Course 5 Marketplace Application Essentials

Course Introduction

Welcome

Welcome to the Marketplace Application Essentials course. This course includes an overview of important information that will help you provide consumers in Federally-facilitated Marketplace states (FFMs) with account creation and eligibility and enrollment assistance.

Course Goal

Goal:

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

Topics:

By the end of this course, you will understand:

- Consumer consent and personally identifiable information (PII).
- Assessing consumers' needs.
- Account creation process.
- Identity verification and supporting documents.
- Comparing and selecting plans.
- Helping consumers enroll in and terminate coverage.
- Marketplace appeals.
- Marketplace tax forms.

Module 2 - Preparing to Apply

Introduction

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

As a Navigator, Enrollment Assistance Personnel (EAP), or certified application counselor (CAC) in the Marketplace, you must:

- Assist applicants and enrollees submitting Marketplace eligibility applications.
- Explain your duties and responsibilities to each consumer 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 qualified health plans (QHPs), Medicaid, and Children's Health Insurance Program coverage (CHIP).

Here is a reminder about providing appropriate services for consumers with specific needs.

Appropriate Services

It's important to communicate with consumers in a manner that is culturally appropriate. You should respect 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 are expected to provide referrals to Navigators or the Marketplace Call Center if they can't assist consumers with LEP.

For more information, refer to the courses on *Serving Select Population Groups and Communities*, *Cultural Competence and Language Assistance*, and *Working with Consumers with Disabilities*.

Consumer Consent and Personally Identifiable Information (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 if necessary to carry out your required duties. If consumers accidentally leave behind documents containing PII at your organization's facility or an enrollment event, you should store them in a safe, locked location and return them 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 about applying for or enrolling in coverage as well as their preferred contact information, you may keep their names and contact information.

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 should assess their health coverage needs. Consumers will have different levels of knowledge about health coverage and the Marketplace. Here are a few questions you can keep in mind when you meet with consumers to make sure they understand their coverage options.

- Do they need additional information about the Affordable Care Act (ACA), health coverage, or the Marketplace?
- 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 Marketplace eligibility application process?
- Who needs coverage—an individual, child, spouse, or the whole family?
- What health plan features are most important to them? 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.

Discussing Individual Market FFMs with Consumers

When you meet with consumers, make sure they know that the Marketplace provides access to programs that could 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 coverage programs like Medicaid and CHIP.

Consumers who may be eligible for programs to help lower their QHP costs include:

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

Affordable

For 2025, a plan is considered "affordable" for the employee if the plan's premiums for the employee do not exceed 9.02 percent of the employee's household income.

Previously, a job-based plan was considered affordable for all family members to whom an employer's offer extends if the premium for the employee's self-only coverage was affordable. The premium required to cover family members was not considered.

The IRS issued new regulations that apply starting in PY 2023. If a consumer has an offer of employer coverage that extends to their family members, the affordability of employer coverage for those family members will be based on the family premium amount, not the self-only employee premium cost. This helps more consumers qualify for advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs) through the Marketplace.

Businesses with No Employees

Generally, self-employed consumers whose businesses have no employees may not purchase group coverage through a Small Business Health Options Program (SHOP) Marketplace.

Consumers Applying for Medicaid or CHIP

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.
- Contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325) 24 hours a day, seven days a week.

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 Marketplace. 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 *Health Coverage 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.
- Former foster care children.

Some states cover other groups of consumers referred to as optional eligibility groups, which federal, 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 groups.
- 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.

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 QHPs in their area. Let's review each tool.

The Savings Estimator Tool helps consumers check if they can save on Marketplace premiums based on their household income. 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 household 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.

Reminders

Let's go over some important reminders before we review the application process.

Eligible Citizenship and Immigration Statuses

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

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.

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 Marketplace coverage, you may only use the keyboard or mouse to follow their specific directions.

Remember that you can’t recommend specific health plans or make eligibility determinations for consumers.

Knowledge Check

There are many rules to remember when assisting consumers. What rule should you remember when assisting consumers?

Answer: When using the Window Shopping Tool, consumers will be able to review QHPs available in their area and estimated prices based on their projected household income. You should not tell consumers which plans are best for them or choose a plan for them. Additionally, consumer consent is valid until the specified expiration date or the consumer revokes their consent.

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 coverage 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. Consumers who aren't lawfully present can apply for coverage for family member(s) who are lawfully present.

Module 3 – Account Creation

Introduction

Once you've obtained a consumer's consent, assessed their 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

Consumers should follow five steps to create a Marketplace account at HealthCare.gov.

Here's a quick overview of the process.

Step 1: Select State

Visit HealthCare.gov and select Log in. Then select Create account and choose the state the consumer lives in from the drop-down menu.

Step 2: Set Up Login Information

Enter their name and a valid email address, which is also used as a consumer's Marketplace account username. Then the consumer must 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

There are three steps 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 Marketplace sends a password reset email to this address. Select the link in the 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 Marketplace resets consumers' passwords due to security measures. If this happens, consumers won't be able to log in until they reset their password.

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

The Marketplace 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 create a new account if they already have one. Instead, they should call the Marketplace Call Center or follow the steps at the HealthCare.gov page Tips & troubleshooting – Logging into your account.

Step 3: Security Questions

Choose security questions and provide responses. These 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 button.

Step 5: Verify Account

In the last step, the Marketplace will send a verification email to the email address the consumer provided. Consumers must verify their account by selecting the link in that email.

Identity Verification

After a consumer creates a Marketplace account and logs into HealthCare.gov for the first time, they must complete identity (ID) proofing before they can begin an application. You should tell consumers that this process helps prevent someone else from creating a Marketplace account and applying for health coverage in their name. During ID proofing, the FFMs ask questions about a consumer's personal and financial history based on the consumer's Experian credit report that only the consumer is likely to know. If a consumer's identity isn't verified, they may receive a prompt with instructions and next steps. Additional information about Marketplace identity verification is available in the Verifying your Identity in the Marketplace PDF and in the Application Walkthrough & Identity Verification and Screening Questions microlearning modules.

Note: Experian is a contractor that helps the FFMs with ID proofing. The Experian Help Desk may be able to help consumers with issues during the ID proofing process. For example, they may be able to explain that verification was unsuccessful because a consumer used a nickname rather than their legal name. The Experian Help Desk can't help consumers with the same things that you and the Marketplace 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). Experian may be able to explain why a consumer's identity wasn't verified.

When on HealthCare.gov, consumers should select the My Profile button, and then select Verify Now to begin.

Verify Your Identity

When the "Verify Your Identity" screen appears, they should select the Get Started button.

