Course 3 — Affordable Care Act Basics

Module 1 — Course Introduction

Affordable Care Act Basics

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Welcome

Welcome to the Affordable Care Act Basics course! My name is Jo and I'll help you learn how the Affordable Care Act (ACA) made health coverage more accessible and affordable to consumers. We'll review:

- How does the ACA protect consumers and help them get affordable health coverage?
- What responsibilities do health insurance companies have under the ACA?
- How does the ACA affect consumers who are eligible for public health coverage like Medicare and Medicaid?

Course Goal

Congress enacted the Patient Protection and Affordable Care Act on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 on March 30, 2010. Together, these two laws are referred to as the ACA.

Goal:

This course will help you understand the ACA, including major provisions, consumer protections, health insurance company and consumer responsibilities, and how consumers can lower their health coverage costs.

This course also introduces basic eligibility and benefit information for Medicaid, the Children's Health Insurance Program (CHIP), and Medicare coverage.

By the end of this course, you will understand:

- using the Marketplaces to obtain coverage
- consumer protections (coverage for preventive services, pre-existing conditions, etc.)
- requirements for insurers
- minimum essential coverage (MEC)
- individual shared responsibility provision and exemptions
- employer responsibilities
- options for lowering coverage costs
- advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs)
- modified adjusted gross income (MAGI)
- Medicaid expansion
- Medicaid, CHIP, and the Marketplaces

Module 2 — Overview of the ACA

Module Introduction

The Affordable Care Act (ACA) is a comprehensive health care reform law that provides rights and protections to consumers and makes health coverage more accessible. By the end of this module, you should be able to understand these concepts and accomplish the associated tasks below them.

Major Provisions

Identify the major provisions of the ACA.

Marketplaces

Describe how the Marketplaces can help consumers obtain health coverage.

Lower Costs

State how the ACA lowers consumers’ health coverage costs.

Major Provisions of the ACA

The ACA gives consumers tools to make informed choices about their health care coverage.

The law provides:

- Options for individuals, families, and small employers and their employees to enroll in health coverage
- Legal protections that help consumers get coverage — even if they're sick

Consumer Protections and Health Insurance Company Responsibilities

There are several key consumer protections under the ACA that make health coverage more accessible.

Qualified individuals are generally able to:

- Get affordable health coverage regardless of any pre-existing conditions.
- Access health coverage through the Marketplace in their state.
- Keep existing health coverage for young adults up to age 26 under a parent's plan.
- Obtain certain preventive services without cost sharing.

There are also several ways health insurance companies must make coverage easier to understand.

Major features of the ACA require most health insurance companies and the plans they offer to:

- Provide a standardized Summary of Benefits and Coverage (SBC) so consumers can easily understand their coverage and compare it to other available options.
- Refrain from excluding coverage for consumers based on pre-existing conditions.
- Refrain from terminating coverage after they have already agreed to cover consumers (unless an exception applies).
- Offer a core comprehensive set of benefits, known as essential health benefits (EHB), when offering coverage to individual consumers and small employers.
- Prohibit annual and lifetime dollar limits on coverage of EHB.

Consumer Protections and Health Insurance Company Responsibilities (Cont'd)

The following table explains the changes to consumer protections and health insurance company responsibilities under the ACA.

Provision	Before the ACA	Under the ACA
Preventive services	Consumers with health coverage generally paid a copayment or other cost sharing amount for common preventive health care services.	Most health plans — whether offered inside or outside of the Marketplaces — must cover certain preventive services (e.g., annual physicals, vaccines, and mammograms) without cost sharing.
Dollar limits on EHB	Federal law didn't prohibit health insurance companies from setting lifetime or annual dollar limits on the benefits they covered. After a consumer reached their annual or lifetime dollar limit, plans would no longer pay for covered services.	Health insurance companies generally can't set dollar limits on what they spend for coverage of EHB, either during the plan year or over the entire period that consumers are enrolled in the plan. However, health insurance companies can still set lifetime or annual dollar limits on covered benefits that aren't EHB.
Pre-existing conditions **These are health problems (e.g., diabetes or cancer) that started before an individual's health insurance went into effect.**	Federal law generally didn't prohibit health insurance companies from denying health coverage to consumers in the individual market based on pre-existing conditions.	The ACA guarantees that consumers with pre-existing conditions can apply for and purchase health insurance if they're otherwise eligible. Consumers may generally renew an existing policy regardless of their health status. Health insurance companies can no longer refuse to sell coverage to consumers with pre-existing conditions or charge them more for coverage because of a pre-existing condition.

Provision	Before the ACA	Under the ACA
Coverage cancellation	Federal law didn't prohibit health insurance companies from retroactively canceling consumers' coverage because of mistakes on their applications.	Insurers can only cancel a consumer's coverage retroactively if the consumer committed fraud and/or made an intentional misrepresentation of material fact. Unless an exception applies, health insurance companies must also refrain from canceling consumers' coverage if premiums are paid.
Coverage for young adults	States could limit how long young adults were allowed to remain enrolled in coverage through a parent's health insurance plan.	The ACA generally requires issuers in all states to allow children and young adults up to age 26 to stay on their parents' health insurance plans (if the plans cover dependent children). States may still elect to require issuers to cover young adults longer.
Explanation of benefits and coverage	Health insurance companies weren't required by federal law to explain the benefits and cost of coverage to consumers in ways that were clear and easy to understand.	Health insurance companies are required to provide clear, consistent, and comparable information about consumers' health benefits and coverage by providing a standard SBC for each plan, free of charge. Each plan's SBC must be written and presented in a standard format and use basic terms. Health insurance companies must also provide consumers with a uniform glossary of commonly used terms.

Lifetime dollar limits

Lifetime dollar limits are limits on what plans will pay for covered EHB during the entire time consumers are enrolled in a plan.

Annual dollar limits

Annual dollar limits are limits on what plans will pay for covered EHB over the course of the plan year.

Parents' health insurance plan

- For plans purchased through the Marketplace, issuers may not terminate coverage on the basis of age for dependent children until the end of the plan year (e.g., December 31) in which they turn 26 (or the minimum age under state law). The dependent will need to apply for their own plan for the next year during Open Enrollment.
- For plans purchased outside the Marketplace, coverage usually ends when the dependent turns 26 (or the minimum age under state law) or shortly thereafter. Consumers should check with their plans to be sure. Some states and plans have different rules. Dependents who lose coverage when they turn 26 are eligible for a Special Enrollment Period to enroll in other coverage.

Knowledge Check

The ACA provides consumers with several rights and protections. What is not a right or protection included in the ACA?

Answer: Under the ACA, issuers cannot sell plans that exclude coverage based on an enrollee's pre-existing condition. The law requires most health plans to cover certain preventive health services without cost sharing to consumers — including annual physicals. The ACA requires most plans that offer dependent child coverage to allow children and dependents to be covered under their parents' plans up to age 26 (for Marketplace plans, through December 31 of the year they turn 26) or other higher allowable age as defined by the state.

