

Marketplace Update for Assisters

January 4, 2018

In this Marketplace Update for assisters, you'll find guidance on how to help consumers [effectuate](#) their Marketplace coverage, submit an [appeal](#) and resolve/prevent [DMIs](#). This update also includes the final weekly enrollment [snapshot](#) for the 2018 open enrollment period and provides guidance regarding the [Loss of MEC](#) SEP and [SEPV](#).

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Reminder: Health Plan Coverage Effectuation

Summary: Consumers who enroll in a qualified health plan (QHP) through the Federally-facilitated Marketplaces (FFM) must pay their first monthly premium (or “binder payment”) to effectuate their coverage. Consumers must pay their binder payment to complete the enrollment process and to begin their coverage on their effective date. However, in accordance with the Market Stabilization Rule, under certain circumstances QHP issuers can require satisfaction of delinquent payments before issuing coverage. Thus, if a consumer owes any past due premium amount, the QHP issuer may attribute a payment intended to effectuate coverage instead to past due amounts.

How to Assist Consumers with their First Premium Payment

After a consumer has selected a QHP, the Marketplace may redirect the consumer to the issuer’s website—when applicable—or will instruct the consumer to contact the health insurance company directly to make premium payments. Consumers should contact their health insurance company with any specific questions about acceptable methods or deadlines for premium

payment. Please ensure that consumers understand that the FFM does not accept payments on behalf of insurance companies.

Before assisting consumers with making a payment, it's important to understand that consumers' financial payment information (e.g., bank account, debit cards, credit cards) must be kept private and secure, just like all consumer personally identifiable information (PII) that you may encounter while helping a consumer.

What happens if a consumer misses a payment?

The Marketplace may give consumers who have paid their binder payment, and have outstanding premium payments, an additional period to pay before the insurance company can terminate their coverage. This short period of time is called a "grace period" and its length varies depending on whether a consumer is receiving advanced premium tax credits (APTCs) or not.

Under current rules, marketplace plan issuers must:

- Allow consumers who receive APTCs when they fail to timely pay premiums a three-month grace period (See 45 CFR 156.270(d)).
- Grant consumers who do not receive APTCs a grace period in accordance with state rules (See 45 CFR 155.430(d)(5)). Assistors may want to contact their state department of insurance (DOI) for more information on grace periods based on state rules.

How are medical claims managed when a consumer misses a payment?

If the consumer is receiving APTCs, the issuer must pay all appropriate claims for services rendered to the consumer during the first month of the three-month grace period. For a consumer receiving APTCs, the issuer may pend claims for services rendered during the second and third months of the grace period.

If a consumer fails to pay all outstanding premium, or an amount that satisfies any applicable premium threshold, before the end of the grace period:

- The consumer's coverage will be terminated for non-payment of their premium.
- The issuer will deny any claims that were pended during the second and third months of the three-month grace period.

Frequently Asked Questions (FAQ) by Assistors:

Q1: Are there any other requirements besides receiving APTCs that consumers must meet to receive a 3 month grace period if they fail to pay the full monthly premium payment for their health coverage?

A1: No, if an enrollee is receiving the benefit of APTC's at the time of delinquency, he or she gets a 3 month grace period (even if the enrollee loses the benefit of APTC's during the grace period). The requirement that a payment be made during the benefit year has been eliminated.

Q2: If a consumer reaches the end of his or her 3 month grace period and has not paid all outstanding premium payments in full, when does coverage terminate?

A2: In this situation, a consumer's coverage would terminate retroactive to the last day of the first month of the grace period. For example, if a consumer misses a premium payment for May, the grace period that went into effect would expire July 31, and the consumer could lose coverage retroactive to the last day of May.

Q3: Does a consumer need to pay all outstanding premiums during a grace period in order to avoid termination of coverage?

A3: Yes. It is very important to keep in mind that the start date for a three consecutive month APTC-related grace period does not "reset" if a consumer does not pay in full all outstanding premiums owed, or an amount that satisfies any applicable premium threshold, within three months. For example: If a consumer misses a premium payment for May and then submits payments appropriately for June and July, but remains delinquent for May, the grace period will expire July 31 and the consumer could lose coverage retroactive to the last day of May, which is three months since the initial premium lapse, due to the still-outstanding May payment.

