviews.

If individuals are unsuccessful in appealing their eligibility for Medicaid or CHIP coverage, they can still enroll in Marketplace insurance through an SEP if eligible. Additionally, consumers who were originally determined eligible for APTC/CSRs through a Marketplace remain eligible for those programs. Remember, consumers can appeal their eligibility determinations for PTCs and CSRs as well.

Sometimes consumers may appeal because they think they should have been determined eligible for a larger PTC and don't want to pay the premium for coverage through a Marketplace until they get the larger PTC amount. If it turns out that the initial eligibility determination was correct, the consumer can't enroll in or change plans through the Marketplace if the original enrollment period in which they applied has ended.

Successful Appeal

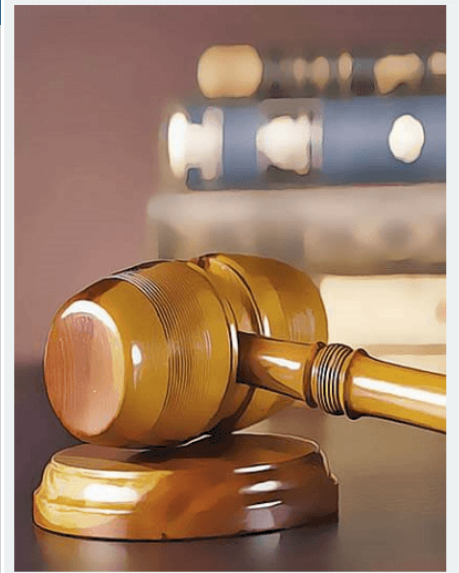
If it turns out the initial eligibility determination was wrong and consumers didn't enroll in a plan, they will receive an SEP to enroll in Marketplace insurance.

Beginning with Navigator grants awarded in 2022, including non-competing continuation awards, Navigators are required to provide information on and assistance with understanding the process of filing Marketplace eligibility appeals; CACs in FFMs are permitted but not required to assist consumers with Marketplace appeals. However, if you don't provide appeals assistance, you should refer consumers to another individual who can.

In your role as an assister, remember that you shouldn't provide legal advice regarding appeals or any other matter. For example, the Marketplace appeal request form has an option for an expedited (faster) appeal. While you may help consumers understand the difference between an appeal and an expedited appeal, you shouldn't help a consumer decide which one is best suited to their circumstances. Consumers can decide to file requests for expedited appeals if the time needed for the standard appeal process would jeopardize their lives, health, or their ability to achieve, maintain, or regain maximum function.

CMS regulations permit assisters to provide information about free or low-cost legal help in their area when necessary, including local legal aid or legal services organizations and other state offices that can help with the Marketplace eligibility appeals process. CACs in FFMs are not required to provide these types of referrals, but they may do so as long as they have sufficient knowledge to make them. Beginning with Navigator grants awarded in 2019, FFM Navigators may but are no longer required to provide these types of referrals.

You can tell consumers that they can have a friend, lawyer, or someone else help them with their appeal, but you can't provide legal advice within your capacity as an assister. You can also refer consumers to free and low-cost legal service providers in your community, including legal aid organizations funded by the Legal Services Corporation, state Consumer Assistance Programs (CAPs), Health Insurance Ombudsmen, or other state agencies. When making such referrals, always follow CMS guidance at [Marketplace.cms.gov/technical-assistance-resources/assister-guidance-on-referrals-to-outside-organizations.pdf](https://www.cms.gov/technical-assistance-resources/assister-guidance-on-referrals-to-outside-organizations.pdf).



Beginning with Navigator grants awarded in 2022, including non-competing continuation awards, Navigators are required to provide information on and assistance with understanding the process of filing Marketplace eligibility appeals; CACs in FFMs are permitted but not required to assist consumers with Marketplace appeals. However, if you don't provide appeals assistance, you should refer consumers to another individual who can.