Knowledge Check

Health insurance companies have certain responsibilities under the ACA. What is not a responsibility for health insurance companies included in the ACA?

Answer: Under the ACA, nearly all health plans sold to individuals or small employers must cover a core comprehensive package of items and services known as EHB. Insurer must provide clear, consistent, and comparable information about consumers' health benefits and coverage, and they generally can't set dollar limits on what they spend for coverage of EHB. Insurer can only cancel a consumer's coverage retroactively if the consumer committed fraud or if the consumer made an intentional misrepresentation of material fact.

The Health Insurance Marketplaces

The ACA also established the Health Insurance Marketplaces. Eligible consumers can get coverage through the Marketplaces. Consumers who don't have health insurance through an employer, Medicare, Medicaid, CHIP, or another source that provides qualifying health coverage may also qualify for financial assistance through the Marketplaces.

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

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

State-Based Marketplaces

States that manage all Marketplace functions have an SBM.

Federally-Facilitated Marketplaces

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

SHOP Marketplaces

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

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

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

Small Employers

Generally, a small employer is one that:

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

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

You can find more information about small employers and their options at HealthCare.gov | Small Businesses.

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

SHOP Marketplaces (Cont'd)

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

Key differences between Marketplaces for individuals and families and the SHOP Marketplaces:

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

QHP

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

- the employee hasn't enrolled in the SHOP coverage offered by their employer
- the employer's offer isn't considered affordable and/or
- the employer's offer doesn't meet minimum value

Plan Year (PY) 2027 Marketplace Information by State

You can find important characteristics about your state's Marketplace by selecting your state in The Marketplaces in your State on the Healthcare.gov website. We encourage you to record your state's information and store it for easy access.

How Consumers Use the Marketplaces

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

The Marketplaces allow consumers to:

- use a single streamlined application to find out if they're eligible for coverage, including Marketplace coverage (i.e., QHPs), Medicaid and/or the Children's Health Insurance Program (CHIP)
- conduct an apples-to-apples comparison of QHPs

Individuals and families can also apply for programs to help lower their costs.

QHPs

Under the ACA, a health insurance plan that's certified by a Marketplace is called a QHP.

A QHP:

- provides EHB, including recommended preventive services that are covered with no additional out-of-pocket costs
- follows established limits on cost sharing (e.g., deductibles, copayments, coinsurance, and out-of-pocket maximum amounts)
- must be certified by each Marketplace in which it is sold
- meets other requirements

How Consumers Use the Marketplaces (Cont'd)

Eligible consumers can enroll in QHPs during the annual Open Enrollment Period or during an applicable SEP.

Additionally, consumers can apply for Medicaid and CHIP at any time during the year. Medicare and other public health coverage options have different annual Open Enrollment Periods and may offer their own SEPs for qualifying circumstances. Refer to Medicare.gov for the Medicare Open Enrollment dates.

Open Enrollment Period

In the FFM, the Open Enrollment Period typically starts on November 1. Coverage will begin on January 1 for consumers who enroll by December 15.

In the SHOP Marketplaces, eligible small employers determine their group's annual Open Enrollment Period for themselves and their eligible employees/dependents. Small employers can complete a group enrollment at any time during the year by working with a QHP issuer or SHOP-registered agent or broker.

Special Enrollment Period

Consumers who experience certain life events, like getting married or having a child, may qualify for an SEP to enroll in or change QHPs outside of the Open Enrollment Period.

In your capacity as an Assister, you must provide fair, accurate, and impartial information when you help consumers:

- apply for health coverage through the Marketplace, including QHPs, Medicaid, and CHIP
- compare QHPs
- apply for programs to help lower their QHP costs

Open Enrollment For 2027 Coverage: What's New

For Plan Year 2027, the Marketplace Open Enrollment Period starts on November 1, 2026, and ends January 15, 2027. Coverage will begin on January 1, 2027, for consumers who enroll by December 15, 2026.

Eligibility for QHP Coverage in the Marketplaces

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

- be U.S. citizens, U.S. nationals, or lawfully present non-citizens and reasonably expect to maintain this status for the entire time they plan to have coverage
- not be incarcerated (unless pending the disposition of charges)
- live in the U.S. and live in a state served by the Marketplace where they're applying

Incarcerated

For purposes of the Marketplace, "incarcerated" means serving a term in prison or jail.

- Incarceration doesn't mean living at home or in a residential facility under supervision of the criminal justice system or living there voluntarily. In other words, incarceration doesn't include probation, parole, or home confinement.
- A person isn't considered incarcerated if they're in jail or prison pending disposition of charges, or being held before a trial has concluded.

Essential Health Benefits

The ACA requires many types of health coverage to offer essential health benefits (EHB), including:

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

Essential Health Benefits

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

- ambulatory patient services (e.g., doctor and clinic visits)
- emergency services (e.g., ambulance, first aid, and rescue squad)
- hospitalization
- maternity and newborn care
- mental health and substance use disorder services, including behavioral health treatment
- prescription drugs
- rehabilitative and habilitative services and devices (e.g., therapy sessions, wheelchairs, oxygen)
- laboratory services
- preventive and wellness services and chronic disease management (e.g., blood pressure screening, immunizations)
- pediatric services, including dental and vision care

A note about dental coverage:

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

Health Plan Categories

Medical QHPs in the Marketplaces are separated into five categories:

1. Bronze
2. Silver
3. Gold
4. Platinum
5. Catastrophic

Catastrophic health insurance plans

Catastrophic plans are only available to individual market consumers under age 30 or consumers aged 30 or older who qualify for a hardship or affordability exemption (e.g., a life situation that may prevent them from affording health insurance coverage, like a flood or natural disaster). For PY 2027, individuals can be eligible for an affordability exemption if the amount they would pay for minimum essential coverage exceeds 8.50 percent of their annual household income. Catastrophic plans protect consumers from very high medical costs by only providing coverage when they need a lot of care. However, they do cover certain preventive services with no cost sharing and cover at least three primary care visits per year before the deductible is met. Generally, Catastrophic plans have lower premiums than the other health plan categories, but consumers are responsible for higher cost sharing amounts. Consumers can't use APTC and CSRs to lower the costs of a Catastrophic plan like they can with other health plan categories.

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

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

Bronze metal level: 60 percent

Insurance pays 60 percent on average

Consumer pays 40 percent on average

Silver metal level: 70 percent

Insurance pays 70 percent on average

Consumer pays 30 percent on average

Gold metal level: 80 percent

Insurance pays 80 percent on average

Consumer pays 20 percent on average

Platinum metal level: 90 percent

Insurance pays 90 percent on average

Consumer pays 10 percent on average

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

Out-of-pocket Maximums: What’s New

Starting with plan year 2027, the out-of-pocket maximum for most Marketplace plans will be $12,000 or self-only coverage and $24,000 for group coverage.

