Page: 1 of 44: Welcome to the ELIGIBILITY FOR INSURANCE AFFORDABILITY PROGRAMS Module

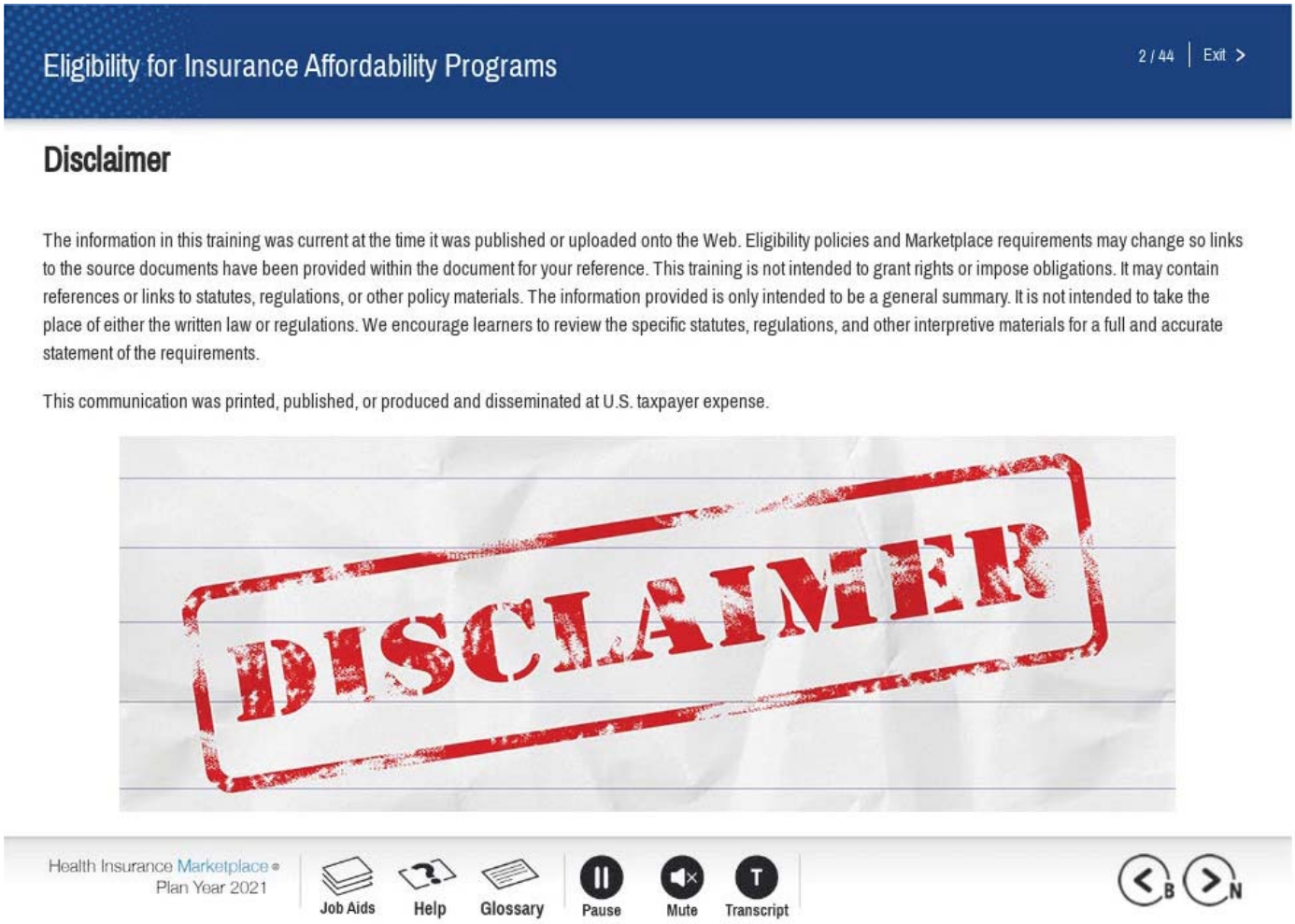
Page Text

Welcome to the Eligibility for Insurance Affordability Programs Module

Long Description

Animated introduction screen containing the following text at the top and left of the screen: Welcome to the Individual Marketplace Eligibility for Insurance Affordability Programs Module. Beneath this text on the left is the logo for the Department of Health & Human Services (HHS), which is made up of the profiles of people, stacked on top of each other, resulting in the profile of an eagle. The words "Department of Health & Human Services USA" form a circle that extends out and to the left from the profiles. To the right of the logo are the words “Health Insurance Marketplace®.” On the right side of the screen are three images from the module representing agents and brokers and module-specific concepts. The health caduceus symbol is behind these images.

