MARKETPLACE
ASSISTER TOOLKIT

# *Standard Operating Procedures Manual for Assisters in the Individual Federally-facilitated Marketplaces*

## *SOP 8—Compare, Save, & Select Health Plans*

Version 5.0 November 2016. This information is intended only for the use of entities and individuals that are certified to serve as Navigators, certified application counselors, or non Navigator assistance personnel in a Federally facilitated Marketplace. The terms "Federally facilitated Marketplace" and "FFM," as used in this document, include FFMs where the state performs plan management functions and State Partnership Marketplaces. Some information contained in this manual may also be of interest to individuals helping consumers in State based Marketplaces and Federally supported State based Marketplaces.

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# SOP 8— Compare, Save, & Select Health Plans

## A. Introduction

The Marketplace allows consumers to compare their qualified health plan (QHP) options, including estimated premiums and other health care costs. Even if consumers have not created a Marketplace account and prefer to apply by calling the Marketplace Call Center or using a paper application, they can view and compare some Marketplace QHP options. However, until they submit an application and are determined eligible for enrollment through the Marketplace, the premiums and advance payments of the premium tax credit they see will simply be estimates, and they will not be able to select health plans for enrollment.

Consumers without a Marketplace account may:

- View key plan details (e.g., premiums, deductibles, estimated advanced payments of premium tax credit [APTC] and cost-sharing reductions [CSRs]) using the "2017 health insurance plans & prices" feature on HealthCare.gov.
- View, download, or print the plan's Summary of Benefits and Coverage.
- View the plan's provider directory and drug formulary.
- View Quality Rating information, if the consumer lives in Virginia or Wisconsin, where the new star ratings for plans will be piloted.
- View the relative breadth of health plans' provider networks for adult primary care providers, pediatricians, and hospitals in the consumer's county if the consumer lives in one of approximately two pilot states selected by Center for Medicaire & Medicaid Servicies (CMS).

If consumers choose to compare plans without creating an online account and submitting an application, explain that the health plan and cost options that they receive are only estimates based on consumers' responses to a few general questions. More consumer-specific information on available plans and costs can be viewed after consumers complete an application and are determined eligible for enrollment through the Marketplace.

If consumers are interested in more detailed information about plans available to them, or believe they may be eligible for other coverage programs or options to lower their costs (i.e., Medicaid, Children's Health Insurance Program [CHIP], advance payments of the premium tax credit, and cost-sharing reductions), encourage them to create an online account and complete an eligibility application. To create an account, proceed to SOP-3 Create an Account.

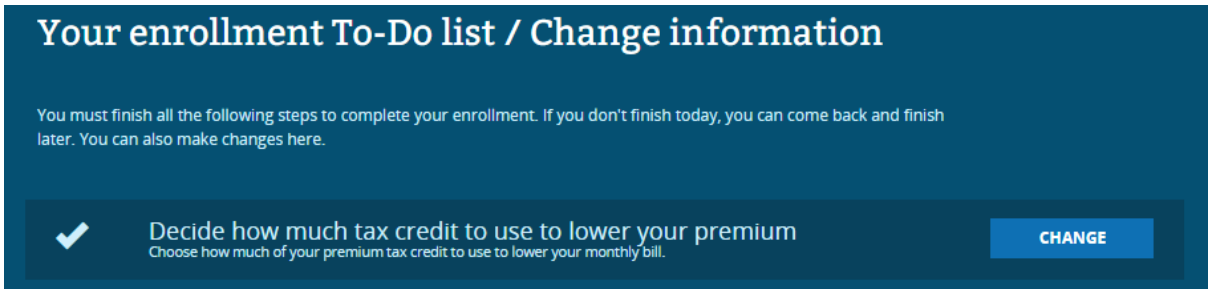
This Standard Operating Procedure (SOP) provides guidance on how to assist consumers with Marketplace accounts who have been determined eligible for enrollment through the Marketplace to compare QHPs, save plan information, and make a final QHP selection.

# B. Procedures

## 1. Selecting Advance Payments of the Premium Tax Credit Amount

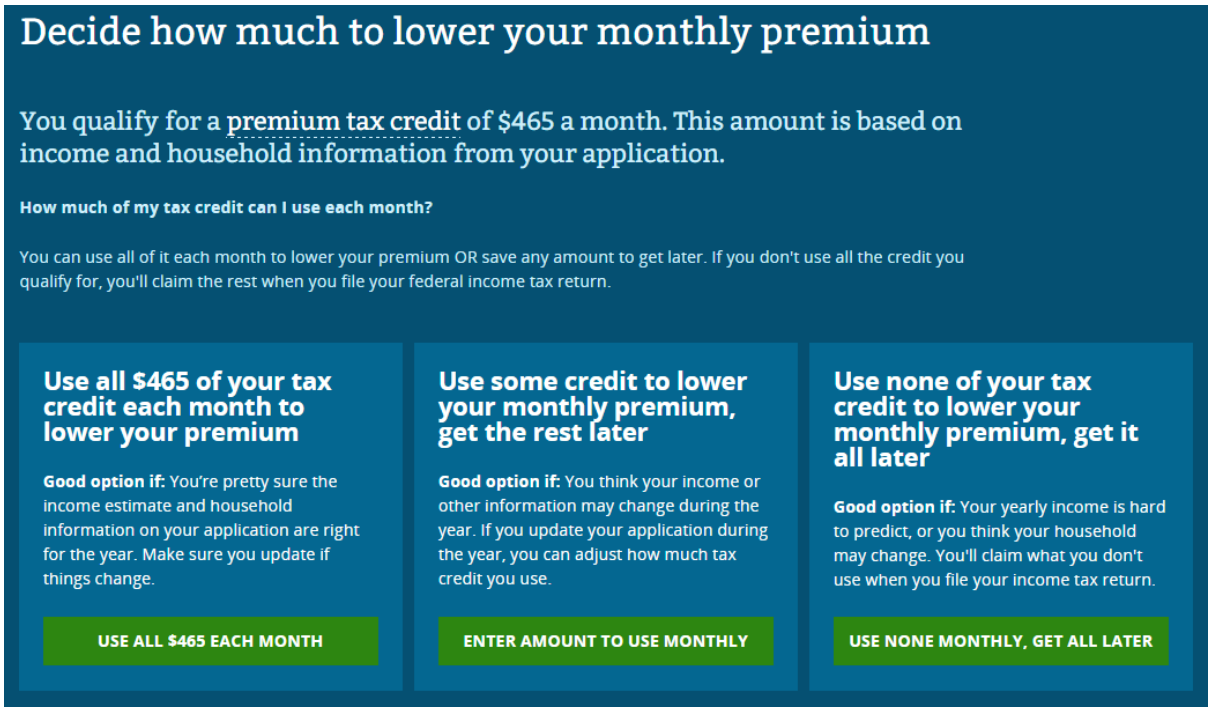
Consumers who are determined to be eligible for advance payments of the premium tax credit may choose to use all, some, or none of that amount to lower their monthly premiums. If consumers are eligible for advance payments of the premium tax credit, the system will prompt them to set the amount of advance payments of the premium tax credit that they would like to apply to their monthly premiums before viewing their QHP options, as shown in Exhibit 1.