HealthCare.gov

Consumers can learn more about the ACA and the Health Insurance Marketplaces at HealthCare.gov, including:

- types of health coverage available
- consumer protections and benefits
- other information to make informed choices when applying for and enrolling in health coverage

For technical information about the Marketplaces or other information about the ACA, consumers can also visit:

- HHS Health Care website for information about the benefits and progress of the ACA
- Center for Consumer Information & Insurance Oversight (CCIIO) website for regulations, policy, and guidance from the Center for Consumer Information and Insurance Oversight (CCIIO)

The Marketplaces and other Marketplace-related resources are covered in detail in other training courses.

Knowledge Check

Susan, a hairstylist, comes to you to find out how the ACA can help her enroll in health coverage. What do you tell her?

Answer: The ACA allows consumers to compare QHPs and enroll in health coverage through the Marketplaces if they’re eligible.

Key Points

- The ACA:
  - provides consumer protections
  - requires health insurance companies to provide standard information for consumers to easily understand their coverage and compare it to other available options
  - requires that most individual and small group health insurance plans cover EHB
  - enables eligible consumers to get health coverage through the Marketplaces
  - provides access to coverage for certain preventive services without cost sharing under most health plans
- Marketplaces can be operated by a state, the Federal Government, or a combination of both.
- Individual Marketplaces collect and verify eligibility for consumers and their families.
- SHOP Marketplaces collect information from small employers.
- Eligible consumers can enroll in QHPs during the annual Open Enrollment Period or during a Special Enrollment Period.
- Consumers who enroll in a QHP through the Marketplaces for individuals and families may also be eligible for programs that lower costs.

Module 3 — Consumer Responsibilities Under the Affordable Care Act (ACA)

Module Introduction

In addition to understanding health insurance companies' responsibilities under the Affordable Care Act (ACA), you should be able to explain consumers' and employers' responsibilities. By the end of this module, you should be able to understand these concepts and accomplish the associated tasks below them.

Minimum Essential Coverage (MEC)

Describe the requirement for maintaining minimum essential coverage (MEC).

Exemptions

Understand who should apply for a hardship or affordability exemption through the Marketplace.

Employer Responsibilities

State the responsibilities of an employer under the ACA.

Minimum Essential Coverage (MEC)

The ACA requires consumers to have health coverage that's considered MEC or qualify for an exemption from the individual shared responsibility requirement.

The following consumer responsibilities will be discussed in this training:

- maintaining MEC
- individual shared responsibility provision
- hardship exemptions for Catastrophic coverage
- employer shared responsibility provisions

Types of Health Coverage That Qualify as MEC

Most private health insurance plans are considered MEC. Taxpayers are required by law to have MEC or qualify for a health coverage exemption. However, consumers who don't maintain MEC or qualify for a health coverage exemption do not need to make an individual shared responsibility payment because the Tax Cuts and Jobs Act reduced the individual shared responsibility payment to zero beginning with tax year 2019. Below are different types of health coverage and whether they qualify as MEC:

Types of Health Coverage That Qualify as MEC

- any Marketplace medical plan or any individual health insurance plan you already have (other than certain excepted benefits)
- most individual health plans bought outside the Marketplaces, including grandfathered plans (not all plans sold outside the Marketplaces qualify as MEC)
- employer-sponsored coverage, including retiree plans and Consolidated Omnibus Reconciliation Act (COBRA) continuation coverage
- Medicare Part A
- Medicare Part C (also known as Medicare Advantage)
- full benefit Medicaid coverage
- most Children's Health Insurance Program (CHIP) coverage, including CHIP buy-in programs that provide identical coverage to the state's Title XXI CHIP program
- coverage under a parent's plan (that qualifies as MEC)
- health coverage for Peace Corps volunteers
- certain types of veterans' health coverage through the Veterans Affairs (VA)
- most TRICARE plans
- Department of Defense Non-appropriated Fund Health Benefits Program
- Refugee Medical Assistance

Excepted benefits

Excepted benefits are health coverage that don't qualify as MEC, including but not limited to:

- coverage only for accidents
- disability income insurance
- liability insurance
- coverage issued as a supplement to liability insurance
- worker's compensation or similar insurance
- long-term care benefits
- limited scope dental or vision benefits
- coverage only for a specific disease or illness (e.g., cancer policies)
- Medicare supplemental health insurance (e.g., Medigap or MedSupp insurance)

Types of Health Coverage That Do Not Qualify as MEC

Types of Health Coverage That Do Not Qualify as MEC

- Medicaid coverage of family planning services only
- Medicaid coverage of emergency services only
- coverage only for vision care or dental care
- workers' compensation
- coverage only for a specific disease or condition
- medical discount plans, or plans that offer only discounts on medical services

Exemptions from the Requirement to Have MEC

Consumers who don’t have MEC for part or all of a tax year don’t need to make an individual shared responsibility payment or file Form 8965, Health Coverage Exemptions, with their tax returns.

However, individuals aged 30 and above must continue to apply for, obtain, and report an exemption certificate number (ECN) for a Marketplace affordability or hardship exemption if they wish to purchase Catastrophic health coverage. We will cover this process later in this course.

Employer Shared Responsibility Payment

Some employers with 50 or more full-time and full-time-equivalent (FTE) employees who don't offer MEC may be subject to a fee called the employer shared responsibility payment. If they do offer MEC to their employees, they may still have to pay a fee if their offer of coverage:

- isn’t affordable
- doesn’t meet the minimum value standard

These terms will be defined in the next module.

Employers may pay a fee if at least one full-time employee enrolls in a plan through a Marketplace and receives advance payments of the premium tax credit (APTC).

Knowledge Check

Jackie is a 28-year-old freelance writer who earned more than $50,000 this year. She didn't enroll in a qualified health plan (QHP) or obtain MEC for the year. Jackie is concerned because she heard she'll have to pay a fee. What should you explain to Jackie?

Answer: Even if Jackie is self-employed and not offered employer-sponsored coverage, she is still required to maintain MEC under the ACA. However, Jackie won’t owe a fee for failing to obtain MEC. As of 2019, individuals who choose to go without insurance are not subject to making shared responsibility payments.

Key Points

- Consumers are required to maintain MEC under the ACA.
- Consumers who didn’t maintain MEC during tax year 2019 or later are not subject to making individual shared responsibility payments because the fee is reduced to $0.
- Certain employers may have to pay a fee if the coverage they offer employees isn’t affordable or doesn’t meet minimum value.

Module 4 — Lowering Consumers' Health Coverage Costs

Module Introduction

The Affordable Care Act (ACA) created insurance affordability programs that can lower eligible consumers' costs when they enroll in health coverage through a Marketplace. When determining consumers' eligibility for advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs), the Marketplaces count consumers' incomes differently from public health coverage programs like Medicaid and the Children's Health Insurance Program (CHIP). You're responsible for explaining how consumers' modified adjusted gross income (MAGI) is used to determine their eligibility for each of these programs under the ACA. By the end of this module, you should be able to understand these concepts and accomplish the associated tasks below them.

Options to Lower Costs

Discuss the options in the ACA that can help eligible consumers lower their health coverage costs.