Verification Questions

The FFMs ask for contact information and other questions about consumers to verify their identity.

Identity Verification Failure

The FFM will indicate whether a consumer's identify has been verified successfully. If the Marketplace 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 the Marketplace fails to identify a consumer's identity after two tries, they will receive a message with instructions to call the Experian Help Desk and a reference code number to provide them.

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 Experian can't verify a consumer's identity over the phone, the consumer will be directed to submit updated contact information and to upload documents that verify their identity by selecting the Upload Documents button.

The Marketplace will try to verify a consumer's identity after Experian has verified it. If the Marketplace can't verify a consumer's identity after Experian verifies it, the consumer will have to upload documents electronically or submit them by mail. Remind consumers that sending verification documents by mail takes more time to process and that they should mail copies and keep the original documents. They should include their name, date of birth, and Social Security Number (SSN) 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 7-10 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 the Department of Health and Human Services (HHS).

Documents to Verify Identity

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

In this case, consumers should upload or mail paper copies of documents to verify their identities. The application provides a list of acceptable documents or combinations of documents consumers can provide under different circumstances.

Consumers who experience difficulty with the identity verification process may feel negative emotions such as confusion and frustration, particularly if they also have experienced barriers to health coverage or health care access. Please refer to *Course 006 – Serving Vulnerable and Underserved Populations* for more information and guidance on assisting individuals experiencing barriers to health care, as well as *Course 009 – Customer Service Standards and Community Outreach* for best practices on challenging consumer situations.

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 single documents, they can submit copies of two of these documents:

- U.S. public 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

Key Points

- You should know how to guide consumers through each step of creating a Marketplace account and verifying their identity.
- The Marketplace uses information from a consumer's Experian consumer report to verify their identity.
- Consumers may need to upload documents to verify their identity if the Marketplace cannot verify it using trusted data sources.

Module 4 – Application Completion

Introduction

Before consumers begin a Marketplace application, you should discuss with them the information they will need to provide to the Marketplace during the application process.

- Consumers need to provide the following information to the Marketplace when they apply:
- Contact information
- Who's applying for coverage
- Whether they'd like to check their eligibility for advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs) or other coverage programs (e.g., Medicaid and Children's Health Insurance Program (CHIP))
- Personal information for each applicant (e.g., name, date of birth, relationship to consumer filing the application)
- Citizenship or satisfactory immigration status for each applicant (but not for non-applicants)
- Information about life events that may qualify them for a Special Enrollment Period (SEP)

If applying for help paying for coverage:

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

Tax Household Information

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?

Tax Filers + Tax Dependents = Household Size

Generally, 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. 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 qualified health plan (QHP) coverage in the Marketplace without any help paying for it, they should only include those household members who want coverage.
- 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 for 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 if they aren't applying for coverage themselves:

- All people 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, including stepchildren, under 21 who live with them, even if they aren't on the same tax return

For children under 19 who are applying for help paying for coverage, the Marketplace application may ask for information about the following individuals, even if they aren't applying for coverage themselves:

- All people who are on the same federal income tax return, including parents and siblings
- Any parents, including stepparents, who live with them, even if they're not on the same tax return
- Any siblings (including stepsiblings 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 *Complex Application Issues* 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 submit separate applications. For more information, refer to the *Complex Application Issues* course.
- Family members who live together but file separate federal income tax returns

Note: The Marketplace application asks applicants whether they're 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

For Medicaid and CHIP eligibility, consumers' household size can be based on immediate family members they live with, like a spouse, children, and their siblings. Marketplace, Medicaid, and CHIP applications will ask for the information needed to determine household size for consumers.

Reporting Income: MAGI

The Marketplace uses 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 applicable:
- Untaxed foreign income,
- Non-taxable Social Security benefits, and
- Tax-exempt interest.

MAGI is generally very similar to consumers' AGI. However, it doesn't appear as a line on federal income tax returns and doesn't include Supplemental Security Income (SSI).

Remember, the Marketplace calculate MAGI differently from state Medicaid and CHIP agencies. Refer to the *Health Coverage Basics* course for more information.

Federal Income Tax Return

Advise consumers who file federal income tax returns to have their 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 federal income tax returns should have similar information about a consumer's household size.

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

Types of Income to Report

If consumers choose to apply for financial assistance when they submit a Marketplace application, it's important that they provide accurate projected annual income information for each household member. This table lists types of income consumers should and shouldn't include on their application.

Report this income:	Don't report this income:
• Wages, salaries, bonuses • Self-employment income • Tips and gratuities • All Social Security retirement and disability income • Unemployment compensation • Rent income • Alimony received (for divorces or separations finalized before 1/1/2019)	• Temporary Assistance for Needy Families (TANF) payments • Child support payments • SSI • Veterans' benefits • Workers' compensation • Proceeds from loans • Child tax credit payments • Gifts • Alimony received (for divorces or separations finalized on or after 1/1/2019)

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

Note: This is not a complete list. Refer to Internal Revenue Service (IRS) Publications 17 and Publication 525 for more details on what income is taxable and not taxable.

Alimony received

The Tax Cuts and Jobs Act of 2017 made important changes to how consumers should treat alimony when reporting their income:

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.

Most consumers who qualify for Medicaid on a basis other than MAGI (e.g., disability or blindness) must also meet other income requirements. These consumers will likely need to complete another application or provide additional information to their state Medicaid agency.

Some Medicaid and CHIP agencies may have different policies to calculate MAGI for eligibility. You should refer consumers to their state Medicaid or CHIP agency to learn more about the policies in their state.

Knowledge Check

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

What information will this consumer need to complete their Marketplace application?

Answer: This consumer should complete the application, and the Marketplace will determine whether they or members of their family are eligible for other programs to 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. With this new text (now two sentences): However, the consumer needs to know which household members are applying for coverage and personal information for each applicant. You don't need to explain pre-existing conditions to applicants.

Key Points

- You should know how to guide consumers through each step of completing a Marketplace application.
- 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 and help consumers accurately report their income if they choose to apply for them.

Module 5 - Interpreting Eligibility Results

Introduction

After consumers submit a Marketplace application, the Marketplace (FFM) verifies information about each household applicant and assesses or determines their eligibility for:

- A Special Enrollment Period (SEP) (Consumers applying for an SEP may have to submit supporting documents to an FFM to verify their eligibility before the Marketplace sends their information to a qualified health plan (QHP) issuer for processing.)
- Medicaid
- Children's Health Insurance Program (CHIP)
- QHP coverage with advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs)
- QHP coverage without APTC and CSRs—either because they haven't applied for them or are ineligible

Review Eligibility Results

You should be able to explain consumers' eligibility determination notice (EDN) results and describe each program they’re 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 data matching issue (DMI). 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. Consumers may wish to appeal a decision in their EDN.