**Exhibit 1—Setting the Amount of Advance Payments of the Premium Tax Credit Screenshot**




**Step 1.** Consumers who are eligible for advance payments of the premium tax credit will see three different options on how to use the advance payments of the premium tax credit for which they are eligible, much like the screen shown in Exhibit 2. Consumers can generally use all, some or none of the amount for which they are eligible. The three scenarios show how the options affect the consumer's monthly premium cost and, potentially, their tax liability when they file their tax return. After reviewing, the consumer will select his or her preferred amount of premium tax credit and click "Continue."

**Exhibit 2—Advance Payments of the Premium Tax Credit**




**Step 2.** You can help consumers use the advance payments of the premium tax credit amount selection tool shown in Exhibit 2 to set the amount they would like to apply to their premium each month.

The amount that consumers select is not permanent. When consumers view and compare QHPs, the Marketplace will reduce the premium amounts displayed according to the amount of advance payments of the premium tax credit they select. At any time before enrolling in a plan, consumers may adjust the amount of advance payments of the premium tax credit that they would like to use. (Consumers will also be able to change the amount after enrolling in a plan, but the time at which that change takes effect will depend on the calendar date on which the change is made).

**Step 3.** You can help consumers select the amount of advance payments of the premium tax credit that they would like to have made on their behalf. Exhibit 3 provides an explanation of the tax consequences that consumers might encounter.

**Exhibit 3—Tax Consequences for Advance Payments of the Premium Tax Credit**

| Scenario | | Tax Consequence |
|---|---|---|
| Consumers elect *lower* advance payments of the premium tax credit than the maximum for which they are eligible **AND/OR** their annual household income is *less than* projected for the tax year or their household size *increases*. | → | Consumers' tax liability might decrease, and they might get a tax refund if the premium tax credit for which they are eligible at tax time exceeds the advance payments of the premium tax credit that they received during the year. |
| Consumers elect the *maximum* advance payments of the premium tax credit for which they are eligible **AND/OR** their annual household income is *more than* projected for the tax year or their household size *decreases*. | → | Consumers' tax liability might increase, and they might owe money at tax time if the premium tax credit for which they are eligible at tax time is less than the advance payments of the premium tax credit that they received during the year. |

**Step 4.** It is important to remind consumers that they are required to report changes to eligibility information, such as certain income and household –related changes, to the Marketplace within 30 days, and should do so as soon as possible. The amount of premium tax credit and/or cost-sharing reductions for which they are eligible, may be affected.

## 2. Comparing QHPs

This section provides information on different criteria (e.g., cost, benefits covered) consumers may want to use to compare and evaluate QHPs.

**Step 1.** Explain to consumers the factors that might affect their available QHP options and the costs of the QHPs:

a. Place of residence;

b. Age;

c. Family size;

d. Tobacco use; and

e. Eligibility for advance payments of the premium tax credits or cost-sharing reductions.

**Step 2.** Assist consumers with comparing health plans using the "Metal Table" which summarizes plans by:

a. Metal level;

b. Displaying premium ranges (after application of advance payments of the premium tax credit); and

c. Cost-sharing (e.g., deductibles)

Once the consumer is on the plan results page, summary information about individual plans is presented, including the cost of premiums.

**Step 3.** Assist consumers with filtering and sorting QHPs to find plans that best meet their needs and budget. Encourage consumers to consider different aspects of coverage, including costs (premiums, copayments, coinsurance, deductible, out-of-pocket maximums, etc.), coverage (such as: services, devices, and medications), and provider network (ensuring preferred medical providers are covered in the plan's network). Consumers should review all aspects they think are important before choosing and enrolling in a plan.

a. The Marketplace can provide consumers with an estimate for their total health plan costs for the year, based on how much medical care the consumers think they will use (low, medium, or high). This can help consumers consider and compare different types of health insurance and health care costs beyond just monthly premiums. It is important to remind the consumer that these are estimates only, and that actual costs to the consumer can vary, based on actual health care use throughout the plan year.

b. The Marketplace initially sorts plans from the lowest to highest premium amount. Consumers may filter and view QHPs by other sorting criteria, such as alphabetically by QHP name or by maximum out-of-pocket costs.

c. Consumers may also filter QHPs to narrow the results to display only plans that meet selected criteria.

d. Exhibit 4 specifies the various filtering options available to consumers for customizing their QHP lists and lists examples of when to use each filtering option. It may be helpful to review the chart with consumers and identify the filtering options that are most important to them.

**Things You Should Know**

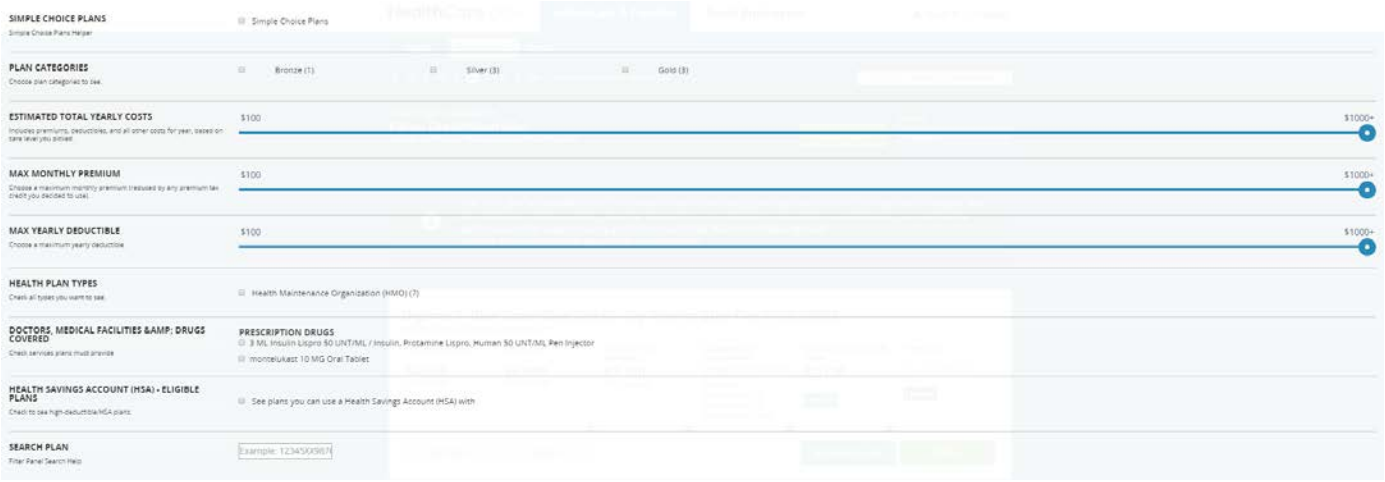
- While you can help consumers compare plans based on the applicant and their family members' unique coverage needs, you should never advise consumers to choose specific plans.