Advance Payments of the Premium Tax Credit (APTC)

Describe the premium tax credit.

Cost-sharing Reductions (CSRs)

Describe CSRs available to eligible individuals who enroll in a Silver health plan.

Income Types

Identify the income types included in MAGI for determining eligibility for Medicaid and CHIP.

Medicaid Expansion

Describe how some states have expanded their Medicaid programs to cover low-income adults.

Options for Lowering Health Coverage Costs

Consumers' household income and family size can determine whether they qualify for three types of savings:

- Consumers may be eligible to receive APTCs that can be used in advance to reduce monthly premiums when they enroll in a qualified health plan (QHP) through a Marketplace.
- Consumers may qualify for additional savings like lower copayments, coinsurance, and deductibles.
- Consumers and/or their children may be eligible for coverage through Medicaid or CHIP.

Premium Tax Credits

If consumers' projected annual household income falls between 100 percent and 400 percent of the federal poverty level (FPL), they may qualify for a Premium Tax Credit (PTC) when they file federal income tax returns.

PTCs are only available to consumers who enroll in QHPs through a Marketplace. Eligible consumers can use all, some, or none of their PTC in advance to lower their monthly premiums — these are called advance payments of premium tax credits (APTCs). You will learn about eligibility for APTCs later in this module.

Consumers with lower incomes or larger household sizes generally qualify for larger PTCs. For example, a family of two with a yearly household income of $35,000 would receive a larger PTC than a family of two with a yearly income of $45,000 if all else is equal.

You will learn more about reconciling APTC with PTC in another training course.

Federal Poverty Level (FPL)

The federal poverty guidelines, often referenced as FPL, are a version of the federal poverty measure. They are issued each year by the Department of Health and Human Services (HHS). The guidelines are used to help determine consumers' financial eligibility for certain programs and benefits, including savings on Marketplace health insurance, Medicaid, and CHIP coverage.

For more information about the FPL, visit the Office of the Assistant Secretary for Planning and Evaluation (ASPE) HHS Poverty Guidelines.

2026 FPL Table

The Marketplaces will use the 2026 FPL table for eligibility determinations for PY 2027.

Below is the 2026 FPL table for the 48 contiguous states and D.C. (Visit ASPE HHS Poverty Guidelines FPL levels for Alaska and Hawaii.)

Household Size	100 percent	133 percent	150 percent	200 percent	250 percent	300 percent	400 percent
1	$15,960	$21,226.80	$23,940	$31,920	$39,900	$47,880	$63,840
2	$21,640	$28,781.20	$32,460	$43,280	$54,100	$64,920	$86,560
3	$27,320	$36,335.60	$40,980	$54,640	$68,300	$81,960	$109,280
4	$33,000	$43,890	$49,500	$66,000	$82,500	$99,000	$132,000
5	$38,680	$51,444.40	$58,020	$77,360	$96,700	$116,040	$154,720
6	$44,360	$58,998.80	$66,540	$88,720	$110,900	$133,080	$177,440
7	$50,040	$66,553.20	$75,060	$100,080	$125,100	$150,120	$200,160
8	$55,720	$74,107.60	$83,580	$111,440	$139,300	$167,160	$222,880

Premium Tax Credits (Cont'd)

To be eligible for PTC, a consumer must:

- be a non-incarcerated U.S. citizen, U.S. national, or beginning January 1, 2027, be an eligible noncitizen.
- generally, have a household income between 100 percent and 400 percent of the FPL
- have no other minimum essential coverage (MEC) and not be considered eligible for MEC other than individual health insurance coverage, including employer-sponsored coverage that is *affordable (and meets the *minimum value standard)
- file a federal income tax return for a prior benefit year in which the consumer enrolled in a QHP and received APTC and attest to reconciling APTC
- file a joint tax return if married, unless the consumer is a survivor of domestic abuse or spousal abandonment
- not be claimed as a dependent on another taxpayer's federal income tax return

Affordable

An offer of employer-sponsored coverage is considered affordable if the employee's required contribution for self-only coverage does not exceed the required contribution percentage of household income.

The Internal Revenue Service (IRS) issued new regulations in Plan Year 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.

Required Contribution

The required contribution is the portion of the annual premium the employee must pay for self-only coverage. For PY2027, the required contribution is 10.22 percent of household income.

Plan Year 2023

Before Plan Year 2023, 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 any family members was not taken into account.

Minimum Value

Minimum value is a standard of minimum coverage that applies to employer-sponsored health plans. A health plan meets the minimum value standard if, for both the employee and their family members:

- it's designed to pay at least 60 percent of the total cost of medical services for a standard population, and
- its benefits include substantial coverage of physician and inpatient hospital services

Premium Tax Credit Eligibility for Immigrants: What's New

Here are some recent updates in premium tax credit eligibility policy for immigrants.

Marketplace PTC Eligibility for Immigrants

Beginning January 1, 2027, Marketplace premium tax credit (PTC) eligibility for immigrants will be restricted to individuals who are eligible noncitizens, which includes individuals who are:

- Lawful Permanent Residents (LPRs or green card holders)
- Cuban or Haitian entrants
- Compact of Free Association (COFA) migrants

Individuals Who Will No Longer Be Eligible for PTCs

Individuals with the following lawfully present statuses, who had previously been considered eligible for PTCs, will no longer be eligible beginning January 1, 2027, but can still apply for full price coverage:

- asylees;
- refugees;
- individuals paroled into the U.S. for at least one year;
- conditional entrants granted entry to the U.S. before 1980;
- survivors of domestic violence with a pending or approved application for lawful status under the Violence Against Women Act;
- survivors of trafficking and their spouses, children, siblings, or parents, including individuals with a pending application for a Victim of Trafficking visa;
- individuals who are granted Withholding of Deportation;
- member of a Federally recognized Indian Tribe or American Indian born in Canada;
- individuals with Temporary Protected Status;
- individuals with employment visas, student visas and other temporary, and valid visas;
- individuals with U-visas; and
- all other statuses considered lawfully present

These individuals can still apply for full-price Marketplace coverage.

Premium Tax Credits (Cont'd)

Explain to consumers that — when they file federal income tax returns for the year — the amount of APTC they use could affect the amount of taxes they owe the IRS or the refund they get back when they reconcile their APTC.

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

You should always make sure consumers understand the importance of reporting changes in household income and other eligibility factors as soon as they occur.

APTC Reconciliation

When consumers file federal income tax returns, they need to use IRS Form 8962 to calculate the amount of PTC they were eligible for during the year and reconcile that amount with any APTC they received. You can learn more about APTC reconciliation in *Course 5: Marketplace Application Essentials*.

Consumers must file a federal income tax return for any year during which they receive APTC. Consumers who didn't file a federal income tax return in previous years when they didn't receive APTC can still qualify for APTC if they are otherwise eligible.