Data Matching Issues

In some cases, DMIs may occur if:

- A consumer's information doesn't match information from the Marketplace's trusted data sources.
- A trusted data source does not have information for a consumer.

Information that is missing or incorrect on the application may also lead to a DMI, such as:

- A consumer didn't provide a Social Security Number (SSN) on their application.
- A consumer didn't provide all household income on their application.
- A consumer's attested household income isn't within the acceptable threshold of 50 percent or $12,000, whichever is greater, as reported by the Marketplace's data sources.
- A consumer's name used for their application differs from how it appears on their citizenship document or other document.
- A consumer failed to provide their immigration document numbers and / or ID numbers.

The most common types of DMIs are income, citizenship, and immigration. Consumers have a certain number of days from the date the eligibility notice was sent to resolve the issue:

- 90 days for income-related DMIs
- 95 days for citizenship and immigration DMIs

Note: Effective June 18, 2023, consumers have an additional 60 days (for a total of 150 days) to resolve an income-related DMI, at the option of the Exchange.

If a consumer receives a notice asking for additional supporting documents to resolve a DMI, the notice will indicate when the consumer must submit them and receive a final eligibility determination. For more information on DMIs, review the microlearning module entitled Locating Information About and Resolving Data Matching Issues in the Post-enrollment Assistance microlearning series.

Consumer Outreach to Resolve a DMI

Consumers with DMIs will receive 90-, 60-, and 30-day warning notices as well as a phone call and email to ask for documents if the DMI has not been resolved, based on communication preferences.

If a consumer submits an application and a DMI is created, then the consumer receives an eligibility notice and a 90-day warning notice. If the consumer submits document(s), and the document is sufficient, then the Marketplace will resolve the DMI and send a notice.

If the consumer submits document(s) that are not sufficient, then the consumer will receive an insufficient document notice and phone call. If the consumer receives an eligibility notice and a 90-day warning notice and do not submit document(s), then a 60-day warning notice via email and text message will be sent. If the consumer continues not to submit document(s), then a 30-day warning notice via email and text message will be sent. If the consumer continues not to submit document(s), then they will receive a 15 day warning phone call. If the consumer continues to not submit document(s) after the warning call, then their DMI will expire, and the Marketplace will send a notice.

Submitting Documents to Resolve a DMI

You're responsible for helping consumers submit documents to verify their information to resolve a DMI. Consumers can access tips and troubleshooting tricks for uploading documents on HealthCare.gov.

Enrolling in Health Coverage with a DMI

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

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 DMIs.

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.

Key Points

- You should know how to help consumers interpret their eligibility results.
- You should be able to explain what DMIs are and why they occur, and help consumers submit documents to resolve them.

Module 6 – Helping Consumers Enroll in Coverage

Introduction

After you help consumers review their eligibility results and resolve any data matching issues (DMIs) if applicable, you'll help consumers who qualify for advance payments of the premium tax credit (APTC) set the amount of APTC they'd like to use, then help consumers set their health insurance preferences, compare plans, and choose a qualified health plan (QHP) that meets their needs.

The “Enroll To-Do List”

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.

Choosing How Much APTC to Apply

You should be prepared to explain consumers' options if their eligibility determinations show that they qualify for APTC and cost-sharing reductions (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.

Explain to consumers that the amount of APTC they apply to their monthly premiums could affect the amount of taxes they owe to the Internal Revenue Service (IRS) or the refund they get back when they file federal income tax returns for the year. Consumers who anticipate changes throughout the year, like an increase in household income, may want to reduce the amount of APTC they apply to their monthly premium.

Plan Comparison

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

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.

Helping Consumers Enroll

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

Remind consumers that their QHP enrollment generally isn't complete until 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.

Consumers generally must pay their first month's premium for new coverage by the deadline noted by their health insurance issuer in the enrollment materials. If there are questions about the deadline for payment, the consumer should call their issuer directly.

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 Open Enrollment Period (OEP), January 1 (for consumers who enroll between November 1 and December 15, or February 1 (if they enroll between December 16 and January 15); or
- For Special Enrollment Periods (SEPs), 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 they use the coverage to get care.

Grace Period

There's a three-month grace period for consumers receiving APTC when they fail to pay their premiums (after their first month’s premium) 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 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 (unless they have paid the amount required under the QHP’s premium payment threshold policy). 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

Remember to tell consumers they're 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 review their application information once a year to make sure their eligibility information is up to date.

- Asking consumers the following questions will help you assist them:
- Do you currently have a Marketplace plan?
- Do you use it?
- What has your experience been like?
- What questions do you have about your current plan?
- Has the plan been sufficient for your needs? Why or why not?

Before each OEP, the Marketplace sends a Marketplace Open Enrollment Notice (MOEN) to current enrollees to encourage them to return to update their application during Open Enrollment. This notice also informs certain enrollees when they're at risk of losing financial assistance if they don't update their information.

Enrollees will also receive a notice from their issuer which states whether their current plan will be available for the next plan year and describes any changes to the plan. If there's no plan available from the same issuer, the Marketplace will match the enrollee to a plan offered by a different issuer selected to be as similar as possible and send a notice that this will be their coverage for the next plan year if they don't return to the Marketplace to actively choose one.

You should advise consumers to review the MOEN and contact the Marketplace if anything is incorrect. If the Marketplace 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 important for consumers who receive financial assistance. If a consumer's household is no longer eligible for financial assistance, the Marketplace 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.

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

Before Open Enrollment, the Marketplace requests updated tax return information from the IRS for all consumers who have agreed to allow the Marketplace to recheck their information. If these consumers are currently enrolled in QHPs, the Marketplace will determine whether they're eligible to receive APTC and CSRs. Any changes in coverage or eligibility because of the redetermination process are effective 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, 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

Marketplace will still renew consumers' QHP coverage without APTC and CSRs for the following year, unless the FFM determines they’re no longer eligible to purchase a QHP.

Special Enrollment Periods

Some changes in circumstances are "qualifying life events," meaning consumers are eligible for an SEP to newly enroll in or change QHPs outside of the annual OEP as well as during Open Enrollment for an earlier coverage start date. A qualifying life event can occur at any time during the year. Consumers enrolled in Marketplace coverage must report changes to eligibility information as soon as possible, generally within 30 days of the change. If consumers qualify for an SEP, they generally have 60 days from the date of their qualifying event to newly select or change their Marketplace coverage. When consumers report changes on a Marketplace application, the Marketplace redetermines consumers' eligibility and notifies them of:

- Any changes in eligibility for Marketplace coverage or help paying for coverage.
- Whether they are eligible for an SEP.
- Whether they are eligible for coverage through Medicaid or Children's Health Insurance Program (CHIP).
- When their coverage will start.
- Their next steps.