Q4: If a consumer believes that his or her coverage has been wrongly terminated, is there a way that he or she can appeal the decision?

A4: Yes. If a consumer's health insurer refuses to pay a claim or ends his or her coverage, he or she has the right to appeal the decision and may have the ability to have the decision reviewed by a third party. Refer to [this page](#) for more information. It is important to be aware of the protections a grace period and the appeals process can offer, but we also encourage assistors to remind consumers that making the effort to pay premiums regularly, and on time, is the best way to avoid the challenges and confusion of lapses in coverage.

TIP: We also encourage assistors to refer to [this Tip Sheet on Helping Consumers Affected by Grace Periods Related to Non-Payment of Premiums](#), and SOP-9 of the [Standard Operating Procedures Manual for Assistors in the Individual Federally-facilitated Marketplaces](#).

Reminder: Help Consumers Resolve their DMIs

A) Resolving Data Matching Issues (DMIs)

Now that open enrollment for 2018 coverage is over, it's important for assisters to understand how to reduce potential data matching issues (DMIs). Similarly, it's crucial for consumers to know how and when to submit requested information and the timeline to do so in order to resolve the DMI and avoid having their coverage terminated.

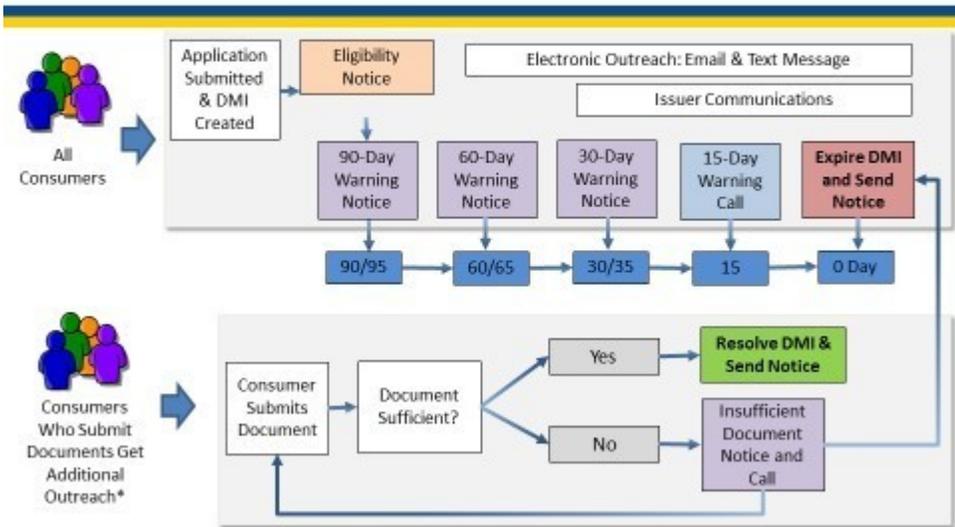


After submitting a Marketplace application, the system verifies the consumer's information to determine eligibility. But in some cases, the information the applicant provides does not match existing records from trusted data sources (TDSs) such as Internal Revenue Service (IRS), Social Security Administration (SSA), Department of Homeland Security (DHS), etc., or the applicant does not provide enough information to match existing records from TDSs. Under those circumstances, the application generates a DMI, and consumers are given 90/95 days to submit documentation to verify their application information.

Generally, the Marketplace grants temporary eligibility for coverage and financial assistance during the 90/95 days inconsistency period, however, consumers need to submit supporting documentation to resolve a DMI. If consumers fail to submit information within the 90/95-day window, they risk losing their Marketplace health care coverage and/or having their financial assistance adjusted, in some cases to \$0.

For example, consumers with citizenship/immigration DMIs will be terminated from coverage if they do not submit the requested information, and consumers with annual income DMIs will have their advanced premium tax credits (APTCs) and/or cost sharing reductions (CSRs) re-determined based on available tax data. When Marketplace coverage is terminated as a result of an unresolved DMI, consumers may be required to pay back any APTCs and/or CSRs they received during the 90/95-day period.

Consumer Outreach



* Consumers who submit documents can get additional notices and calls, which do not replace the notices and calls that all consumers receive.