In your role as an assister, remember that you shouldn't provide legal advice regarding appeals or any other matter. For example, the Marketplace appeal request form has an option for an expedited (faster) appeal. While you may help consumers understand the difference between an appeal and an expedited appeal, you shouldn't help a consumer decide which one is best suited to their circumstances. Consumers can decide to file requests for expedited appeals if the time needed for the standard appeal process would jeopardize their lives, health, or their ability to achieve, maintain, or regain maximum function.

CMS regulations permit assisters to provide information about free or low-cost legal help in their area when necessary, including local legal aid or legal services organizations and other state offices that can help with the Marketplace eligibility appeals process. CACs in FFMs are not required to provide these types of referrals, but they may do so as long as they have sufficient knowledge to make them. Beginning with Navigator grants awarded in 2019, FFM Navigators may but are no longer required to provide these types of referrals.

You can tell consumers that they can have a friend, lawyer, or someone else help them with their appeal, but you can't provide legal advice within your capacity as an assister. You can also refer consumers to free and low-cost legal service providers in your community, including legal aid organizations funded by the Legal Services Corporation, state Consumer Assistance Programs (CAPs), Health Insurance Ombudsmen, or other state agencies. When making such referrals, always follow CMS guidance at [Marketplace.cms.gov/technical-assistance-resources/assister-guidance-on-referrals-to-outside-organizations.pdf](https://www.cms.gov/technical-assistance-resources/assister-guidance-on-referrals-to-outside-organizations.pdf).

Knowledge Check

Consumers age ____ and above who wish to purchase Catastrophic coverage must apply for a _____ or _____ exemption through the Marketplace.

Select **the correct answer** and then select **Check Your Answer**.

- A. 26; Loss of coverage or hardship
- B. 26; Hardship or affordability
- C. 30; Loss of coverage or hardship
- D. 30; Hardship or affordability

✓ Check Your Answer



Correct!

Consumers age 30 and above who wish to purchase Catastrophic coverage must apply for a hardship or affordability exemption through the Marketplace. Consumers under age 30 don't need an exemption to purchase Catastrophic coverage.

Consumers age ____ and above who wish to purchase Catastrophic coverage must apply for a _____ or _____ exemption through the Marketplace.

- A. 26; Loss of coverage or hardship
- B. 26; Hardship or affordability
- C. 30; Loss of coverage or hardship
- D. 30; Hardship or affordability

The correct answer is D. Consumers age 30 and above who wish to purchase Catastrophic coverage must apply for a hardship or affordability exemption through the Marketplace. Consumers under age 30 don't need an exemption to purchase Catastrophic coverage.

Key Points



- Beginning with tax year 2019, individuals who choose to go without insurance are no longer subject to making individual shared responsibility payments.

- In situations where multiple household members qualify for exemptions, each consumer in the household will receive a separate ECN.

- If consumers don't agree with a decision made by a Marketplace, they may be able to file an appeal.

- When you're assisting consumers, you should never provide tax or legal advice regarding exemptions, appeals, or any other matter.

- Beginning with tax year 2019, individuals who choose to go without insurance are no longer subject to making individual shared responsibility payments.
- In situations where multiple household members qualify for exemptions, each consumer in the household will receive a separate ECN.
- If consumers don't agree with a decision made by a Marketplace, they may be able to file an appeal.
- When you're assisting consumers, you should never provide tax or legal advice regarding exemptions, appeals, or any other matter.

Conclusion

Conclusion
Conclusion

Text Only



Great job!

You learned to provide consumers in FFMs with eligibility and enrollment assistance or support them with exemptions and appeals.

Remember, you can always refer to [The Assister's Standard Operating Procedures \(SOP\) Manual](#) for more information about these topics.

You've finished the learning portion of this course. Select the link to take the [Marketplace Assister Essentials](#) exam, or you can close the course and return to the exam later.

Great job!

You learned to provide consumers in FFMs with eligibility and enrollment assistance or support them with exemptions and appeals.

Remember, you can always refer to [The Assister's Standard Operating Procedures \(SOP\) Manual](#) for more information about these topics.