SEPs typically last 60 days and provide an opportunity for consumers to enroll in coverage outside of the individual market OEP. Select each term below to learn more about SEPs.

Qualifying Life Events

Consumers may visit HealthCare.gov/screener to find out if they may qualify for an SEP to enroll in or change plans. There are six categories of SEP qualifying events:

- Loss of qualifying health coverage.
- Change in household size.
- Change in primary place of living.
- Change in eligibility for Marketplace coverage or help paying for coverage.
- Enrollment or plan error.
- Other qualifying changes.

For a full list of qualifying events, visit the Special Enrollment Periods page on HealthCare.gov.

SEP Eligibility Verification

- Consumers who are newly enrolling in Marketplace coverage during an SEP due to loss of qualifying coverage may be required to verify their eligibility by submitting supporting documents showing their loss of coverage.
- Consumers generally have 60 days before or 60 days after the date of their coverage loss 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.
- Once their eligibility is verified, the FFM can transfer their information to an issuer if they selected a QHP.

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

For more information on SEP eligibility verification and to find a list of documents consumers can provide to verify their SEP eligibility, visit the Send Documents to Confirm a SEP page on HealthCare.gov.

Plan Category Limitations

- Existing Marketplace enrollees and their dependents generally will only be able to choose a plan from their current plan category or must wait until the next OEP to change to a plan in a different category.
- Some circumstances allow existing enrollees and their dependents to change plan categories. For example, enrollees who become newly eligible for CSRs and aren't already enrolled in a Silver plan can change to a Silver plan to use their CSRs.
- Consumers newly enrolling in Marketplace coverage aren't limited in the plans they can choose.

For more information on plan category limitations, visit the Changing plans – What you Need to Know page on HealthCare.gov.

Prior Coverage Requirements

Some SEPs are available to anyone who's eligible for coverage and has experienced a qualifying life event.

Some SEPs are only for:

- Consumers who had prior coverage for one or more days in the 60 days preceding their SEP qualifying event (e.g., marriage, change in primary place of living).
- Consumers who already have Marketplace coverage (e.g., change in household income or eligibility for help paying for coverage).

Prior coverage requirements do not apply to members of a federally recognized Tribe or Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders.

The Marketplace will provide details and instructions on whether and how consumers need to prove prior coverage in their eligibility notice.

Coverage Effective Dates

- The effective date of coverage for most SEPs is the first day of the month following plan selection (for consumers who will lose coverage in the future, Marketplace coverage starts the first day of the month following their last day of prior coverage).
- For some SEPs, including but not limited to gaining or becoming a dependent through birth, adoption, placement for adoption, placement in foster care, or due to child support or other court order, coverage is effective retroactive to the date of the qualifying event, such as the date of birth. If they prefer, consumers have the option to call the Marketplace Call Center to request that coverage take effect on the first day of the month following the date of plan selection.

- For consumers who qualify for the loss of qualifying coverage SEP and select a plan between 60 days before the loss of coverage and the last day of the month preceding the loss of coverage, a Marketplace has the option to provide a coverage effective date of the first of the month in which the loss of coverage occurs, instead of the first of the month after the loss of coverage occurs.

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

- For more information on SEPs, review the SEP Overview for Assisters or visit the Special Enrollment Periods page on HealthCare.gov.

SEP Policy Updates: What's New

SEP Policy Updates

- Beginning January 1, 2025:
    - A monthly SEP will be permanently available to consumers who have an estimated annual household income at or below 150 percent of the federal poverty level (FPL) in their state and are APTC-eligible. This SEP allows consumers to enroll in Marketplace coverage or change their Marketplace coverage once per month, if they so choose. Previously, this SEP was only available when these individuals were expected to contribute zero percent of their income toward premiums.
    - Marketplaces must provide coverage that's effective the first day of the month following plan selection if a consumer enrolls in a QHP during certain SEPs (i.e., SEPs for which regular coverage effective dates apply).
- Consumers who are enrolled in employer-sponsored coverage (ESC) may qualify for an SEP if they are determined newly eligible for APTC because their ESC no longer offers affordable coverage, and they drop their employer coverage. This applies to consumers whose coverage is no longer affordable due to the change in IRS rules that went into effect on January 1, 2023 ("the family glitch"). Consumers can access this SEP by attesting "Yes" to the application question about losing qualifying health coverage and providing the date they can end their employer coverage or the date they lost it in the past.
- In March 2024, the Centers for Medicare & Medicaid Services extended a temporary SEP available to individuals and their families losing Medicaid or CHIP coverage due to the end of the Medicaid continuous enrollment condition, also known as "unwinding." This SEP, referred to as the "Unwinding SEP," is now available through November 30, 2024. Marketplace-eligible consumers who are disenrolled from Medicaid, CHIP, or, if applicable, the Basic Health Program (BHP) coverage can select a plan under the Unwinding SEP by submitting or updating an application through HealthCare.gov, an approved enrollment partner that supports direct enrollment during SEPs, or the Marketplace Call Center. Consumers who are determined eligible for this Unwinding SEP will have 60 days from the date on which they submit a new or updated Healthcare.gov application, up until November 30, 2024, to make a plan selection under the Unwinding SEP, for coverage that can be effective the first day of the month following plan selection. For plan selections made from December 1, 2024 through January 15, 2025, consumers disenrolled from Medicaid or CHIP coverage may sign up for coverage for the 2025 plan year under the Marketplace annual Open Enrollment period and do not need an SEP to enroll in Marketplace coverage for January 1 or February 1 coverage.
- Effective January 1, 2024, Marketplaces must provide consumers 90 days (instead of 60 days) after they lose Medicaid or CHIP coverage that counts as minimum essential coverage (MEC) to enroll in a Marketplace plan using an SEP. In 2024, CMS and approved enrollment partners will begin making updates to eligibility applications and logic used for the Marketplaces serviced by HealthCare.gov to implement this new rule after plan selection under the Unwinding SEP is no longer available on HealthCare.gov on November 30, 2024.

Loss of Employer-sponsored Coverage and COBRA Eligibility

When consumers lose ESC, their former employer may offer Consolidated Omnibus Budget Reconciliation Act (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 to elect COBRA continuation coverage (starting on the date they're 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 ESC qualify for a 60-day SEP, that wouldn't be available if they enrolled in COBRA continuation coverage, and may be eligible for APTC and CSRs.