If a DMI is unresolved, consumers will receive 90-day, 60-day, and 30-day warning notices as well as a 15-day reminder call before their DMIs are set to expire. These notices will be mailed in English or Spanish based on the consumer’s language preference. We encourage assisters to help consumers review their Marketplace DMI notices to identify what documents the Marketplace needs, and help them determine whether or not they have submitted sufficient supporting documentation.

Table 1: Impact of DMI Expiration

DMI	Expiration Description	Impact
Annual Income	Applicant is unable to document annual household income is within 25% or \$6,000 of attested income	Household's eligibility for financial assistance is adjusted, possibly to nothing, based on the level of income on record with Marketplace trusted data sources
Citizenship/Immigration (Cit/Imm)	Consumer is unable to verify an eligible citizenship or lawful presence status	Consumer loses their eligibility for Marketplace coverage and is terminated if enrolled
American Indian/Alaskan Native (AI/AN) Status	Consumer is unable to verify they are a member of a Federally-recognized tribe or shareholder in an Alaska Native corporation (ANCSA)	Consumer loses their eligibility for financial assistance provided specifically to members of Federally-recognized tribes, which is eliminated if enrolled
Non-Employer Sponsored Coverage Minimum Essential Coverage (non ESC MEC)	Consumer is unable to verify they are not eligible/enrolled in Non-Employer Sponsored Coverage	Consumer loses their eligibility for financial assistance, which is eliminated if enrolled
ESC MEC (OPM Only)	Consumer is unable to verify they are not eligible/enrolled in Employee Sponsored Coverage from OPM	Consumer loses their eligibility for financial assistance, which is eliminated if enrolled

B) Steps to Help Resolve DMIs

In many instances, DMIs are generated due to missing or incorrect information on the application. The most common mistakes producing DMIs are:

1. A consumer failed to provide a Social Security Number (SSN) on the application.
2. A consumer failed to provide all household income on the application.
3. A consumer's name as entered in the application differs from how it appears in his or her citizenship document or other document.
4. A consumer failed to provide his or her immigration documents and ID numbers.

We strongly recommend that assisters work with consumers to clarify and simplify the DMI process, reduce confusion, improve document collection and submission, and negate the potential for disruptions in coverage. In cases that require follow-up, assisters should follow these steps to help consumers resolve DMIs:

- Help confirm if the consumer has a DMI through My Account and notices;

- Help the consumer go back to the application to confirm the information that is included is correct; and
- Help the consumer submit document(s) online or by mail to resolve his or her DMI.

For more information about how to prevent and resolve DMIs, please refer to the following documents:

- How do I Resolve an Inconsistency? <https://www.healthcare.gov/help/how-do-i-resolve-an-inconsistency/>
- Tips to Resolve Outstanding Data Matching Issue Presentation: <https://marketplace.cms.gov/technical-assistance-resources/resolve-data-match-issues.pdf>
- Consumer Guide for Annual Data Matching Issues: <https://marketplace.cms.gov/outreach-and-education/household-income-data-matching-issues.pdf>
- DMI Blog Post: <https://www.healthcare.gov/blog/the-marketplace-might-need-more-information-from-you/>
- Sample Data Matching Notices to consumers: <https://marketplace.cms.gov/applications-and-forms/notices.html>
- How do I Upload a Document?: <https://www.healthcare.gov/help/how-to-upload-documents/>
- Uploading Documents Tips: <https://www.healthcare.gov/tips-and-troubleshooting/uploading-documents/>
- Tips for Submitting Supporting Documents to the Marketplace Presentation: <https://marketplace.cms.gov/technical-assistance-resources/submitting-supporting-documents.pdf>
- Five Things Assisters Should Know About Data Matching Terminations Factsheet: <http://marketplace.cms.gov/technical-assistance-resources/data-matching-terminations.pdf>

Refresher: Marketplace Appeals

Consumers who have applied for coverage through a Marketplace will receive an eligibility notice explaining what coverage they qualify for. For example, the notice may say they are not eligible to enroll in Marketplace coverage, or they do not qualify for coverage through Medicaid or the Children's Health Insurance Program (CHIP). If a consumer disagrees with the determination in the notice, you should let them know they may be able to appeal that determination. Consumers have 90 days from the date they receive their eligibility notice to start an appeal. As an assister, you can help them understand this process.