**Exhibit 4—Filtering Options**

| Filtering Option | Examples of Consumer Scenarios | Description of Filtering Option |
|---|---|---|
| **Plan Categories** | Consumers want to view only those plans that can be expected to cover, on average, 70% or more of their health care costs (i.e., a Silver-level plan or higher). | • Assignment of plan categories designated by metal level: Bronze, Silver, Gold, Platinum, and Catastrophic (e.g., a Platinum category plan, on average, will cover a higher percentage of costs of care than a Bronze category plan, but will generally have a higher premium).<br>• You may want to remind consumers eligible for cost-sharing reductions that they can only take advantage of those reductions if they pick a Silver plan |
| **Max Monthly Premium** | Consumers are concerned about monthly premium costs. | • Price range that consumers pay monthly for their QHPs. |
| **Max Yearly Deductible** | Consumers want to view only those plans that have a deductible amount within a certain range. | • The required amount consumers must pay before their health coverage begins to cover most health care costs. |
| **Estimated Yearly Costs** | Consumers are interested in the estimated total yearly cost for the plan premiums, deductible, copayments, and other costs. | • Estimated total yearly costs, from lowest to highest. |
| **Health Plan Types** | Consumers are concerned with flexibility of access to providers inside and outside of a network or are interested in coverage in multiple states. | • Types of provider access, such as Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Point of Service (POS), and multi-state or national provider networks.<br>• Stand-alone dental plans available to purchase* |
| **Health Savings Account (HSA) Eligible Plans** | Consumers are considering enrolling in a high deductible health plan (HDHP). | • Tax-advantaged medical savings account available to consumers who are enrolled in an HDHP. The funds contributed to the account are not subject to federal income tax at the time of deposit. |
| **Search Plan** | Consumers who already know which plan they want can search for it by the plan number | • Enter the plan number to find a preferred plan quickly. |

**Under the Affordable Care Act, dental insurance is treated differently for adults and children 18 and under. Dental coverage for children is a category of essential health benefit. All stand-alone dental plan QHPs offer through the Marketplace must cover the pediatric dental essential health benefit, but are not required to cover adult dental services.*

**Exhibit 5—Filter Plans by Metal Level Screenshot**



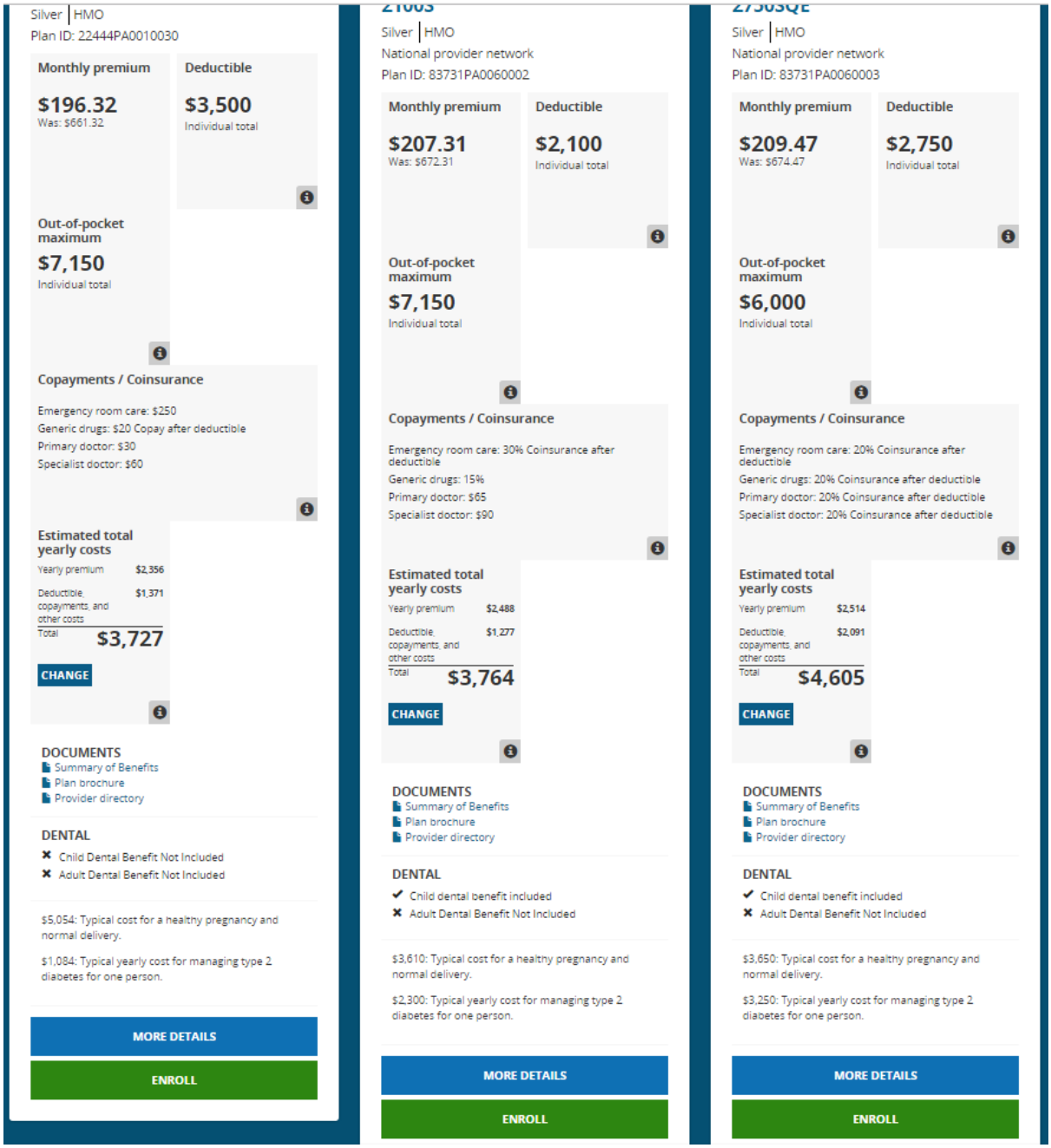

**Step 4.** Once consumers identify QHPs in which they are interested in enrolling, consumers may make direct plan-to-plan comparisons using the side-by-side function.

a. To select QHPs for comparison, consumers can click the "Compare & Save" box listed below the QHP name. Next, select the "Compare & Save Plans" button at the top of the page. See Exhibit 6 for an illustration of this process. Note that consumers can select and compare up to three plans at one time. Consumers can also hover their cursor over the "i" icons for explanations about what the different dollar amounts mean.

**Exhibit 6—Select a QHP for Plan Comparison Screenshot**


b. The side-by-side comparison, shown in Exhibit 7, allows consumers to compare QHPs' monthly premiums and annual deductibles, medical and prescription drug benefits, and other key information.

**Exhibit 7—Side-by-Side Plan Comparison Screenshot**



**Step 5.** Remind consumers to make sure their doctors or other health providers are in-network for the specific plan they are considering before they enroll. Also remind consumers to enter the information for any medications they take to verify if the medications are on the plan's drug formulary. The best way for consumers to ensure a provider participates in the specific plan they are selecting is for consumers to call **both** their doctor/provider and the insurance company to make sure the doctor is in the relevant network. If consumers want a plan that includes their health provider(s) or specific prescription drugs in the plan's formulary, direct them to the following external resources for additional information about the QHPs:

a. Plan websites;

b. Individual plan provider directories; and

c. Summaries of Benefits & Coverage (SBCs). This information may be found by clicking on the "Details" link for the plan on HealthCare.gov.

**Changes to Plan Comparison**

Starting in the 2017 benefit year, consumers will have the option to select "Simple Choice plans," which come with a uniform set of deductibles, copayments, coinsurance rates, and annual limitations on certain cost-sharing features. The uniform cost sharing features will allow the consumer to compare plans based on other important factors, such as providers in the plan's network, with the knowledge that cost-sharing for certain categories of covered benefits will be the same across Simple Choice plans. The "Simple Choice plans" will display in Plan Compare.

Additionally, in some states, consumers will see quality star rating information, which will provide consumers information about the quality of health care services and enrollee experiences, and overall patient and consumer experience for health plans offered on the Marketplace in those states. The quality star ratings will only display for QHPs in 2 states for the 2017 plan year: Virginia and Wisconsin, which use the HealthCare.gov platform. CMS anticipates quality star rating information will be available in all Federally Marketplaces for the 2018 open enrollment period.