- Consumers may be eligible for a 60-day SEP to enroll in a QHP through an FFM if their former employer ceases employer contributions for COBRA.
- Consumers who choose to end COBRA early will have to wait until the next OEP, their COBRA runs out, or qualify for another SEP to enroll in Marketplace coverage.
- Consumers who lose ESC may also be eligible for Medicaid or CHIP.
- COBRA continuation coverage is typically more expensive than when the consumer was employed and may increase to 102 percent of the cost of the premium. Employers aren't required to pay any portion of the premiums.

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. For more information about COBRA continuation coverage and the FFMs, visit the COBRA coverage & the Marketplace page on HealthCare.gov.

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 the Marketplace 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 can terminate this coverage while remaining enrolled in their Marketplace health plan.

Assisting Consumers Who Want to Switch QHPs

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

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 the Marketplace. Consumers must reconcile the difference between any APTC they received and the 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.

Module 7 - Coverage Gaps

Introduction

You may wonder how you can help consumers who don’t qualify for Medicaid, CHIP, Medicare, or programs to lower their costs if coverage is unaffordable for them. By the end of this module, you should understand the following concepts and accomplish the tasks below them.

Coverage Gaps

Define coverage gaps

Consumer Options

Explain state options available to consumers in a coverage gap

What is a Coverage Gap?

In states that haven't expanded Medicaid to low-income adults, many adults with incomes below 100 percent of the federal poverty level (FPL) fall into a coverage gap. Their incomes are too high to get Medicaid and are too low to qualify for help paying for coverage in a Marketplace.

Options for Consumers Who Fall into a Coverage Gap

Falling into a coverage gap does not mean there are no health care options for a consumer. It might be helpful to refer consumers who fall into a coverage gap to other programs or organizations. Here are some options you should discuss:

Obtain health care services at federally qualified community health centers (FQHCs). These centers provide services on a sliding scale depending on income. Use the following tool to find a community health center near the consumer: findahealthcenter.hrsa.gov/.

Purchase Catastrophic health coverage. Catastrophic plans are only available to consumers under age 30 or consumers age 30 or older who qualify for a hardship or affordability exemption. For more information, visit the How to Pick a Health Insurance Plan page on HealthCare.gov or refer to the course *Affordable Care Act Basics*.

Identify what pharmaceutical assistance programs may be available. Some pharmaceutical companies offer assistance programs for the drugs they manufacture. You can help consumers find more information on the Find a Pharmaceutical Assistance Program page on Medicare.gov.

Obtain a short-term plan. Consumers may enroll in short-term, limited-duration insurance (STLDI) designed for people who experience a temporary gap in comprehensive health coverage. STLDI plans are exempt from the federal consumer protections imposed on comprehensive coverage (such as Marketplace QHPs). For example, under federal law, STLDI issuers can deny coverage due to a pre-existing condition, may include annual limits on the amount an insurer will pay, and are not legally required to cover federal EHB. Assisters should recommend consumers read STLDI plan documents to fully understand what is covered.

You should always follow Centers for Medicare & Medicaid Services (CMS) guidance when working with or referring consumers to organizations that aren't Federally-facilitated Marketplace (FFM) assister organizations or Department of Health & Human Services (HHS) entities. Working with and referrals to outside organizations are covered in the *Customer Service and Community Outreach Basics* training course.

Health Coverage Exemptions to Purchase Catastrophic Coverage

Let's review the hardship and affordability exemptions.

Hardship exemptions

A hardship exemption applies to consumers facing 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.

To claim most hardship exemptions, consumers must fill out a paper application and mail it to the FFMs. The downloadable hardship exemption form is available on HealthCare.gov.

Affordability exemptions

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 either:

1) The lowest-price Bronze-level plan available through a Marketplace would cost more than 7.28 percent (2025) of the consumer's projected household income; or,
2) For consumers with offers of employer-sponsored coverage (ESC):
   a) For an employee: The annual premium for the lowest-cost self-only plan is more than 7.28 percent (2025) of their annual household income.
   b) For the employee's spouse and dependents: The annual premium for the lowest-cost family plan is more than 7.28 percent (2025) of their annual household income (if filing a joint return and the policy covers everyone on the return).

You can find affordability exemption application information on the Health Coverage Exemptions, Forms & How to Apply page on HealthCare.gov.

Catastrophic Coverage: What's New

Beginning January 1, 2025, all Marketplaces will be required to re-enroll individuals who do not actively select a plan and are enrolled in catastrophic coverage, including enrollees who will lose eligibility for catastrophic coverage, into a new qualified health plan (QHP) for the coming plan year to help ensure continuity of coverage. CMS also prohibits Marketplaces from auto re-enrolling into catastrophic coverage someone who is currently enrolled in a metal level QHP.

Applying for Exemptions through the Marketplace to Purchase Catastrophic Coverage

Remember, consumers under the age of 30 don't need to claim an exemption or obtain an exemption certificate number (ECN) to purchase Catastrophic coverage, 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 on the Download Health Coverage Exemption Forms page on HealthCare.gov.

Step 1: Personal Information

The application asks the consumer to fill out their personal information, including name, address, phone number, and whether they want 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 employer-sponsored 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, consumers must provide "proof of income" documents, like a recent pay stub and/or 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 them 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 information 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 the 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 ECN 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.

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.

Providing ECNs When Purchasing Catastrophic Coverage

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 so they can proceed with enrolling in a Catastrophic plan.

Tips for Helping Consumers Apply for Exemptions

- Be familiar with the 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 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 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 missing information. This will slow the exemption application process.
- Encourage consumers to submit all supporting documents requested on the application.
- Remind consumers that missing information may delay processing since the Marketplace can't process exemption applications until they receive consumers' supporting documents.
- Remind consumers that they shouldn't send original documents to the Marketplace (other than the application).
- Advise consumers to keep copies of their exemption application, the original documents submitted with them, proof of mailing, and their ECNs (if an exemption was granted).
- Make sure you return any hard copies of consumers' records when you assist them. If consumers leave their documents with you by accident, take immediate measures to return them and be sure to follow your organization's privacy protection procedures.

Knowledge Check

Consumers age blank and above who wish to purchase Catastrophic coverage must apply for a blank or blank exemption through the Marketplace. What information could fill in the blanks?

Answer: 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

- Some consumers may fall into a coverage gap.
- Consumers in a coverage gap who wish to purchase Catastrophic health coverage and are age 30 and above must apply for, obtain, and report an affordability or hardship exemption through the Marketplace.
- In situations where multiple household members qualify for exemptions, each consumer will receive a separate ECN.
- You can refer consumers in a coverage gap to other sources for care, including FQHCs; Catastrophic health plans; pharmaceutical assistance programs; and short-term, limited-duration insurance policies.