- Consumers can submit an appeal request by mailing an appeal request form, mailing an appeal request letter, or faxing the form or letter. See the different ways consumers can [request an appeal](#) (also available in [Spanish](#)).
- Different states have different appeals request forms. Find [Appeal Request Forms](#) that apply for the consumer's state (also available in [Spanish](#)).
- Help consumers learn how to request an [expedited appeal](#) (also available in [Spanish](#)) if the time needed for the standard appeal process would jeopardize the consumer's life, health, or ability to attain, maintain, or regain maximum function.
- Some consumers will file certain appeals through the Marketplace or through their State Medicaid or CHIP agency; depending on their state and eligibility result. Make sure to review consumers' eligibility notices for directions. Find out what [eligibility notices](#) look like.
- Encourage consumers to include a copy of their eligibility notice when they file an appeal. Find [information](#) on what to do if a consumer submits an appeal request and the Marketplace Appeals Center tells them their appeal is "invalid." They might need to take certain actions to get their request considered.
- Check out this presentation to learn about the [Marketplace eligibility appeals process](#).
- There is a different process for requesting an appeal of a decision a consumer's health insurance plan made not to cover a certain service or item. Check out this [resource](#) to understand key differences between appealing Marketplace decisions versus plan coverage decisions.

Loss of Qualifying Health Coverage SEP

Consumers may qualify for a Special Enrollment Period (SEP) if they (or anyone in your household) lost qualifying health coverage (or "minimum essential coverage"). Some examples of qualifying coverage include:

1. Loss of Qualifying Health Coverage
 - Coverage through a job, or through another person's job
2. Medicaid or Children's Health Insurance Program (CHIP) Coverage
 - Includes pregnancy-related coverage and medically needy coverage
3. Medicare
4. COBRA
 - Consumers who selected COBRA may qualify for a Loss of Qualifying Coverage SEP if an employer stops making payments toward part of the consumer's COBRA premium
5. Individual or group health plan coverage that ends during the year
6. Coverage under your parent's health plan (if you're on it)
 - If you turn 26 and lose coverage, you can qualify for this Special Enrollment Period

Remember: Under Marketplace rules, consumers are not eligible for a SEP based on loss of minimum essential coverage (MEC) if they:

- Voluntarily terminated their coverage
- Didn't pay their premiums
- Coverage was taken away because of fraud or intentional misrepresentation.

However, in cases when an employee terminates employer sponsored coverage (that meets the MEC standard) on behalf of a spouse or dependent, the spouse or dependent is considered an involuntary termination of coverage. This means that the spouse or dependent may be eligible for a SEP based on loss of qualifying coverage.

Note: Some consumers may not have been automatically re-enrolled in 2018 coverage because their former plan was discontinued for 2018 and the insurance company doesn't offer a similar plan, or their insurance company is no longer offering plans through the Marketplace for 2018. In these cases, the consumer may qualify for a loss of qualifying coverage SEP to enroll in a different plan for 2018.

To check if a consumer was re-enrolled in 2018 coverage, or see whether a consumer was re-enrolled into an alternate plan with a different insurance company, consumers can:

1. Log in and click "Start a new application or update an existing one." A blue box at the top of the next page will display, if they have been automatically enrolled in a plan. They can review plan details under "My Plans & Programs."
2. If a consumer was automatically enrolled, they would have received a notice. Log in and click "Messages" to view the notice.
3. If a 2018 application is marked "Status: Complete" in a consumer's Marketplace account, the consumer is enrolled in a plan for 2018.

For more information on Loss of Qualifying Coverage SEP, please refer to the following links:

1. “Understanding Special Enrollment Periods” – <https://marketplace.cms.gov/outreach-and-education/special-enrollment-periods-available-to-consumers.pdf>
2. “Special Enrollment Period (SEP): Overview for the Federally-facilitated Marketplace” - <https://marketplace.cms.gov/technical-assistance-resources/sep-overview-session.pdf>
3. “Complex Case Scenarios Preventing Gaps in Health Care Coverage Mini-Series: Transitioning from Employer-Sponsored Coverage to Other Health Coverage” - <https://marketplace.cms.gov/technical-assistance-resources/transitioning-from-employer-coverage.pdf>
4. Find more information about the annual redetermination and auto re-enrollment process here: <https://marketplace.cms.gov/technical-assistance-resources/annual-redetermination-and-auto-reenrollment.PDF>

“If you lose job-based health insurance” - <https://www.healthcare.gov/have-job-based-coverage/if-you-lose-job-based-coverage/>

“Pre-enrollment SEP Verification” Process

Summary: Last summer, CMS launched a pre-enrollment SEP Verification (SEPV) process to verify SEP eligibility for consumers newly enrolling in Marketplace coverage through the most common SEP types. Under the process, the Marketplace creates an SEP Verification Issue, referred to as an SVI, for new Marketplace applicants who submit an application and attest to information that qualifies them for an SEP. Consumers are required to submit documents to confirm their SEP eligibility before they can complete enrollment, make their first premium payment, and start using their Marketplace coverage.