## 3. Saving QHP Selections

**Step 1.** If consumers would like to review certain QHPs at a later time, consumers may save the QHPs to their account by clicking the "Compare & Save" check box, as shown in Exhibit 38. Consumers may view these QHPs at a later time by logging in to their account and clicking the "Saved Plans" button also shown in Exhibit 8.

**Exhibit 8—Save QHP Screenshot**


## 4. Selecting a QHP

**Step 1.** After consumers have reviewed and compared their available QHP options, they may select plans to enroll in for themselves and/or family members included on their application. After clicking "Enroll," different warnings may appear that indicate the consumer may have missed the opportunity to participate in a plan with cost-sharing reductions (for example, if the consumer has selected a plan that is not a Silver-level plan) or that they selected a plan covering a child that does not provide child dental coverage. One example of this warning message appears in Exhibit 9. Consumers will be asked to confirm their plan selection, as shown in Exhibit 10.

**Exhibit 9—Warning Message Screenshot**

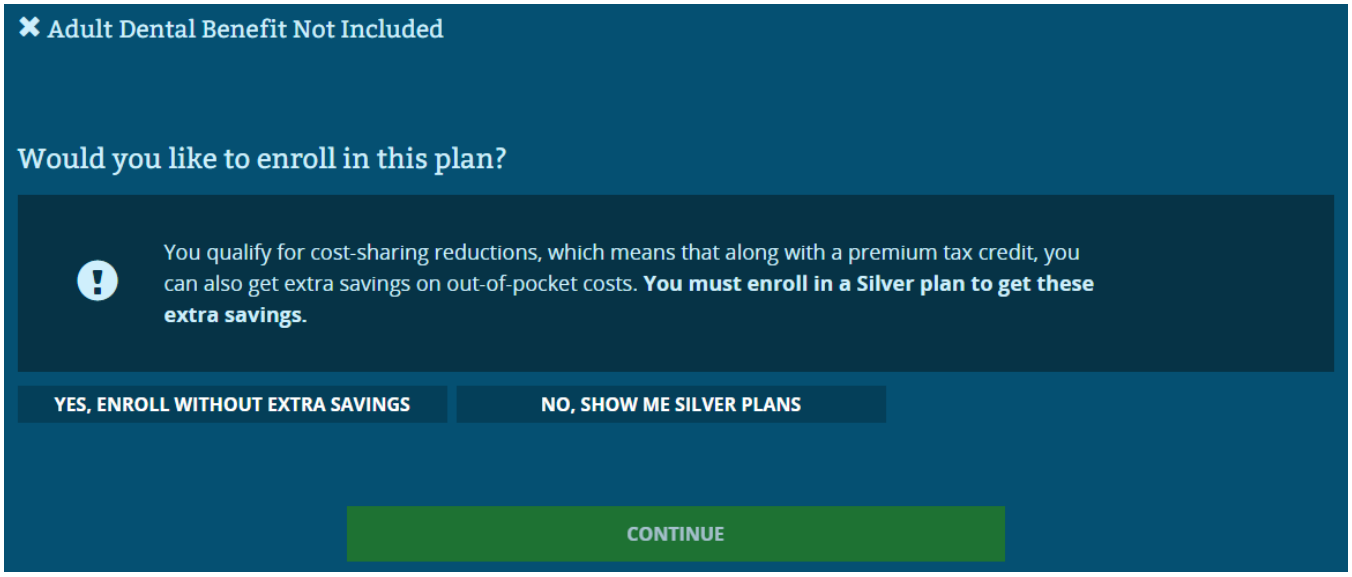
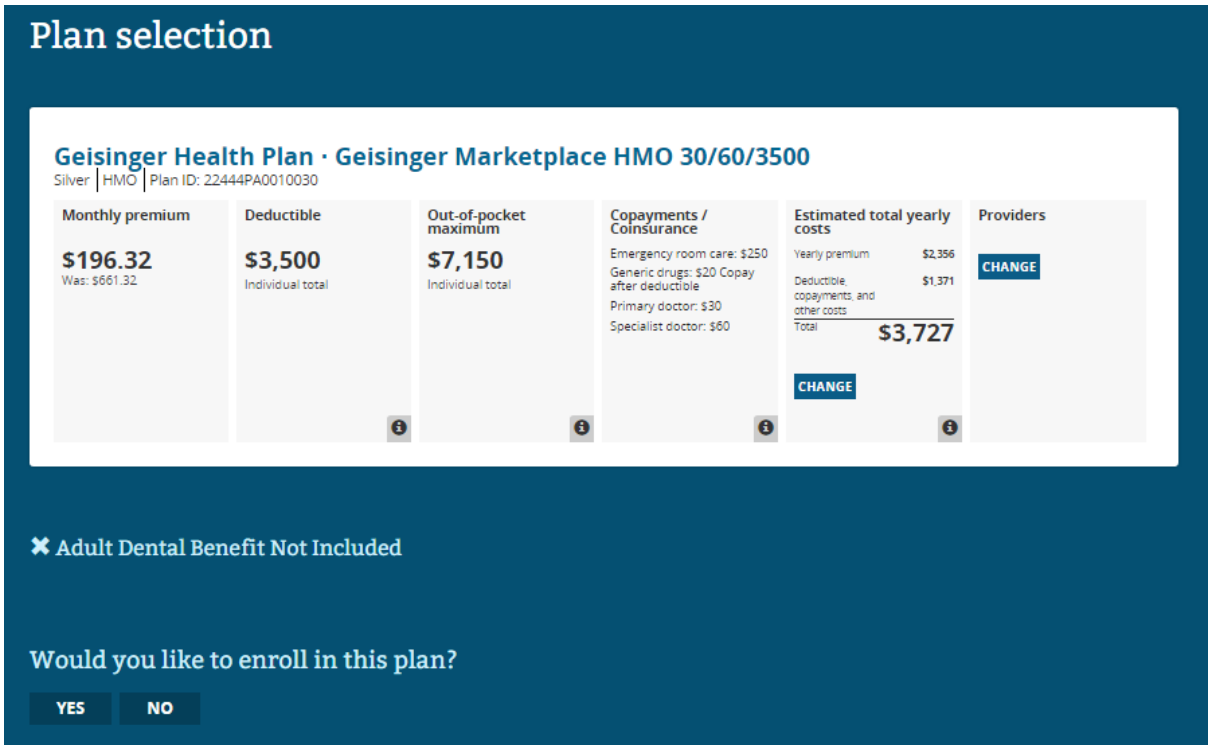


**Exhibit 10—Confirm Plan Selection Screenshot**




## 5. Dental Coverage

**Step 1.** Some medical plans include child and/or adult dental coverage. If consumers want dental coverage, they can select a medical plan that includes dental coverage or select a stand-alone (separate) dental plan.[1] If no separate dental plan is desired, consumers can skip directly to the "Review and Confirm" task. If consumers wish to select a stand-alone dental plan, proceed to Step 2.

**Step 2.** You can help consumers indicate they are interested in stand-alone dental coverage. The process will proceed similarly to the medical plan compare and selection process. Once available dental plans appear, you can assist consumers with enrolling in a dental plan.