Cost-sharing Reductions: Out-of-pocket Savings Only with a Silver Plan

Some consumers who apply for coverage through the Marketplaces and are determined eligible for APTC may also qualify for additional savings called CSRs. Consumers who qualify for income-based CSRs and enroll in a Silver plan through a Marketplace may save money a second way — by paying less out of pocket when they get certain services.

To be eligible for CSRs based on income, consumers must meet the following requirements:

- Have a household income under 250 percent of the FPL
- Be eligible to receive APTC
- Enroll in a Silver plan through a Marketplace

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

Cost-sharing Reductions for American Indians and Alaska Natives

Members of Federally recognized Indian Tribes qualify for zero cost-sharing, which means no copays, deductibles or coinsurance when receiving care from Indian health care providers (IHCP), regardless of which metal level health plan they choose. They can also continue to receive health services from the following:

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

For more information on helping American Indians and Alaska Natives with Marketplace coverage, refer to *Course 6: Serving Select Population Groups and Communities*.

The Impact of CSRs on Affordability

If consumers qualify for CSRs and enroll in a Silver plan:

- **They will generally have a lower deductible.** This means the plan starts to pay its share of consumers' medical costs sooner. For example, if a Silver plan has a $750 deductible, a consumer would normally have to pay the first $750 of medical care before the insurance company pays for anything (other than certain preventive services included without cost sharing, like annual physicals). A consumer eligible for CSRs might have a $300 or $500 deductible for that same Silver plan depending on their household income.
- **They will generally have lower copayments or coinsurance.** These are payments consumers make each time they get care. For example, if a particular Silver plan has a $30 copayment for a doctor visit, a consumer eligible for CSRs might pay $15 or $20 for doctor visits under that same plan.
- **They will generally have a lower "out-of-pocket maximum."** This is the maximum amount a consumer could have to pay for their health care costs for EHB in a year. For example, if a particular Silver plan has a $5,000 out-of-pocket maximum, a consumer eligible for CSRs might have a $3,000 out-of-pocket maximum under that same plan.

Use this HealthCare.gov See Plans & Prices tool to search for Silver plans available in a consumer's area.

Knowledge Check

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

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

Modified Adjusted Gross Income

Modified Adjusted Gross Income (MAGI) is used by Marketplaces and state Medicaid and CHIP agencies to determine a household's income when calculating eligibility for APTC and CSRs, and most categories of Medicaid eligibility and CHIP.

Generally, MAGI includes:

- a household's adjusted gross income (AGI)
- untaxed foreign income
- non-taxable Social Security benefits and
- tax-exempt interest

For example, earned wages and unemployment benefits are counted in MAGI calculations while most kinds of cash assistance, including child support and Supplemental Security Income (SSI), are not.

State Medicaid and CHIP agencies calculate MAGI using current monthly income, while the Marketplaces use annual income. Medicaid and CHIP agencies also construct a MAGI household by counting a pregnant woman's household as including the number of children expected in the household size, whereas the Marketplaces always count a pregnant woman as one in the household. There are some other key differences in how agencies count MAGI. Refer to the MAGI Calculation section below to learn more.

Most Categories

MAGI is generally used to determine Medicaid and CHIP eligibility for children, pregnant women, parents, and other adults who may be eligible.

Adjusted Gross Income (AGI)

Federal tax rules for determining AGI include the following types:

- earned income (e.g., wages, salary, or any compensation for work) minus any pretax deductions (i.e., dependent care, retirement)
- net income from self-employment
- taxable Social Security income, including Social Security Disability Insurance (SSDI) and retirement benefits but not Supplemental Security Income
- unemployment benefits
- investment income, including interest, dividends, and capital gains

MAGI Calculation

MAGI for Medicaid and CHIP is based on current monthly income rather than annual income. Some states may use a MAGI-based flexibility for predictable income fluctuations to make more accurate monthly income determinations. MAGI doesn't consider resources like bank accounts or stocks when determining Medicaid eligibility.

For MAGI calculations for Medicaid and CHIP, an amount received as a lump sum is counted as income only in the month it was received. Gambling and lottery winnings count as income in the month they were received if the amount is less than $80,000, and count as income over more than one month if greater than $80,000.

The MAGI calculation for Medicaid, CHIP, and other programs does NOT include:

- educational scholarships, awards, or fellowship grants not used for living expenses.
- certain American Indian or Alaska Native income, like:
  - distributions from Alaska Native Claims Settlement Act (ANCSA) Corporations and Settlement Trusts
  - distributions from any property held in trust, subject to federal restrictions located within the most recent boundaries of a prior federal reservation, or otherwise under the supervision of the Secretary of the Interior
  - distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from:
    - rights of ownership or possession in any lands or
    - federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources
  - distributions resulting from real property ownership interests related to natural resources and improvements:
    - located on or near a reservation or within the most recent boundaries of a prior federal reservation or
    - resulting from the exercise of federally protected rights relating to such real property ownership interests
  - payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom
  - student financial assistance provided under the Bureau of Indian Affairs education programs or an Indian Tribe
  - income that falls within the IRS General Welfare Doctrine; or
  - any other income that is non-taxable according to federal law or IRS guidance

Modified Adjusted Gross Income (Cont'd)

Household size and composition are also important factors when calculating MAGI. For many people, the basic equation for calculating household size, or the number of individuals in a family, is:

Tax Filers + Tax Dependents = Household Size

Because people who do not file federal income taxes can be eligible for and enroll in Medicaid or CHIP, in determining Medicaid and CHIP eligibility, consumers' household size may 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.

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

Some Medicaid and CHIP agencies have elected 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.

MAGI Family Size and Income Counting Rules

MAGI used by the Marketplace is determined based on federal tax rules for how income is counted. MAGI income largely aligns Medicaid and CHIP income tests with eligibility for advanced payments of premium tax credits. Generally, the MAGI of all individuals in an individual's household must be counted toward household income. Family size for Medicaid is determined differently from household size for Marketplace. Marketplace consumers must file a federal income tax return for any year during which they receive APTC. However, filing a federal income tax return is not a condition of Medicaid.

Do individuals need to file federal income tax returns to count their household sizes accurately for Medicaid or CHIP?

No. Individuals who apply for Medicaid or CHIP don't need to file federal income tax returns or be claimed as dependents on someone else's federal income tax return. For Medicaid and CHIP eligibility, household size for consumers who do not plan to file a federal income tax return can be based on immediate family members they live with like a spouse, children and their siblings.

Is MAGI used to determine a consumer's eligibility for APTC and CSRs through a Marketplace?

Yes, but with some modifications compared to Medicaid and CHIP. For example, Medicaid and CHIP generally rely on current monthly household income to determine eligibility. However, the Marketplaces rely on projected annual household income for the year consumers are seeking coverage when they assess eligibility for APTC and CSRs. This means consumers need to estimate their income for the year and report any changes to the Marketplaces as soon as they happen.

Remember, Medicaid and CHIP MAGI calculations don't include certain American Indians or Alaska Natives income.