You've finished the learning portion of this course. Select the link to take the [Marketplace Assister Essentials](#) exam, or you can close the course and return to the exam later.

Resources

Resources Page for Assistors on Medicare.gov:

Information on joining a Medicare health plan or drug plan.

[Medicare.gov/sign-up-change-plans/when-can-i-join-a-health-or-drug-plan/when-can-i-join-a-health-or-drug-plan.html](https://www.medicare.gov/sign-up-change-plans/when-can-i-join-a-health-or-drug-plan/when-can-i-join-a-health-or-drug-plan.html)

SHOP Marketplace Overview

A summary of the Small Business Health Options Marketplace Program.

[HealthCare.gov/small-businesses/provide-shop-coverage/shop-marketplace-overview](https://www.healthcare.gov/small-businesses/provide-shop-coverage/shop-marketplace-overview)

The Assister's Standard Operation Procedures (SOP) Manual

The SOP Manual serves as your primary guide to helping consumers with activities within the individual market Federal-facilitated Marketplaces (FFMs, like enrolling in health coverage).

[Marketplace.cms.gov/technical-assistance-resources/the-assisters-sop-manual.html](https://www.marketplace.cms.gov/technical-assistance-resources/the-assisters-sop-manual.html)

Tips to get started in the Health Insurance Marketplace®

4 tips about the Health Insurance Marketplace®.

[HealthCare.gov/quick-guide/one-page-guide-to-the-marketplace](https://www.healthcare.gov/quick-guide/one-page-guide-to-the-marketplace)

Incarceration

Information regarding incarceration and the Marketplace.

[HealthCare.gov/incarcerated-people](https://www.healthcare.gov/incarcerated-people)

Savings Estimator Tool

Provides consumers with a quick view of income levels that qualify for savings in 2019.

[HealthCare.gov/lower-costs](https://www.healthcare.gov/lower-costs)

Identity Proofing in the Marketplace

A description of the identity proofing process that occurs before completing a Marketplace application.

[Marketplace.cms.gov/outreach-and-education/your-marketplace-application.pdf](https://www.marketplace.cms.gov/outreach-and-education/your-marketplace-application.pdf)

Logging Into Your Account

Tips on troubleshooting login issues for Marketplace accounts at HealthCare.gov.

[HealthCare.gov/tips-and-troubleshooting/logging-in](https://www.healthcare.gov/tips-and-troubleshooting/logging-in)

TRICARE and the ACA

A summary of how consumers with TRICARE coverage are affected by the ACA and associated regulations.

[Tricare.mil/About/MEC.aspx](https://www.tricare.mil/About/MEC.aspx)

5 Things Assistors Should Know about Data Matching Terminations

Information about how data matching issues impact consumers.

[Marketplace.cms.gov/technical-assistance-resources/data-matching-terminations.pdf](https://www.marketplace.cms.gov/technical-assistance-resources/data-matching-terminations.pdf)

Income Definitions for Marketplace and Medicaid Coverage

Information regarding how Modified Adjusted Gross Income (MAGI) is calculated for the Marketplace and Medicaid.

[Healthreformbeyondthebasics.org/key-facts-income-definitions-for-marketplace-and-medicaid-coverage](https://www.healthreformbeyondthebasics.org/key-facts-income-definitions-for-marketplace-and-medicaid-coverage)

Medicaid and CHIP Overview

Summary of important facts regarding Medicaid and CHIP eligibility.

[Marketplace.cms.gov/technical-assistance-resources/fast-facts-medicaid-chip.pdf](https://www.marketplace.cms.gov/technical-assistance-resources/fast-facts-medicaid-chip.pdf)

Federal Poverty Level (FPL) Guidelines

Up-to-date information regarding the Federal Poverty Guidelines (FPL) for families and individuals.

[Aspe.hhs.gov/poverty-guidelines](https://aspe.hhs.gov/poverty-guidelines)

COBRA coverage and the Marketplace

A description of COBRA health coverage and how it relates to the Marketplace.