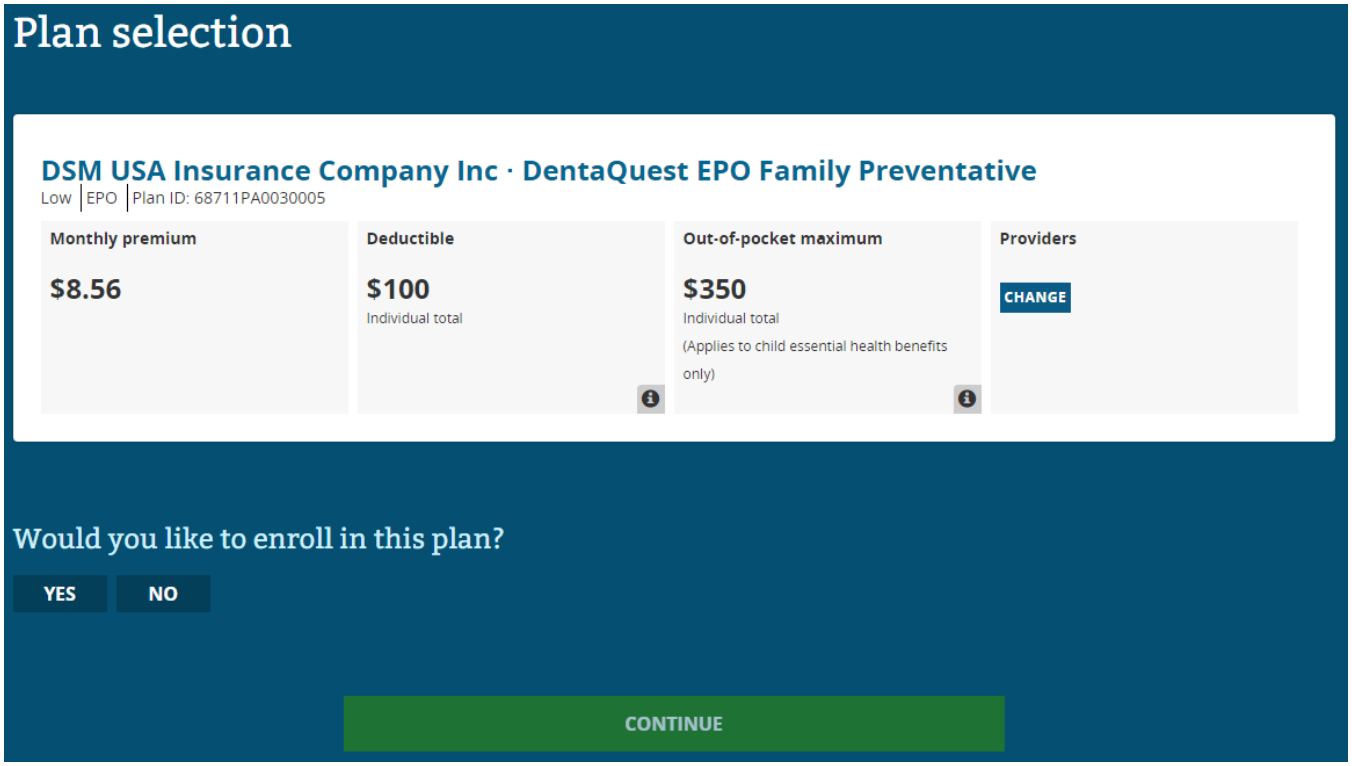
[1] Note that, as adult dental coverage is not an Essential Health Benefit, APTCs cannot be used to pay any portion of a premium attributable to coverage of adult dental benefits.

a. A consumer must enroll in a medical plan in order to enroll in a stand-alone dental plan through an Individual Health Insurance Marketplace[SM].

b. Consumers can enroll in a stand-alone dental plan through the Marketplace even after they have already enrolled in health coverage as long as it is still Open Enrollment or if they have a special enrollment period (SEP). To do so, Marketplace operations require that consumers return to the Marketplace, re-select their Marketplace health plan, and then select a dental plan at the same time to add a dental plan. Assisters helping consumers in this situation can remind consumers that the coverage effective date of their dental plan will depend on the date that they enroll, not on the date when they originally selected health coverage.

**Step 3.** Once consumers select "Enroll," a confirmation window will appear. It will provide a summary of the plan selection and if the consumer agrees, they will select "Yes" and "Continue," as shown in Exhibit 11.

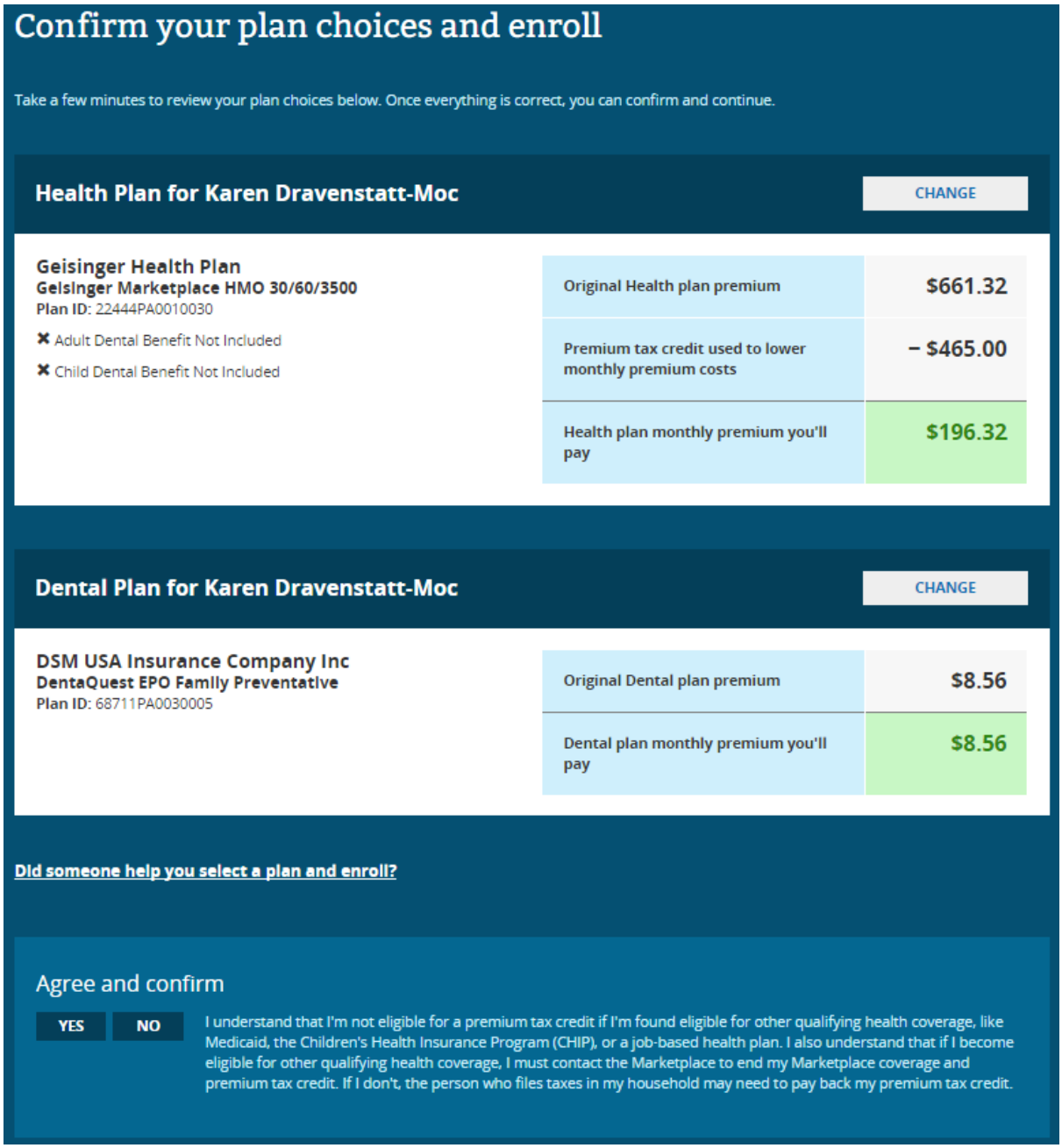
**Exhibit 11—Confirming Dental Plan Selection Screenshot**



## 6. Review and Confirm

**Step 1.** After confirming their dental plan, consumers will be brought to the "Confirm your plan choices and enroll" page, where the consumer can see a summary of the plan(s) he or she selected and must provide a final approval to enroll in the plans. An example of this summary and enrollment appears in Exhibit 12.