Duty to Report Accurate Income

You should always help consumers report their current and projected yearly income accurately to the best of their knowledge (and make changes as soon as they occur) and remind them not to misrepresent personal information.

All consumers who apply for health coverage through a Federally-facilitated Marketplace (FFM) must sign their applications under penalty of perjury. The Federal Government can impose monetary penalties on any person who provides false information on a Marketplace application.

Medicaid/CHIP and the Marketplaces: Assessment Versus Determination

When a consumer applies for coverage and help paying for it, the Marketplaces also assess or determine the consumer’s eligibility for Medicaid and CHIP. You should be able to explain the role of the Marketplace in your state in assessing or determining consumers' eligibility for these programs.

In a Medicaid/CHIP assessment state, the Marketplace uses Medicaid and CHIP rules and applicable state-specific rules to evaluate a consumer’s application and make a preliminary assessment of eligibility for MAGI-based Medicaid or CHIP. If the Marketplace assesses the consumer as potentially eligible on a MAGI basis, the Marketplace sends the consumer’s account information to the state Medicaid /CHIP agency via a secure account transfer (AT) for a final eligibility determination by the state. The state then requests additional information from the consumer needed before conducting a final eligibility determination, sending a notice to the consumer with the final eligibility determination, and enrolling the consumer in Medicaid or CHIP coverage, as applicable.

In a Medicaid or CHIP determination state, the state formally delegates to the Marketplace the authority to make final eligibility determinations for MAGI-based Medicaid and/or CHIP, when the application information is fully verified. Therefore, the Marketplace uses Medicaid and/or CHIP rules and applicable state-specific rules to evaluate a consumer's MAGI and, if no verification issues are present, makes a final determination of eligibility for MAGI-based Medicaid and/or CHIP. The Marketplace sends the consumer’s account information to the state Medicaid/CHIP agency via AT for applicable next steps, such as prompt enrollment (for fully verified applications), completion of outstanding eligibility verifications and subsequent final eligibility determination and enrollment, and consumer notification.

Medicaid/CHIP and the Marketplaces: Assessment Versus Determination (Cont'd)

When a consumer applies for coverage and help paying for it, the Marketplaces also assess or determine the consumer's eligibility for Medicaid and CHIP. You should be able to explain the role of the Marketplace in your state in assessing or determining consumers' eligibility for these programs.

Consumers will be automatically referred via AT from the Marketplace to the state Medicaid agency if they seem potentially eligible for Medicaid on a non-MAGI basis, based on their responses to certain questions on the Marketplace application. State agencies in FFM states (regardless of assessment or determination status) must make final eligibility determinations for all non-MAGI referrals. Consumers may contact their state Medicaid or CHIP agency directly for more information or to appeal a determination.

In addition, an applicant whom the Marketplace evaluates as ineligible for MAGI-based Medicaid, and who did not attest to a recent Medicaid/CHIP denial by the state, can request that their application be sent to the state for a full determination. If this is requested by a consumer:

- In an assessment state, the state must determine the applicant's eligibility on all bases (MAGI and non-MAGI).
- In a determination state, the state must determine the applicant's eligibility only on a non-MAGI basis, as the Marketplace has already made a final determination based on MAGI.

The appeals process is described in *Course 5: Marketplace Application Essentials*.

CHIP Eligibility and the Marketplaces

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

Medicaid/CHIP Eligibility for Immigrants: What's New

Here are some recent updates in Medicaid/CHIP Eligibility policy.

Medicaid/CHIP Eligibility for Immigrants

As of October 1, 2026, Medicaid/CHIP eligibility for immigrants will be restricted to individuals who are:

- Lawful Permanent Residents (LPRs or green card holders)
- Cuban or Haitian entrants
- Compact of Free Association (COFA) migrants
- Lawfully present children and pregnant women in states that offer coverage under Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), often referred to as the "CHIPRA 214 option"

Lawful Permanent Residents are still subject to the five-year waiting period before they can qualify for Medicaid/CHIP, unless they meet an exception or are covered under the CHIPRA 214 option. Cuban/Haitian entrants and COFA migrants continue to be excepted from the five-year waiting period.

Emergency Medicaid

Coverage remains available in Medicaid for the treatment of an emergency medical condition only (often referred to as "emergency Medicaid") for all other noncitizens if they meet all other eligibility requirements in the state, except for having U.S. citizenship or an eligible immigration status.

Lowering Consumers' Healthcare Costs

Meet George: Lowering Consumers' Health Care Costs

Your training has prepared you to:

- Discuss options to help lower health coverage costs
- Describe the PTC
- Describe CSRs
- Identify the income types included in MAGI for determining eligibility for Medicaid and CHIP

George:

- Is 30 years old
- Works at a coffee shop
- Employer doesn't offer health insurance
- Makes $26,000 a year (between 150 percent and 200 percent of the FPL)

Based on his income only, which programs will George likely be eligible for when he submits his application through a Marketplace?

Does George qualify for:

- Children's Health Insurance Program (CHIP)?
- Medicaid?
- Premium Tax Credit (PTC)?
- Cost Sharing Reductions (CSRs)?

CHIP is generally only available for children up to age 19, so it would not apply to George.

George is likely above the income threshold for Medicaid.

PTC Eligibility: 100-400% FPL

It's likely that George will be eligible for the PTC if he enrolls in a Marketplace plan.

CSRs: 100-250% FPL

It's likely George will be eligible for CSRs if he enrolls in a Silver plan.

Thanks a latte! You've given George a better understanding of options for lowering his health coverage costs.

Medicaid Adult Expansion

The ACA aims to significantly reduce the number of uninsured consumers by providing affordable coverage options through the Marketplaces, Medicaid, and CHIP. Under the law, most (but not all) states have expanded their Medicaid programs to cover adults with household incomes below a certain level.

Whether consumers qualify for Medicaid coverage may depend in part on whether their state has expanded its program to low-income adults.

- In all states: Consumers can qualify for Medicaid based on income, household size, disability, age, pregnancy status, status as a current or former foster youth, parent and caretaker status, and other factors. Eligibility rules differ among states.
- In states that have expanded Medicaid coverage: In addition to the above, consumers who are adults age 19 through 64, not pregnant, and not entitled to or enrolled in Medicare and have household income below 133 percent of the FPL (In practice, below 138 percent of the FPL) can qualify for Medicaid.

The Marketplaces help consumers receive an assessment or a determination about whether they qualify for Medicaid based on these criteria. The table on this page shows how much household income consumers in states that have expanded Medicaid coverage can earn and still qualify for Medicaid in the adult group. These amounts are higher for consumers in Alaska and Hawaii. FPL guidelines are updated and published yearly by HHS in January or February, and Medicaid and CHIP eligibility is based on the new guidelines once they're released. Please note that Marketplaces and state Medicaid agencies may use FPL tables from different years.

You should know whether the state you're working in has expanded Medicaid eligibility for adults and the applicable eligibility level. Additional information on Medicaid expansion is provided later in the training. You can use the "Marketplaces by State" map in the course menu to determine if states have expanded Medicaid.