Module 8 – Eligibility Appeals Assistance

Introduction

If consumers don't agree with a decision made by a Marketplace, they may file an appeal. All eligibility determination notices, regardless of whether consumers are determined eligible for a particular program, will inform consumers how to appeal a decision.

Consumers have 90 days from the date of their 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, with an initial eligibility determination or a redetermination:

- Eligibility to enroll in a qualified health plan (QHP) in a Marketplace.
- Denial of a Special Enrollment Period (SEP).
- Denial of advance payments of the premium tax credit (APTC) or cost-sharing reductions (CSRs).
- Level of APTC and CSRs.
- Eligibility for Medicaid or Children's Health Insurance Program (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 appeal eligibility results by:

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

After Filing an Appeal

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

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

To check on the status of an appeal, consumers can call the Marketplace Appeals Center at 1-855-231-1751 (TTY 711). Consumers who need additional assistance with the appeals process may visit the Marketplace Appeals Center at HealthCare.gov/marketplace-appeals.

When helping consumers understand filing Marketplace eligibility appeals, you shouldn’t provide legal advice or become a consumer's legally authorized representative in your role as an assister.

Appeals Process Summary

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 an appeal request.
3. An informal resolution is attempted.
4. The consumer decides whether to accept the informal resolution results.
    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 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 dissatisfied with the appeal decision, the consumer can seek review in court to the extent it's available by law. Beginning January 1, 2024, consumers can request review by the Centers for Medicare & Medicaid Services (CMS) Administrator of the eligibility appeal decision prior to judicial review. This is known as a Marketplace Administrator Review.

If a consumer didn't enroll in a QHP and the consumer's initial eligibility determination was 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 an eligibility change for other members of their household as well.

Determination Notice

Medicaid/CHIP Determination States

Consumers in states that delegated authority to the Marketplace to make final modified adjusted gross income (MAGI)-based 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. Consumers in Medicaid determination states can file an appeal with the state agency; in some cases, they have the option to file an appeal with the Marketplace. Consumers in Medicaid determination states can file an appeal with the state agency; in some cases, they have the option to file an appeal with the Marketplace.

Medicaid/CHIP Assessment States

Some states do not delegate authority to the Marketplaces to make final eligibility determinations for Medicaid and CHIP. In these states, the Marketplaces make a preliminary assessment as to whether consumers are eligible for Medicaid or CHIP. If consumers in assessment states apply for help paying for coverage, they will receive a notice from the Marketplace that states whether they’re eligible to enroll in a QHP and receive advance payments of the premium tax credit (APTC)/CSRs. The notice also includes an initial

assessment from the Marketplace of their eligibility for MAGI-based Medicaid or CHIP. However, the state Medicaid or CHIP agency will provide final Medicaid or CHIP eligibility determination notices to consumers who the Marketplaces assess as eligible.

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 they’re ineligible.

Unsuccessful Appeal

If the appeal process results in a decision that the initial eligibility determination was correct, that determination applies, and the consumer isn’t 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 coverage through an SEP, if eligible. Additionally, consumers who were originally determined eligible for APTC/CSRs through a Marketplace remain eligible. Remember, consumers can appeal their eligibility determinations for APTC and CSRs as well.

Sometimes consumers may appeal because they think they should have been determined eligible for a larger APTC and don't want to pay the premium for coverage through a Marketplace until they get the larger APTC amount. If 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 the initial eligibility determination was wrong and consumers didn't enroll in a plan, they will receive an SEP to enroll in Marketplace insurance.

Legal Advice and Appeals

Navigators and EAPs are required to provide information on and assistance with understanding the process of filing Marketplace eligibility appeals; certified application counselors (CACs) in Federally-facilitated Marketplaces (FFMs) are permitted but not required to assist consumers with appeals. However, if you don't provide appeals assistance, you should refer consumers to another individual who can.

In your role as an assister, you may not 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 is best suited to their circumstances. Consumers can decide to file requests for expedited appeals if the standard appeal process would jeopardize their lives, health, or ability to achieve, maintain, or regain maximum function.

You can tell consumers that they do not have to file their appeal without assistance, but you can't provide legal advice within your capacity as an assister. You can 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 from the Tips for Assisters on Working with Outside Organizations PDF.

Consumers can have someone they trust (like a family member, friend, advocate, or attorney) act on their behalf for their appeal as their authorized representative. To appoint a representative, they'll need to send a form or letter to the Marketplace Appeals Center — even if they already appointed an authorized representative for their Marketplace application. If they appoint an authorized representative, that individual will be the main contact during the appeal process. Note that a Marketplace application filer has authority to appeal on behalf of any members of their household on their Marketplace application without being appointed an authorized representative.

Knowledge Check

What are Marketplace decisions can consumer’s appeal?

Answer: Consumers can appeal decisions on eligibility to enroll in a QHP in a Marketplace, the level of premium tax credit and CSRs they're eligible for, and eligibility for an exemption to enroll in a Catastrophic plan. Consumers can’t appeal a Medicare eligibility decision through the Marketplace.

Key Points

- If consumers don't agree with a decision made by a Marketplace, they can file an appeal.
- Consumers may contact the Marketplace Appeals Center at 1-855-231-1751 (TTY 711) for assistance with filing an eligibility appeal.
- When you're assisting consumers, you should never provide tax or legal advice regarding exemptions, appeals, or any other matter.

Module 9 - Help Consumers Understand Marketplace Coverage Tax Forms

Introduction

Many tax-related resources may be useful when helping consumers.

You may help consumers understand the purpose of certain Internal Revenue Service (IRS) forms and the Marketplace-related components of the premium tax credit reconciliation process. By the end of this module, you should understand the following concepts and accomplish the tasks below them.

Tax Forms

Identify tax forms consumers may need.

Purpose of IRS Tax Forms

State the purpose of IRS tax forms.

Premium Tax Credit Reconciliation

Explain the Marketplace-related components of the premium tax credit reconciliation process.

Tax Forms for the Premium Tax Credit

Consumers can visit the IRS.gov homepage to learn about claiming a premium tax credit (PTC) and reconciling this amount with any advance payments of the premium tax credit (APTC) they received during the year.

All consumers who enroll in QHPs through the individual market FFMs receive Form 1095-A, Health Insurance Marketplace Statement, regardless of whether they apply for programs to lower their costs. Consumers who receive APTC must use IRS Form 8962, Premium Tax Credit, to figure out the amount of PTC they're eligible for and reconcile it with any APTC they received as reported on Form 1095-A. If consumers receive APTC during a coverage year or wish to obtain a PTC for the previous year in which they had Marketplace coverage, they must file federal income taxes and complete Form 8962—even if they're not otherwise required to file taxes.