**Exhibit 12—Review and Confirm Screenshot**




**Step 2.** At the bottom of the "Confirm your plan choices and enroll"page, consumers must attest to their understanding that they may no longer be eligible for APTC if they experience certain life changes; and

that the household tax filer may have to pay back the APTC if the consumer fails to take appropriate action. Next, the consumer will be taken to the "Read these statements and select whether you agree or disagree" page, where they accept eligibility for advance payments of the premium tax credit (if applicable) by agreeing to file a federal income tax return in the upcoming year for the current tax year and/or by attesting to the filing of a joint income tax return with their spouse by the end of the current tax year (if married). Consumers are also attesting that no one else can claim them as a dependent for the current tax year on a federal income tax return. After selecting "Yes," the consumer needs to enter his or her full name and click "Finish Plan Selection."

## C. Next Steps

1. If consumers wish to pay their health plan premium, proceed to SOP-9 Pay Health Plan Premium.
2. For more help answering consumers' specific questions, see Appendix A for Frequently Asked Questions (FAQs) related to SOP-8 Compare, Save, & Select Health Plans.

## Appendix A: Frequently Asked Questions (FAQs)

The FAQs below are designed to help assisters answer consumers' specific questions on comparing and selecting plans through the Individual Marketplace. For more information on this topic, see SOP-8 Compare, Save, & Select Health Plans.

FAQ 1. How do I look at the different plans and compare them?

- Answer: You may view and compare plans by logging in to your HealthCare.gov account or using the "See Plans and Prices" tool on HealthCare.gov before you create an account.

FAQ 2. Can I browse health plans in the Marketplace without creating an account?

- Answer: Yes, you may browse and compare plans on the HealthCare.gov website. However, you may not see all details of QHPs, including the exact amounts of what your costs would be. You are encouraged to create an account and submit an application to see the full details of various QHPs.

FAQ 3. When can I select my health plan?

- Answer: During Open Enrollment or if you are eligible for a SEP, you may select an insurance plan after you have completed an eligibility application and received eligibility results indicating that you are eligible to enroll in a QHP through the Marketplace.

FAQ 4. May I select more than one health plan?

- Answer: You may only select one health plan for each individual. You may also select stand-alone dental coverage, if available. However, you may select different health plans for different people on a single application by forming different enrollment groups in the enrollment section of HealthCare.gov (after submitting the application).

FAQ 5. Can I select a stand-alone dental plan QHP?

- If you want to enroll in a stand-alone dental plan QHP through individual Health Insurance Marketplace[SM], you can select a medical plan that includes dental coverage, and you may also select a stand-alone dental plan. You must be enrolled in a medical plan to enroll in dental coverage in Individual Health Insurance Marketplace[SM][2].

[2] If an employee is enrolling through a Federally-facilitated SHOP Marketplace, and his or her employer offers both medical and stand-alone dental coverage through the SHOP, the employee may enroll in a stand-alone dental plan through the SHOP without also enrolling in a medical plan through the SHOP.

FAQ 6. Can I select a child-only qualified health plan?

- Answer: Yes, you may enroll a child in a child-only plan without enrolling yourself in coverage, but you must include yourself and other members of your tax household as non-applicants on your application if you select that you want to see if you can get help paying for coverage.

However, it's important to remember that if you do not have minimum essential coverage (MEC) for yourself, you may be required to obtain an exemption or pay a fee when you file your annual federal income taxes.

FAQ 7. After I determine the filtering options for my plan comparison, how do I prioritize them?

- Answer: You will need to determine what factors are most important to you. Some factors that you may want to consider include costs, providers (like doctors, hospitals, and pharmacies) that the health insurer or plan has contracted with to provide health care services (known as the "network"), and what prescription drugs the plan's formulary covers.

FAQ 8. Who decides which health plans are QHPs?

- Answer: The Marketplace, with involvement from some states, determines which plans are QHPs.

FAQ 9. When do I see the cost of the health plans?

- Answer: You can see estimated costs of health plans before you apply. If you are determined eligible to enroll in a QHP through the Marketplace and for help paying for coverage, you will be able to view your exact plan costs, taking into account any advance payments of the premium tax credit or cost-sharing reductions for which you qualify.

FAQ 10. Are all QHP benefits the same despite different QHP costs?

- Answer: No, you will see differences within coverage categories and you may see additional benefits that only some plans offer. However, all QHPs provide coverage of the required essential health benefits and all QHPs (other than stand-alone dental plan QHPs) are considered MEC. HealthCare.gov offers several different tools to help consumers compare and contrast plans, including filtering and sorting options, yearly cost estimates, and in-network provider and medication coverage look-up tools. Starting in the 2017 benefit year, consumers will have the option to select "Simple Choice plans," which come with uniform cost-sharing features. The uniform cost-sharing features will allow the consumer to compare plans based on important factors, such as providers in the plan's network, with the knowledge that cost-sharing for certain categories of covered benefits will be the same across Simple Choice plans. The "Simple Choice plans" will display in Plan Compare.

## Appendix B: Acronyms & Definitions

The proceeding sections describe the commonly used acronyms and terms that appear throughout the Manual.

### Frequently Used Acronyms

**Exhibit 13—Frequently Used Acronyms**

| Acronyms | Descriptions |
|---|---|
| APTC | Advance payments of the premium tax credit |
| CAP | Consumer Assistance Program |
| CCIIO | Center for Consumer Information & Insurance Oversight |
| COBRA | Consolidated Omnibus Budget Reconciliation Act |
| CFR | Code of Federal Regulations |
| CHIP | Children's Health Insurance Program |
| CMS | Centers for Medicare & Medicaid Services |
| CSR | Cost-sharing Reduction |
| DHS | Department of Homeland Security |
| DMI | Data-matching Issue |
| EHB | Essential Health Benefits |
| FAQ | Frequently Asked Questions |
| FFM | Federally-facilitated Marketplace |
| FPL | Federal Poverty Level |
| HDHP | High Deductible Health Plan |
| HHS | Department of Health & Human Services |
| HMO | Health Maintenance Organization |
| HSA | Health Savings Account |
| ID | Identification |
| IHS | Indian Health Service |
| IRS | Internal Revenue Service |
| MAGI | Modified Adjusted Gross Income |
| MEC | Minimum Essential Coverage |
| PII | Personally Identifiable Information |
| QHP | Qualified Health Plan |
| SBC | Summary of Benefits and Coverage |
| SEP | Special Enrollment Period |
| SHIP | State Health Insurance Assistance Program |

| Acronyms | Descriptions |
|---|---|
| SHOP | Small Business Health Options Program |
| SOP | Standard Operating Procedure |
| SSI | Supplemental Security Income |
| SSN | Social Security Number |
| VA | Veterans Affairs |
| VHA | Veterans Health Administration |

## Definitions

The following is a list of terms from HealthCare.gov, CCIIO, and the Affordable Care Act explained in plain language that you may reference to assist consumers.