Based on HHS Poverty Guidelines for 2026 for the 48 contiguous states and D.C.

In Practice

The ACA's MAGI calculation is based on taxable income as defined in the Internal Revenue Code. For Medicaid and CHIP, the MAGI-based methodology includes an extra five percentage points of the FPL (when considering eligibility for the MAGI-based group with the highest income standard). With this five-percentage-point-equivalent disregard, the Medicaid adult group eligibility threshold is 138 percent of the FPL.

Medicaid Adult Expansion and the Marketplaces

You can help consumers apply for Medicaid through the Marketplace application process. If a consumer isn't eligible for Medicaid because your state hasn't expanded Medicaid, that person might still be eligible for programs to help lower their costs through the Marketplaces.

Consumers with household incomes between 100 percent and 138 percent of the FPL may be eligible for insurance affordability programs through the Marketplaces (i.e., APTC and CSRs) if:

- their state hasn't expanded Medicaid
- they have been determined ineligible for Medicaid

For the latest information on state plans for Medicaid expansion, refer to The Marketplaces in your State.

Medicaid Expansion: What's New

Three changes to Medicaid eligibility go into effect January 1, 2027, specifically:

1. States will be required to conduct semi-annual eligibility determinations for adults eligible for Medicaid under Medicaid expansion.
2. States must impose community engagement requirements for adults eligible for Medicaid under Medicaid expansion. Most adults between the ages of 19 and 64 will have to complete a minimum of 80 hours of qualifying community engagement activities for one month (or up to 3 consecutive months at state option) prior to an initial application as a condition of Medicaid eligibility. Qualifying community engagement activities include work, participation in a work program or community service, or enrollment in an education program. Certain adults are not subject to the new requirement, such as:
    - American Indians and Alaska Natives
    - Former foster children below the age of 26
    - Individuals compliant with TANF work requirements and individuals not exempt from SNAP work requirements
    - Individuals who are pregnant or entitled to Medicaid postpartum coverage
    - Individuals who are medically frail or otherwise have special medical needs
    - Inmates of a public institution
    - Parents, guardians, caretaker relatives, or family caregivers of a dependent child 13 years of age or under or of a disabled individual
    - Participants in a drug or alcohol rehabilitation or treatment program, and
    - Veterans with a disability rated as total.
3. Retroactive eligibility will be limited to two months (reduced from three) for all Medicaid-eligible populations except the Medicaid expansion population and limited to one month for the Medicaid expansion population.

Medicare and the Marketplace

It's important that consumers close to age 65 applying for coverage through a Marketplace know the benefits of enrolling in Medicare as soon as they become eligible.

Consumers who don't sign up for Medicare during their Initial Enrollment Period (IEP) or another available enrollment period and don’t have employer-sponsored coverage (ESC, including coverage through a SHOP Marketplace) may have to pay higher premiums if they sign up for Medicare later.

Beginning January 1, 2023, consumers who were unable to enroll during their IEP or another available enrollment period due to exceptional circumstances can access five new Medicare special enrollment periods (SEPs) that allow them to enroll without having to wait for the general enrollment period (GEP) and without being subject to a late enrollment penalty. The SEPs are for eligible individuals who miss an enrollment opportunity because:

1. They were impacted by a disaster or government-declared emergency.
2. Their employer or health plan materially misrepresented information related to timely enrollment in Medicare Part B.
3. They were released from incarceration.
4. They missed a Medicare enrollment period to enroll in Medicare after termination of Medicaid eligibility.

They demonstrate to the Centers for Medicare & Medicaid Services (CMS) that they missed an enrollment period because of an event or circumstance outside of their control and those conditions are exceptional in nature.

Medicare and the Marketplace (Cont'd)

Review the following scenarios to learn what you should tell consumers depending on their circumstances.

If consumers are receiving Social Security retirement or Social Security disability benefits…

Then consumers… Will be automatically enrolled in premium-free Part A and Part B once they are eligible. The consumer will receive information about Medicare in the mail a few months before they're automatically enrolled in Part A and Part B.

And… They should consider signing up for Part D during their IEP so they will have prescription drug coverage on their first day of eligibility and so they don't have to pay a late enrollment penalty.

If consumers are newly eligible for Medicare and don't get Social Security benefits yet…

Then consumers… Will have an IEP to sign up for Part A and Part B and can contact Social Security to sign up for Medicare. These consumers should also consider applying for Part D at that time if they want prescription drug coverage. If the individual signs up for Part D later, a late enrollment penalty may apply.

And… For someone turning 65 years old, the IEP includes the three months before, the month of, and the three months after they turn 65. If consumers don't sign up for Medicare during their IEP and don't have ESC (including coverage through a SHOP Marketplace), they may have to pay a late enrollment penalty or wait for a General Enrollment Period to enroll in Part B coverage. There are also Special Enrollment Periods for individuals who experience certain circumstances.

If consumers have ESC coverage based on current employment, including coverage through a SHOP Marketplace...

Then consumers… Should consider signing up for premium-free Part A (if eligible) when their IEP begins. The individual may wish to consider whether they can delay enrollment in Part B until the ESC or current employment ends, whichever occurs first, and at which time they may be able to apply during the SEP that the end of coverage is based on.

If consumers are eligible for programs to lower their QHP costs through a Marketplace (i.e., APTC and CSRs)…

Then consumers… Will lose eligibility for APTC and CSRs through a Marketplace plan when they become eligible for premium-free Part A based on their age or when their Part A coverage starts, regardless of the basis for their eligibility.

Note: Consumers who are enrolled in a Marketplace plan first and then become eligible for Medicare can stay enrolled in the Marketplace plan but will no longer qualify for APTC or CSRs once Medicare begins.

If consumers want help to pay for some of their health care costs that their Medicare doesn't cover...

Then consumers… If they are enrolled in the Medicare Fee-For-Service Program (also called Original Medicare or Traditional Medicare), should consider purchasing a Medicare Supplement Insurance (Medigap) policy.

And… For consumers enrolled in Original Medicare (Part A and Part B) and a Medigap policy, Medicare and Medigap will each pay their share of covered health care costs. Generally, when a consumer buys a Medigap policy, they must have Part A and Part B.

Note: Part C (called Medicare Advantage or MA) is not a Medigap policy. Consumers can’t enroll in a Medigap policy if they are enrolled in an MA plan because Medigap only helps consumers with costs Original Medicare (Part A and Part B) doesn't cover. MA Plans are a type of Medicare health plan offered by private insurance companies that contract with Medicare to provide Part A and Part B benefits. Most MA Plans also offer prescription drug coverage (Part D) for enrollees, and some MA plans may offer other supplemental benefits. For more information, visit Medicare.gov.

Medicare and the Marketplace (Cont'd)

Some consumers may have Marketplace coverage and then become automatically enrolled in Medicare later. Let's take a look at what these consumers need to know.