Consumers newly enrolling in Marketplace coverage through any of the SEPs listed below will be required to submit documents to confirm their SEP eligibility before they can begin using their coverage. If consumers qualify for any of these SEPs, they will be asked in the **Eligibility Determination Notice (EDN)** to submit documents that prove their SEP eligibility. Assisters can download a model of the EDN that consumers will receive, which includes a list of documents they can submit. To do so, please visit the [Notices page](#), scroll down to “Eligibility Notice” and use the link below, “Special Enrollment Period Pre-Enrollment Verification (June 2017).”

SEPs that Require Pre-enrollment Verification:

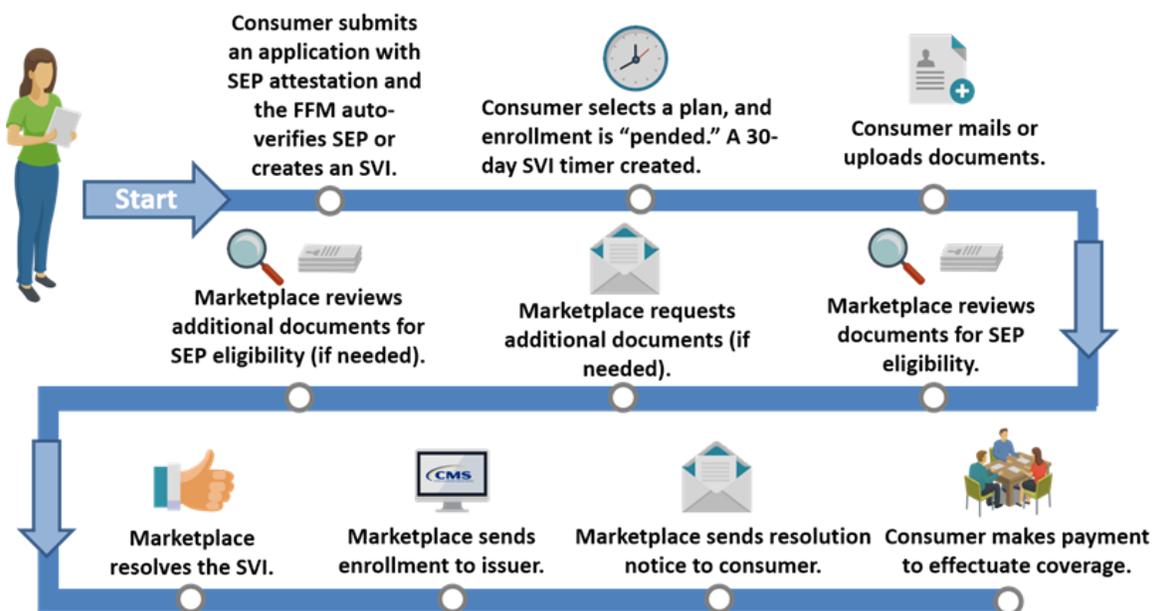
1. Loss of qualifying coverage
2. Move
3. Marriage
4. Gaining or becoming a dependent through adoption, placement for adoption, placement in foster care, or a child support or other court order

5. Medicaid/CHIP denial after applying for Medicaid/CHIP during Open Enrollment, or after applying for Marketplace coverage during Open Enrollment or following another SEP qualifying event.

Consumers with an SVI will be required to submit documents to confirm their SEP qualifying event before they can enroll, make their first premium payment, and start using their coverage. Consumers' coverage will start based on their SEP type and date they chose their plan.