List of Vocabulary in SOP:

**Advance Payments of the Premium Tax Credit: (APTC)** The Affordable Care Act provides a new tax credit to help consumers afford health coverage purchased through a Marketplace. Consumers can use advance payments of the premium tax credit to lower their monthly premium costs. If consumers qualify, they may choose how much in advance payments of the premium tax credit to apply to their premiums each month, up to a maximum amount. If the amount of advance payments of the premium tax credit consumers get for the year is less than the premium tax credit they're due based on their annual household income, they'll get the difference as a refundable credit when they file their federal income tax return. If their advance payments of the premium tax credit for the year are more than the amount of the premium tax credit for which they are eligible, they may be required to repay the excess advance payments with their tax return. (Reference: https://www.HealthCare.gov/glossary/advanced-premium-tax-credit)

**Affordable Care Act:** The comprehensive health care reform law enacted in March 2010. Congress passed the law in two parts. The President signed the Patient Protection and Affordable Care Act into law on March 23, 2010, which was amended by the Health Care and Education Reconciliation Act of 2010 on March 30, 2010. The name "Affordable Care Act" refers to the amended version of the law. (Reference: https://www.HealthCare.gov/glossary/affordable-care-act)

**Agent**: When registered with a Marketplace, an individual or entity that helps individuals and businesses apply for and enroll in QHPs through the Marketplace and may assist in applying for advance payments of the premium tax credit and cost-sharing reductions. States grant licenses to agents to sell insurance in their respective jurisdictions. They may receive compensation from insurance companies with whom they have a contractual relationship to enroll consumers in a QHP or non-QHP. (Reference: Affordable Care Act §1312(e) and 45 CFR §155.20)

**Applicant**: With respect to a Marketplace for the individual market, an applicant is an individual seeking eligibility for him or herself through an application submitted to the Marketplace (or transmitted to the Marketplace by the state Medicaid or CHIP agency) except individuals seeking eligibility for an exemption from

the individual shared responsibility payment. Applicants must be seeking eligibility for at least one of the following: enrollment in a QHP through the Marketplace (with or without advance payments of the premium tax credit and/or cost-sharing reductions) and enrollment in Medicaid or CHIP. (Reference: 45 CFR §155.20 and 42 CFR §435.4)

**Benefits**: The health care items or services covered under a health plan. The health plan's coverage documents define the covered benefits and excluded services. In Medicaid or CHIP, the state program rules define covered benefits and excluded services. (Reference: https://www.HealthCare.gov/glossary/benefits)

**Benefit Year**: A calendar year for which a health plan provides coverage for health benefits. The benefit year for non-grandfathered individual market plans bought inside or outside the Marketplace generally begins January 1 of each year and ends December 31 of the same year. Unless terminated earlier, a consumer's individual market coverage ends December 31 even if the coverage started after January 1. Any changes to benefits or rates of an individual market health insurance plan are generally made at the beginning of the calendar year. (Reference: https://www.HealthCare.gov/glossary/benefit-year)

**Broker:** When registered with a Marketplace, an individual or entity that helps individuals and businesses apply for and enroll in a QHP through the Marketplace and may assist in applying for advance payments of the premium tax credit and cost-sharing reductions. States grant licenses to brokers to sell insurance in their respective jurisdictions. They may receive compensation from an insurance company with whom they have a contractual relationship to enroll consumers into a QHP or non-QHP. (Reference: Affordable Care Act § 1312(e) and 45 CFR §155.20)

**Center for Consumer Information & Insurance Oversight (CCIIO):** A part of the Department of Health & Human Services that helps to implement many provisions of the Affordable Care Act, the historic health reform bill that became law in March 2010. CCIIO oversees the implementation of the provisions related to private health insurance. (Reference: https://www.CMS.gov/CCIIO)

**Centers for Medicare & Medicaid Services (CMS):** The federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs, as well as the Federally-facilitated Marketplaces. For more information, visit CMS.gov. (Reference: https://www.HealthCare.gov/glossary/centers-for-medicare-and-medicaid-services)

**Certified Application Counselor (CAC):** In an FFM, an individual (affiliated with an organization designated by CMS, as operator of the FFMs) who is trained and able to help consumers as they look for health coverage options through the Marketplace, including helping them complete eligibility and enrollment forms. Their services are free to consumers. (Reference: https://www.HealthCare.gov/glossary/certified-applicant-counselor)

**Certified Application Counselor Designated Organization (CDO)**: In an FFM, an organization designated by CMS, as operator of the FFMs, to certify staff members or volunteers to act as certified application counselors. (Reference: 45 CFR §155.225)

**Children's Health Insurance Program (CHIP):** Program jointly funded by state governments and the federal government that provides health coverage to low-income children and, in some states, pregnant women in

families who earn too much income to qualify for Medicaid but cannot afford to purchase private health insurance coverage. (Reference: https://www.HealthCare.gov/glossary/childrens-health-insurance-program-chip)

**Claim:** A request for payment that a consumer, his or her authorized representative, or his or her health care provider submits to the consumer's health insurer when the consumer gets items or services he or she thinks are covered. (Reference: https://www.HealthCare.gov/glossary/claim)

**Coinsurance:** The consumer's share of the costs of a covered health care service calculated as a percent (for example, 20%) of the allowed amount for the service. Consumers pay coinsurance plus any deductibles they owe. For example, if the health insurance or plan's maximum allowed amount for a covered office visit is $100 and the consumer has met the plan's deductible, the consumer's coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. (Reference: https://www.HealthCare.gov/glossary/co-insurance)

**Copayment:** Also referred to as a copay, this is a fixed amount (for example, $15) a consumer pays for a covered health care service, usually when they receive the service. The amount can vary by the type of covered health care service. (Reference: https://www.HealthCare.gov/glossary/co-payment)

**Cost-sharing Reduction**: A discount that lowers the amount consumers have to pay out-of-pocket for deductibles, coinsurance, and copayments. Consumers also have a lower out-of-pocket maximum. Consumers are eligible for cost-sharing reductions if they get health insurance through a Marketplace, they meet household income requirements, and if they enroll in a health plan from the Silver plan category (See Health Plan Categories). Consumers may qualify for additional cost-sharing benefits if they are a member of a federally recognized tribe. (Reference: https://www.HealthCare.gov/glossary/cost-sharing-reduction)

**Deductible:** The amount consumers owe for covered health care services before their health insurance or plan begins to pay. For example, if a consumer's deductible is $1,000, the plan won't pay anything for covered health care services subject to the deductible until the consumer has met the $1,000 deductible. The deductible may not apply to all services. (Reference: https://www.HealthCare.gov/glossary/deductible)

**Enrollee**: In an individual Marketplace, a qualified individual enrolled in a QHP through the Marketplace. (Reference: 45 CFR §155.20)

**Essential Health Benefits (EHB):** A set of health care service categories that certain plans must cover starting with plan years beginning in 2014.