Automatically Enrolled in Medicare

- Generally, consumers are automatically enrolled in premium-free Part A and Part B without an application if they're getting Social Security or Railroad Retirement Board benefits when they meet the entitlement or eligibility requirements for Medicare.
- Additionally, consumers who are receiving Social Security disability benefits are automatically enrolled in Medicare premium-free Part A and Part B in the 25th month of their disability payments.
- Coverage begins the first day of the month they turn 65, but the coverage start date may vary if a consumer is enrolled in disability benefits.

Automatically Enrolled in Medicare and Have Marketplace Coverage

If consumers are automatically enrolled in Medicare, it's important to provide information about when they might be automatically enrolled and how to terminate their Marketplace coverage to avoid gaps in coverage and dual coverage. Marketplace coverage doesn't automatically end when a consumer is enrolled in Medicare.

If consumers are not automatically enrolled in Medicare, they might come to you for help deciding between Marketplace coverage and Medicare. Remember, Part A and Medicare Advantage/Part C count as MEC just like Marketplace plans. However, you should inform these consumers of the consequences of delaying Medicare enrollment—they may have to pay higher premiums if they don't sign up during their IEP. It's also important for these consumers to know they aren't eligible to receive financial assistance from a Marketplace to help lower the costs of coverage (i.e., APTC and CSRs) if they're also eligible for Medicare that counts as MEC.

Remember, some Medicare eligibility scenarios are complex. It is a best practice to refer these consumers to their SHIP or another organization for more detailed information about Medicare.

New HealthCare.gov Application Questions Regarding Medicare Eligibility and Enrollment

The HealthCare.gov application now screens for potential Medicare eligibility when consumers enter their birthdate in the Setup section of the application. If consumers answer “Yes,” the application then asks about their Medicare start date.

Medicare and Immigrant Eligibility: What's New

Under section 1899C(b)(2)(B) of the Social Security Act, only the following individuals may be eligible for Medicare coverage or may enroll in Medicare Advantage Plans under Medicare Part C or Medicare Part D Plans, if they meet all other Medicare eligibility requirements:

- U.S. citizens or nationals
- Lawful Permanent Residents (green card holders)
- Cuban/Haitian entrants
- Compact of Free Association (COFA) migrants

Individuals who were entitled to or enrolled in Medicare as of July 4, 2025, and who are not U.S. citizens, U.S. nationals, lawful permanent residents, Cuban-Haitian entrants, or COFA migrants must be notified as soon as practicable that they are no longer eligible and must be disenrolled from Medicare 18 months after July 4, 2025 enactment date of Public Law 119-21. CMS expects to provide more information on implementation of section 1899C in forthcoming guidance.

You can learn more about Medicare eligibility for immigrants in *Course 6: Serving Select Population Groups and Communities.*

Consumers who aren't U.S. citizens can contact the Social Security Administration (SSA) for more information about Medicare eligibility requirements.

Key Points

- Consumers may be able to lower their cost for Marketplace plans with APTC and CSRs.
- Generally, consumers who receive APTC must reconcile them when they file their federal income tax returns.
- When assessing consumers' eligibility for APTC, CSRs, most categories of Medicaid eligibility, CHIP, all Marketplaces, and state Medicaid and CHIP agencies determine household income using MAGI.
- The Federal Government can impose monetary penalties on any person who provides false information on a Marketplace application.
- Some states have expanded their Medicaid programs to cover certain low-income adults.
- Research whether the state you’re working in has expanded Medicaid eligibility for adults and the applicable FPL.

Conclusion

Congratulations! You learned the key features of the ACA, including provisions that can help eligible consumers lower their health coverage costs. You also read about the responsibilities that consumers must meet to obtain health coverage.

You've finished the learning portion of this course. If you choose to take the exam, the code to access this exam is: 732133. Or you can close the course and return to the exam later.

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 — Overview of the ACA

More Information about the ACA: The text of the Affordable Care Act at HealthCare.gov.

Healthcare.gov/where-can-i-read-the-affordable-care-act/

HealthCare.gov: People Under 30 — How to get or stay on a parent's plan.

Healthcare.gov/young-adults/children-under-26/

HealthCare.gov: People Under 30 — In School? Student health plans and other options.

Healthcare.gov/young-adults/college-students/

Catastrophic Plans: Information on Catastrophic health plans.

Healthcare.gov/choose-a-plan/catastrophic-health-plans/

HealthCare.gov: The Marketplace if you have Medicare.

Healthcare.gov/medicare/

SHOP: Information about small employers and their options

Healthcare.gov/small-businesses/employers/

Medicare.gov: More information about Medicare benefits and enrollment process.

Medicare.gov/

Health Benefits and Coverage: Preventive health services.

Healthcare.gov/coverage/preventive-care-benefits/

Consumer Information and Insurance Oversight: Ensuring the Affordable Care Act Serves the American People.

CMS.gov/marketplace/about/oversight

Module 3 — Consumer Responsibilities Under the Affordable Care Act (ACA)

Exemptions from the requirement to have health insurance: A description of different exemptions available under the ACA and how to apply for them.

Healthcare.gov/health-coverage-exemptions/exemptions-from-the-fee/

Types of Health Insurance that Count as MEC: Definition of MEC.

Healthcare.gov/glossary/minimum-essential-coverage

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

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/

Federal Trade Commission (FTC) Consumer Advice: Spot Health Insurance Scams.

Consumer.ftc.gov/articles/spot-health-insurance-scams#medical

Medicaid Secretary-approved Minimum Essential Coverage:

Medicaid.gov/sites/default/files/2020-01/state-mec-designations.pdf

HHS Poverty Guidelines for 2025: U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Programs.

ASPE.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

Module 4 — Lowering Consumers' Health Coverage Costs

Medicaid and CHIP Eligibility Levels by State: Medicaid, CHIP, & Basic Health Program Eligibility Levels.

Medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels/index.html

Medicaid Expansion: Official resource that provides consumers information on Medicaid expansion.

Healthcare.gov/medicaid-chip/medicaid-expansion-and-you/

Medicaid and CHIP Fast Facts for Assisters: A fact sheet for helping low-income individuals, families, or children who are uninsured or seeking information about health coverage options.

CMS.gov/marketplace/technical-assistance-resources/fast-facts-medicaid-chip.pdf

How to find low-cost health care in your community: Use the following tool to find a community health center.

Healthcare.gov/community-health-centers/

More Information on Immigration Status: Information about immigration status requirements for consumers in a Marketplace.

Healthcare.gov/immigrants/immigration-status/

Incarcerated Consumers: Explanation of incarceration status in relation to eligibility for coverage through a Marketplace.

Healthcare.gov/incarcerated-people/

Pharmaceutical Assistance Programs: A tool to determine if a pharmaceutical company offers an assistance program.

CMS.gov/medicare/coverage/prescription-drug-coverage/patient-assistance-program

Federal Poverty Guidelines: Official HHS guidance on FPL levels for 2025.

ASPE.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

See Plans and Prices: Tool to search for Silver plans available in a consumer's area.

Healthcare.gov/see-plans/#/

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