Note: You may not provide tax advice in your role as an assister. Consumers can get additional help with IRS forms and other tax-related questions by seeking advice from a tax professional.

IRS Form 1095-A

Consumers who have enrolled in a QHP through an individual market FFM will receive Form 1095-A, Health Insurance Marketplace Statement from the Marketplaces by mail. The form will also be available online through their Marketplace account. If household members enroll in different policies during the coverage year, they will receive one 1095-A for each policy in a household. Consumers should use the information on their Form 1095-A to complete Form 8962, Premium Tax Credit (PTC). Form 1095-A contains the following:

- Names and other information for the consumer or family members enrolled in a QHP.
- Coverage information for a QHP, like the premium amount, second lowest cost Silver plan (SLCSP) premium, and monthly APTC if paid to the QHP.

Consumers need to review the information on Form 1095-A to make sure it's accurate. Note: If a consumer believes enrollment-related information may be incorrect, the consumer should contact the Marketplace Call Center. Consumers may also contact the Marketplace Call Center if they didn’t receive their Form 1095-A.

The Second Lowest Cost Silver Plan

SLCSP

The SLCSP is the second lowest cost Silver plan premium available to a consumer and any family members in their geographic area at the time they enrolled in Marketplace coverage. This isn't necessarily the plan a consumer enrolls in; rather, it's the plan premium used to determine the amount of APTC the consumer is eligible for.

Verifying the SLCSP

A consumer may want to verify the SLCSP information provided on Form 1095-A if:

- Consumers had a change in their household they didn't report to the Marketplaces, like having a baby.
- Consumers didn't apply for financial assistance when completing their Marketplace application and now want to find out if they qualify.
- Consumers didn't apply APTC they were eligible for to lower their premium amount.
- Consumers can use the Health Coverage Tax Tool to determine or verify their SLCSP.

SLCSP Results

Consumers can complete simple questions using the tax tool to find the SLCSP in their geographic area. When using the tool, it is important for consumers to select each month they had Marketplace coverage and paid their premiums. Remember, you may not help consumers fill out IRS Form 8962 or help them file their taxes.

The tool will provide the premium amount used to calculate the premium tax credit on Form 8962. Again, the premium amount is the second lowest premium in the Silver plan category available to consumers in their geographic area and will be used to compare or reconcile on Form 8962. If the SLCSP results and the amounts on the form differ, a consumer doesn't need to request a new Form 1095-A. Consumers can print their results from the tax tool and submit them with their federal income tax returns.

Additional IRS Forms 1095

Consumers may receive other 1095 forms, including 1095-B or 1095-C. They will receive these if they or someone in their household had coverage through a job or other source.

For example, consider a consumer who starts the year with employer-sponsored insurance. This consumer then loses his job and qualifies for Medicaid. Later, the consumer finds a new job and no longer qualifies for Medicaid, but his job doesn't offer health insurance coverage. Assuming he buys a QHP through a Marketplace, he will get three different 1095 forms at the end of the year:

- 1095-A for the Marketplace QHP.
- 1095-B for the Medicaid coverage.
- 1095-C for the employer-sponsored insurance.

This consumer would need to use all of these 1095 forms when filing his federal income tax returns.

IRS Form 8962

After consumers receive Form 1095-A and confirm their information is accurate, they can complete Form 8962, Premium Tax Credit (PTC). Form 8962 helps consumers determine the amount of PTC they qualified for during a tax year and reconcile that with the amount of APTC they received. To reconcile Form 8962, consumers should include the premium and SLCSP amounts on Form 1095-A and contribution amounts as described in Form 8962.

Remember, APTC is the amount paid to a QHP to reduce or subsidize a consumer's premium amount. The amount of PTC a consumer qualifies for during the year may affect the amount of taxes they owe to the IRS or the amount they get back when they reconcile their APTC:

- If consumers use more APTC than the PTC they're determined eligible for, they or their taxpayer may be required to repay the difference when they file their federal income tax return.
- If consumers use less APTC than the PTC they're determined eligible for, they may receive the difference as a refund.

Additional information about Form 8962 and instructions for Form 8962 are available from the IRS.

As a reminder, you may not help consumers fill out tax forms, and you may not help consumers file their taxes. Consumers may seek assistance from a tax specialist to complete the form.

APTC Reconciliation: What's New

For PY 2025, the Marketplace may only determine enrollees ineligible for APTC after they have failed to file and their household's federal income tax return and reconcile their APTC for two consecutive years (specifically, years for which tax data will be utilized for verification of household income and family size).

CMS is also requiring all Marketplaces, including State-based Marketplaces, to send notices to consumers or their tax filers in the first year in which they failed to reconcile APTC as an initial warning to inform and educate tax filers that they need to file and reconcile or risk being determined ineligible for APTC if they fail to file and reconcile for a second consecutive year.

Scenario: Tax Forms

You're preparing to meet with consumers to help them review the tax forms received for their premium tax credit. What information should you be prepared to assist with or explain?

- The general purpose of Form 1095-A and Form 8962.
- Why more than one copy of Form 1095-A was received, if applicable.
- How to locate Form 1095-A online at their Marketplace account.
- Next steps if the consumer finds incorrect information on Form 1095-A, like wrong address, incorrect premium amounts or SLCSP, or dependents the consumer added to coverage but were not included on the form.

Providing basic information about Form 1095-A and informing the consumer about IRS resources is the most appropriate action when helping consumers. The consumer should fill out Form 8962 on their own behalf. You may not advise consumers about whether to file an amended tax return and you may not help them complete their federal income tax return. You should direct consumers to IRS resources or to licensed tax advisers or tax preparers for assistance with tax preparation and tax advice related to these forms.

Additional Information

Navigators are required to provide information on and assistance with 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.

Key Points

- IRS.gov offers forms and resources that can be useful when helping consumers.
- You may help consumers understand the general purpose of IRS Forms 1095-A and 8962 and Marketplace-related components of the premium tax credit reconciliation process.
- You may not provide tax advice in your role as an assister. Consumers can get additional help with IRS forms and other tax-related questions by seeking advice from a tax professional.

Conclusion

Great job! You've finished the learning portion of this course.

You learned to provide consumers in FFMs with eligibility and enrollment assistance and support them with exemptions and appeals. If you choose to take the exam, the code to access this exam is: 860951.

Resources

Note: There are some references and links to nongovernmental third-party websites in this section. 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.