The Affordable Care Act ensures that non-grandfathered health insurance plans offered in the individual and small-group markets, both inside and outside of the Health Insurance Marketplaces, offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following ten categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including

oral and vision care. Insurance policies must cover these categories of benefits to be certified as qualified health plans that can be offered in the Health Insurance Marketplaces, and alternative benefit plans offered under Medicaid state plans (which must be offered to the new adult population) must cover these services by 2014. (Reference: https://www.HealthCare.gov/glossary/essential-health-benefits)

**Health Coverage:** Consumers' legal entitlement to payment or reimbursement for their health care costs for covered services or items generally under a contract with a health insurance company, a group health plan offered in connection with employment, or a government program like Medicare, Medicaid, or CHIP. (Reference: https://www.HealthCare.gov/glossary/health-coverage)

**Health Insurance:** A contract that requires a consumer's health insurer to pay some or all of the consumer's health care costs in exchange for a premium. (Reference: https://www.HealthCare.gov/glossary/health-insurance)

**Health Insurance Issuer (Issuer)**: An insurance company, insurance service, or insurance organization that must have a license to engage in the business of insurance in a state and that is subject to state laws that regulate insurance. (Reference: 45 CFR §144.103)

**High Deductible Health Plan (HDHP):** A plan that features higher deductibles than traditional insurance plans. Consumers may combine high deductible health plans with a health savings account or a health reimbursement arrangement to allow them to pay for qualified medical expenses on a pre-tax basis. (Reference: https://www.HealthCare.gov/glossary/high-deductible-health-plan)

**Health Savings Account (HSA)**: A medical savings account available to taxpayers who are enrolled in a HDHP. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Consumers must use funds to pay for qualified medical expenses. Unlike a Flexible Spending Account (FSA), funds roll over year to year if consumers do not spend them. (Reference: https://www.HealthCare.gov/glossary/health-savings-account-HSA)

**Individual Marketplace:** The Marketplace for individuals to purchase health insurance plans for themselves or their families other than through an employer-sponsored group health plan. (Reference: Affordable Care Act §1304(a)(2))

**Marketplace:** A marketplace for health insurance, also known as an "Exchange," operated by a governmental agency or non-profit entity that meets applicable government standards. A Marketplace makes QHPs available to qualified individuals and/or qualified employers. Generally, in CMS documents, this term is often used to refer both to Marketplaces serving the individual market for qualified individuals and to Small Business Health Options Program (SHOP) Marketplaces serving the small group market for qualified employers, and is often used regardless of whether a Marketplace is established and operated by a State or by HHS. However, in this document, the term Marketplace generally is used to refer only to the Federally-facilitated Marketplaces (FFMs), and frequently is used to refer only to the FFMs for the individual market. (Reference: 45 CFR §155.20)

**Medicaid**: A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they

design their programs, in which Medicaid can vary state by state and may have a different name in your state. (Reference: https://www.HealthCare.gov/glossary/medicaid)

**Minimum Essential Coverage (MEC)**: The type of health coverage individuals need to have to avoid having to make the individual shared responsibility payment (unless they qualify for an exemption) when they file a federal income tax return. Many types of coverage qualify as MEC, including qualified health plans offered through the Marketplace, job-based coverage, Medicare, Medicaid, CHIP, and TRICARE. (Reference: Section 5000A(f) of the Internal Revenue Code)

**Navigator**: An individual or organization that receives a grant from the Marketplace and that is trained and able to help consumers, including small employers and their employees, as they look for health coverage options through the Marketplace, including helping them complete the eligibility and enrollment process. These individuals and organizations are required to be unbiased. Their services are free to consumers. (Reference: https://www.HealthCare.gov/glossary/navigator)

**Non-Navigator Assistance Personnel**: Individuals or organizations that are trained and able to provide help to consumers, including small employers and their employees, as they look for health coverage options through a Marketplace, including helping them complete the eligibility and enrollment process. These individuals and organizations are required to be unbiased. Their services are free to consumers. Also referred to as "in-person assisters." (Reference: https://www.HealthCare.gov/glossary/in-person-assistance-personnel-program)

**Open Enrollment Period**: The period of time during which individuals who are eligible to enroll in a QHP can enroll in a plan through the Marketplace. For coverage starting in 2017, the individual market Open Enrollment period is November 1, 2016 – January 31, 2017. Individuals may also qualify for special enrollment periods if they experience certain qualifying events. Consumers can apply for Medicaid or CHIP at any time of the year. (Reference: https://www.HealthCare.gov/glossary/open-enrollment-period)

**Out-of-pocket Costs:** The expenses for health care services that insurance companies do not reimburse. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that are not covered. (Reference: https://www.HealthCare.gov/glossary/out-of-pocket-costs)

**Plan Year**: A consecutive twelve-month period during which a health plan provides coverage for health benefits. A plan year may be a calendar year. (Reference: 45 CFR §155.20)

**Premium:** The amount that consumers or employers pay for a health insurance or job-based coverage. Premiums are paid by the consumer or employers on a monthly, quarterly, or yearly basis. (Reference: https://www.HealthCare.gov/glossary/premium)

**Qualified Health Plan (QHP)**: Under the Affordable Care Act, an insurance plan that is certified by a Health Insurance Marketplace℠, provides essential health benefits, follows established limits on cost- sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. Each QHP is certified by the Marketplace through which the plan is offered. (Reference: https://www.HealthCare.gov/glossary/qualified-health-plan)

**Special Enrollment Period (SEP):** In the individual market, a period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP through the Marketplace outside of the annual individual market open enrollment period. For example, individuals who lose employer-sponsored health coverage, or who lose Medicaid coverage because of an increase in income, would be eligible for a SEP to enroll in a Marketplace plan, if they otherwise qualify. Other triggering events include marriage, divorce, and the birth or adoption of a child. (Reference: 45 CFR §155.20)

**Summary of Benefits and Coverage (SBC):** An easy-to-read summary that lets consumers make apples-to-apples comparisons of costs and coverage between health plans. Consumers can compare options based on price, benefits, and other features that may be important to them. Consumers will get the Summary of Benefits and Coverage when they shop for coverage on their own or through their job, renew or change coverage, or request an SBC from the health insurance company. (Reference: https://www.HealthCare.gov/glossary/summary-of-benefits-and-coverage)

## Appendix C: Support Resources

If consumers require assistance that is outside of assister activities, refer consumers to other organizations and resources as appropriate. Exhibit 14 provides a list of external resources.

**Exhibit 14—External Resources**

| Resource | Contact Information | What does this resource do? | How should consumers use this resource? |
|---|---|---|---|
| Marketplace Call Center | 1-800-318-2596<br>TTY: 1-855-889-4325<br>(all languages available) | The Marketplace Call Center provides assistance to consumers who need information or want to enroll in health coverage through an FFM. | To get answers to questions while applying for health coverage using the online or paper application.<br>To apply for health coverage over the phone. |
| HealthCare.gov | http://www.HealthCare.gov | This website allows consumers to access information about the Affordable Care Act and to enroll in health coverage through an FFM. | To find out about health coverage options available through an FFM.<br>To apply for health coverage online.<br>To get real-time answers to questions using the online chat function. |
| Medicaid | http://www.Medicaid XE "Medicaid" .gov | This state-administered health insurance program is for low-income families and children, pregnant women, the elderly, people with disabilities, and in many states, other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their program, so Medicaid varies state-by-state and may have a different name in your state. | To find answers to questions about health coverage through Medicaid or CHIP.<br>To get further information about their state's Medicaid program and agency contact information. |