[HealthCare.gov/unemployed/cobra-coverage](https://healthcare.gov/unemployed/cobra-coverage)

Tips for Working with Outside Organizations

[Marketplace.cms.gov/technical-assistance-resources/assister-guidance-on-referrals-to-outside-organizations.pdf](https://marketplace.cms.gov/technical-assistance-resources/assister-guidance-on-referrals-to-outside-organizations.pdf)

How to find low-cost health care in your community

Use the following tool to find a community health center near the consumer.

[HealthCare.gov/community-health-centers](https://healthcare.gov/community-health-centers)

Catastrophic Plans

A definition of Catastrophic health plans and their role in the Marketplace.

[HealthCare.gov/choose-a-plan/catastrophic-health-plans](https://healthcare.gov/choose-a-plan/catastrophic-health-plans)

Pharmaceutical Assistance Programs

A tool to see if a pharmaceutical company offers an assistance program for the drugs they manufacture.

[Medicare.gov/pharmaceutical-assistance-program](https://medicare.gov/pharmaceutical-assistance-program)

If you have job-based insurance

An explanation of how job-based insurance affects Marketplace coverage.

[HealthCare.gov/have-job-based-coverage](https://healthcare.gov/have-job-based-coverage)

Health coverage for retirees

An explanation of the different choices retirees have for health coverage.

[HealthCare.gov/retirees](https://healthcare.gov/retirees)

If you already have Medicare coverage

Information regarding consumers who already have Medicare coverage and how this affects their eligibility for Marketplace coverage.

[HealthCare.gov/medicare](https://healthcare.gov/medicare)

How to get or stay on a parent's plan

An explanation of the ACA regulations regarding consumers staying on their parent's health coverage plans.

[HealthCare.gov/young-adults/children-under-26](https://healthcare.gov/young-adults/children-under-26)

Student health plans & other options

An explanation of the ACA regulations regarding different health coverage options for students.

[HealthCare.gov/young-adults/college-students](https://healthcare.gov/young-adults/college-students)

The VA and the ACA

A summary of how VA coverage is regarded under the ACA regulations.

[VA.gov/health/aca/EnrolledVeterans.asp](https://va.gov/health/aca/EnrolledVeterans.asp)

Refugee Medical Assistance

A description of refugee medical assistance programs.

[ACF.hhs.gov/orr/programs/cma/about](https://acf.hhs.gov/orr/programs/cma/about)

Health Coverage Tax Tool

Use this tool to help you figure out your premium tax credit or claim an "affordability" exemption. This tool can

tell you your second lowest cost Silver plan or your lowest cost Bronze plan.

[HealthCare.gov/tax-tool](https://www.healthcare.gov/tax-tool)

Exemptions from the requirement to have health insurance

A description of the different types of exemptions available under the ACA and how to apply for them.

[HealthCare.gov/health-coverage-exemptions/exemptions-from-the-fee](https://www.healthcare.gov/health-coverage-exemptions/exemptions-from-the-fee)

Individual Shared Responsibility Provision

[IRS.gov/affordable-care-act/individuals-and-families/individual-shared-responsibility-provision](https://www.irs.gov/affordable-care-act/individuals-and-families/individual-shared-responsibility-provision)

Individual Shared Responsibility Provision – Exemptions: Claiming or Reporting

[IRS.gov/affordable-care-act/individuals-and-families/aca-individual-shared-responsibility-provision-exemptions](https://www.irs.gov/affordable-care-act/individuals-and-families/aca-individual-shared-responsibility-provision-exemptions)

Hardship and Affordability Health Coverage Exemption Forms

[HealthCare.gov/exemption-form-instructions](https://www.healthcare.gov/exemption-form-instructions)

[HealthCare.gov/health-coverage-exemptions/hardship-exemptions](https://www.healthcare.gov/health-coverage-exemptions/hardship-exemptions)

Types of Health Insurance that Count as MEC

[HealthCare.gov/fees/plans-that-count-as-coverage](https://www.healthcare.gov/fees/plans-that-count-as-coverage)