Module 2 – Preparing to Apply

SHOP Marketplace Overview: A summary of the Small Business Health Options Marketplace Program.
Healthcare.gov/small-businesses/choose-and-enroll/shop-marketplace-overview/

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/

Savings Estimator Tool: Provides consumers with a quick view of income levels that qualify for savings in 2024.
Healthcare.gov/lower-costs/

Logging Into Your Marketplace Account: Tips on troubleshooting login issues for Marketplace accounts at HealthCare.gov.
Healthcare.gov/tips-and-troubleshooting/logging-in/

Medicaid and CHIP Overview: Summary of important facts regarding Medicaid and CHIP eligibility.
CMS.gov/marketplace/technical-assistance-resources/fast-facts-medicaid-chip.pdf

Individual Shared Responsibility Provision: Information about how the ACA impacts filing Federal income tax returns.
IRS.gov/affordable-care-act/individuals-and-families/individual-shared-responsibility-provision and IRS.gov/affordable-care-act/individuals-and-families/aca-individual-shared-responsibility-provision-exemptions

Module 3 – Account Creation

Identity Proofing in the Marketplace: A description of the identity proofing process that occurs before completing a Marketplace application.
CMS.gov/marketplace/outreach-and-education/your-marketplace-application.pdf

Creating an Account: Tips and troubleshooting for creating a Marketplace account online.
Healthcare.gov/tips-and-troubleshooting/creating-an-account/

Marketplace Assister Microlearnings: Microlearnings for Account Creation.
CMS.gov/marketplace/technical-assistance-resources/marketplace-assister-microlearning

Verifying your Identity in the Marketplace:
CMS.gov/marketplace/outreach-and-education/your-marketplace-application.pdf

Module 4 – Application Completion

Marketplace Assister Microlearnings: Microlearnings for Application Walkthrough.
CMS.gov/marketplace/technical-assistance-resources/marketplace-assister-microlearning

IRS Publications 17 and 525: More details on what income is taxable and not taxable.

IRS.gov/pub/irs-pdf/p17.pdf and

IRS.gov/pub/irs-pdf/p525.pdf

Module 5 – Interpreting Eligibility Results

5 Things Assisters Should Know about Data Matching Terminations: Information about how data matching issues impact consumers.
HHS.gov/guidance/document/job-aid-5-things-assisters-should-know-about-data-matching-terminations

Redesigned Marketplace Eligibility Notice: Presentation that focuses on changes just for the Eligibility Notice.
CMS.gov/marketplace/technical-assistance-resources/redesigned-marketplace-eligibility-notice-training.pdf

Module 6 – Helping Consumers Enroll in Coverage

Federal Poverty Level (FPL) Guidelines: Up-to-date information regarding the Federal Poverty Guidelines (FPL) for families and individuals.
ASPE.hhs.gov/topics/poverty-economic-mobility/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/

Understanding COBRA: Job aid for Assisters on helping consumers learn about COBRA continuation coverage.
CMS.gov/marketplace/technical-assistance-resources/understanding-cobra-job-aid.pdf

HealthCare.gov: How employer-sponsored coverage affects Marketplace coverage.
Healthcare.gov/have-job-based-coverage/

Types of Health Insurance that Count as MEC: Definition of MEC.
Healthcare.gov/glossary/minimum-essential-coverage

Special Enrollment Opportunities: Full list of qualifying life events, SEP eligibility verification, and plan category limitations.
Healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/,
Healthcare.gov/coverage-outside-open-enrollment/confirm-special-enrollment-period/, and
Healthcare.gov/coverage-outside-open-enrollment/changing-plans/

Special Enrollment Periods: Fact sheet for Assisters on helping consumers apply for, enroll in, or change health coverage during an SEP.
CMS.gov/marketplace/technical-assistance-resources/special-enrollment-periods-fact-sheet.pdf

Module 7 – Coverage Gaps

Resources Page for Assisters on Medicare.gov: Information on joining a Medicare health plan or drug plan.
Medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan

Tips for Working with Outside Organizations: Fact sheet with information and guidance for Assisters about referrals and worthing with outside organizations.
CMS.gov/marketplace/technical-assistance-resources/assister-guidance-on-referrals-to-outside-organizations.pdf

How to find community health centers in your area: Use the following tool to find a community health center near the consumer.
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/

Pharmaceutical Assistance Programs: A tool to see if a pharmaceutical company offers an assistance program for the drugs they manufacture.
https://www.medicare.gov/plan-compare/#/pharmaceutical-assistance-program

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/

Hardship and Affordability Health Coverage Exemption: Forms and instructions for applying for health coverage exemptions.
Healthcare.gov/exemption-form-instructions/ and
Healthcare.gov/health-coverage-exemptions/forms-how-to-apply/

Module 8 – Eligibility Appeals Assistance

Income Definitions for Marketplace and Medicaid Coverage (How MAGI is Calculated): 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/

Income Eligibility Using MAGI Rules: Webinar to assist with whose income is counted, which income types are counted, and case examples.
CMS.gov/marketplace/technical-assistance-resources/income-eligibility-using-magi-rules.pdf

Income Eligibility Using MAGI Rules: Fact sheet for Assisters to explain MAGI and how to calculate household income to consumers applying for Marketplace coverage and financial assistance.
CMS.gov/marketplace/eligibility-enrollment-resources/MAGI-rules.pdf

Marketplace Eligibility Appeals: Eligibility appeals process overview webinar.
CMS.gov/marketplace/technical-assistance-resources/training-materials/marketplace-eligibility-appeals.pdf

How to appeal a Marketplace decision:
Healthcare.gov/marketplace-appeals/

Module 9 – Help Consumers Understand Marketplace Coverage Tax Forms

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/#/

Post Enrollment Assistance: Locating form 1095-A and determining the SLCSP premium.
CMS.gov/files/document/form-1095a-and-silver-plan-premium.pdf

Best Practices for Assisters: Webinar for assister approached to helping consumers during tax season.
CMS.gov/marketplace/technical-assistance-resources/approaches-to-helping-consumers-during-tax-season.pdf

Tax Information: Tax forms for consumers.
CMS.gov/marketplace/in-person-assisters/technical-resources/tax-information

Form 8962: Addition information and instruction from the IRS.
IRS.gov/pub/irs-pdf/i8962.pdf

Health coverage choices for retirees: An explanation of the different choice's retirees have for health coverage. Healthcare.gov/retirees/

Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) Worksheet: Use this worksheet to find out if the QSEHRA meets the requirements for "affordability."
Healthcare.gov/downloads/qsehra-worksheet.pdf