- For example, a consumer who qualifies for a loss of coverage SEP and chooses a plan in January will have his or her coverage start either the first of the next month if they've already lost coverage and picked a plan, or will start the first of the month after the plan ends if they have a future end date. If he or she sends documents to resolve the SVI after the coverage starting date, once the SVI is resolved, coverage will be retroactively adjusted.

Consumers' deadline to submit documents is **30 days after they pick a plan**. Once they confirm their plan selection, consumers will receive a **pending plan selection notice** with this deadline. Like the EDN, this notice will also include a list of documents consumers can submit. Consumers' plan selections will be pended (put on hold) until the Marketplace confirms their SEP eligibility based on the documents they send. Consumers won't be able to use their coverage during this time, and should contact the Marketplace if they have questions. Consumers who don't send documents by their deadline could be found ineligible for this SEP and lose their opportunity to enroll in Marketplace coverage until the next annual open enrollment period, unless they experience another SEP qualifying event.



Frequently Asked Questions (FAQ) by Assisters:

Q: Can consumers who need to send documents to prove SEP eligibility pick a plan before they send documents, and before CMS reviews their documents?

A: Yes – consumers can pick a plan before sending the Marketplace documents to prove their eligibility. In fact, consumers **must** pick a plan before 60 days have passed from the time of their SEP qualifying event. However, consumers' plan selection will be pended (put on hold) until they send documents and the Marketplace confirms their SEP eligibility.

Q: How long will consumers have to submit documents to the Marketplace to prove their SEP eligibility?

A: Consumers have 30 days after they pick a plan to submit documents to prove their SEP eligibility. This deadline will appear in the notice consumers receive after they pick a plan.

Remember: This deadline is the date by which they must submit required documents to the Marketplace. That is, this deadline is not also the date by which the Marketplace must verify consumers' SEP eligibility.

Q: How do I help consumers upload documents to their online accounts?

A: More information about how consumers can upload documents online to prove their SEP eligibility is [available here on HealthCare.gov](#).

Uploading documents to their Marketplace account is the fastest way to get documents to us. However, consumers may also mail copies of their documents to the Marketplace if they prefer; information on how to send copies of documents by mail is [available here on Healthcare.gov](#).

Remember: There is no option to fax documents or to send them by email.

Q: Is there anything consumers need to do after they submit documents to prove their SEP eligibility?

A: Once they've submitted documents to confirm their SEP eligibility, consumers should regularly check their Marketplace account, email, regular mail, and voicemail for more information from the Marketplace, because the Marketplace will follow up with more information on whether their documents successfully confirmed their SEP eligibility and, if not, information that they still need to confirm.

Consumers who have questions about the status of their documents can contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

Q: Will consumers' Eligibility Determination Notices (EDNs) include information on which member of a household needs to submit documents to prove their SEP eligibility?

A: Yes – consumers must submit documents to prove SEP eligibility for at least one household member on their application who experienced the SEP qualifying event. Consumers' EDN, Pended Plan Selection Notice, and other notices they receive related to their SEP will identify

which member(s) of a household can submit information to prove their eligibility for the SEP.

Q: What happens if a consumer doesn't submit documents?

A: Consumers who don't respond to requests for documentation, or who don't provide sufficient documentation, could be found ineligible for their SEP and lose their opportunity to enroll in Marketplace coverage until the next annual open enrollment period or unless they experience another SEP qualifying event. If a consumer receives an EDN instructing him or her to submit documents to prove his or her eligibility for an SEP, it is critical that he or she submit the documents by the deadline listed in the Notice.

Remember: Consumers have **30 days from when they choose a plan to submit documents that prove their SEP eligibility**. Consumers should read the EDN they get after they complete their application and **the notice they get after they pick a plan carefully**, and follow the instructions to resolve an SVI by their deadline.

Q: What if a consumer has a data matching issue (DMI) and also has to send documents to prove SEP eligibility?

A: If the consumer also has a data-matching issue (DMI, sometimes referred to as an "inconsistency") and therefore needs to submit other types of documents, their EDN will also include this information.

Consumers generally have 90/95 days from when they **complete their application** to submit documents to resolve a DMI, and 30 days **from when they pick a plan to submit documents to prove their SEP eligibility**.

If consumer has both a DMI and SVI then they'll need to resolve their SVI before they can begin using coverage. In some cases, this may occur before the DMI is resolved in which case the consumer could start using coverage prior to the DMI resolution. Visit [HealthCare.gov/verify-information](https://www.healthcare.gov/verify-information) to learn more about how you can help consumers to resolve a DMI.

For more information on which types of documents consumers can submit to resolve an SVI, please refer to the following links:

- After you submit documents: <https://www.healthcare.gov/verify-information/after-you-submit-documents/>
- When the Marketplace asks for more documents: <https://www.healthcare.gov/verify-information/>
- Special Enrollment Periods Available to Consumers: <https://marketplace.cms.gov/outreach-and-education/special-enrollment-periods-available-to-consumers.pdf>
- Overview: Special Enrollment Period Pre-Enrollment Verification (SEPV):

<https://marketplace.cms.gov/technical-assistance-resources/sepv-session.pdf>

- Special Enrollment Period Pre-Enrollment Verification (SEPV): Phase 2 Overview: <https://marketplace.cms.gov/technical-assistance-resources/sepv-phase-2-overview.pdf>

Final Weekly Enrollment Snapshot For 2018 Open Enrollment Period

Approximately 8.7M people selected or were automatically re-enrolled in plans using the HealthCare.gov platform during the 2018 open enrollment period. To access the snapshot, visit <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-12-28.html>.

These snapshots provide point-in-time estimates of weekly plan selections, call center activity and visits to HealthCare.gov or CuidadoDeSalud.gov. The final snapshot reports new plan selections, active plan renewals and automatic enrollments. It does not report the number of consumers who paid premiums to effectuate their enrollment. This snapshot also does not include plan selections from State-based Exchanges, other than those using the HealthCare.gov platform.

CMS plans to release a more detailed 2018 enrollment report in March, including final plan selection data from State-based Exchanges that do not use the HealthCare.gov platform.

Standing Assister Resources: Helpful Links / Call Center Hours / Contact Us

Links to Helpful Resources

- Marketplace Assister Training [Resources and Webinar](#)
- [Technical Assistance Resources](#)
- CMS Marketplace [Applications & Forms](#)
- CMS [Outreach and Education Resources](#)
- [Marketplace.CMS.gov Page](#)
- [CMSzONE Community Online Resource Library Pilot for Marketplace Assisters](#)
- [Find Local Help](#)

Marketplace Call Center and Shop Center Hours

Health Insurance Marketplace Call Center: 1-800-318-2596 (TTY: 1-855-889-4325). For customer service support, to start or finish an application, compare plans, enroll or ask a question. Available 24 hours a day, 7 days a week. Closed Memorial Day, July 4th, Labor Day, Thanksgiving Day and Christmas Day. CACs and Navigators should call their dedicated phone lines so the Call Center can better track the needs of assisters. The dedicated Assister Line can also help with password resets and can help with access to non-application SEPs. Contact your Navigator Project Officer (for Navigators) or your designated organization leadership (for CACs) for more information on the Assister Line.

Navigator Marketplace Call Center line: 1-855-868-4678

CAC Marketplace Call Center line: 1-855-879-2683

General consumer Call Center line: 1-800-318-2596 (TTY: 1-855-889-4325).

SHOP Call Center: For customer service support, including assisting employers and employees apply for and enroll in SHOP. 1-800-706-7893 (TTY: 711). Available M-F 9:00 am-7:00 pm EST. Closed New Year's Day, Martin Luther King Day, Memorial Day, July 3rd, Labor Day, Veterans Day, Thanksgiving and the day after, and Christmas.

Stay in Touch

To sign up for the CMS Weekly Assister Newsletter, please send a request to the Assister Listserv inbox (ASSISTERLISTSERV@cms.hhs.gov) write "Add to listserv" in the subject line, please include the email address that you would like to add in the body of your email. For requests to be removed from the listserv, please forward a copy of a webinar invite or newsletter received and write "Remove" in the subject line.

If you have specific questions or issues that you would like to see us highlight in our weekly webinar series or here in this newsletter please contact us.

- For HHS Navigator grantees - please get in touch with your Navigator Project Officer.
- For CAC Designated Organizations in FFM or SPM states - please send an email to CACQuestions@cms.hhs.gov.

Follow @HealthCaregov on Twitter with the hashtag #ACAassisters for updates, reminders, and new publications for assisters.

We welcome questions, suggestions and comments, so please feel free to contact us!

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Health Insurance Marketplace