Page: 2 of 44: Disclaimer



Page Text

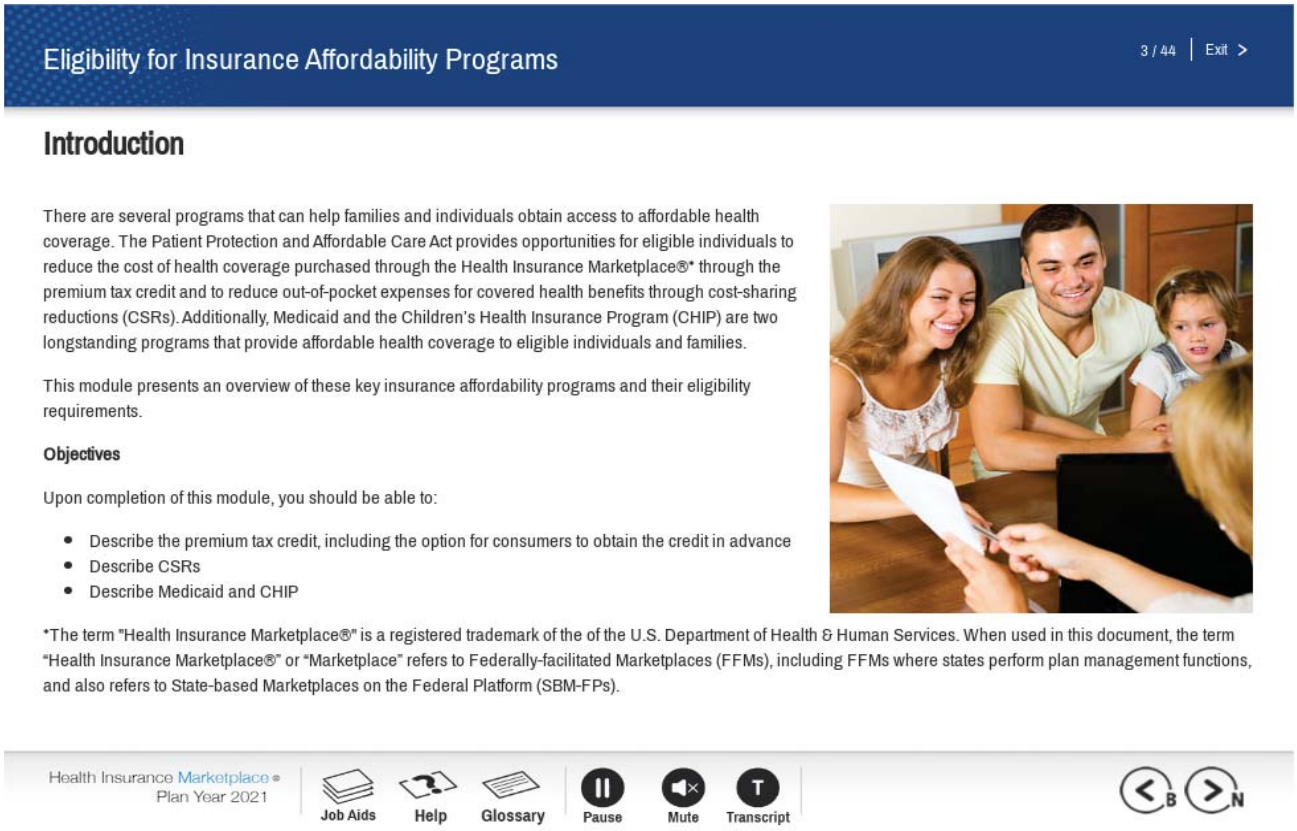
The information in this training was current at the time it was published or uploaded onto the Web. Eligibility policies and Marketplace requirements may change so links to the source documents have been provided within the document for your reference. This training is not intended to grant rights or impose obligations. It may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage learners to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of the requirements.

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

Alt Text

A page of text with horizontal lines across it; a red box containing the word “'Disclaimer”' within it

Page: 3 of 44: Introduction



Page Text

There are several programs that can help families and individuals obtain access to affordable health coverage. The Patient Protection and Affordable Care Act provides opportunities for eligible individuals to reduce the cost of health coverage purchased through the Health Insurance Marketplace®* through the premium tax credit and to reduce out-of-pocket expenses for covered health benefits through cost-sharing reductions (CSRs). Additionally, Medicaid and the Children's Health Insurance Program (CHIP) are two longstanding programs that provide affordable health coverage to eligible individuals and families.

This module presents an overview of these key insurance affordability programs and their eligibility requirements. Objectives Upon completion of this module, you should be able to:

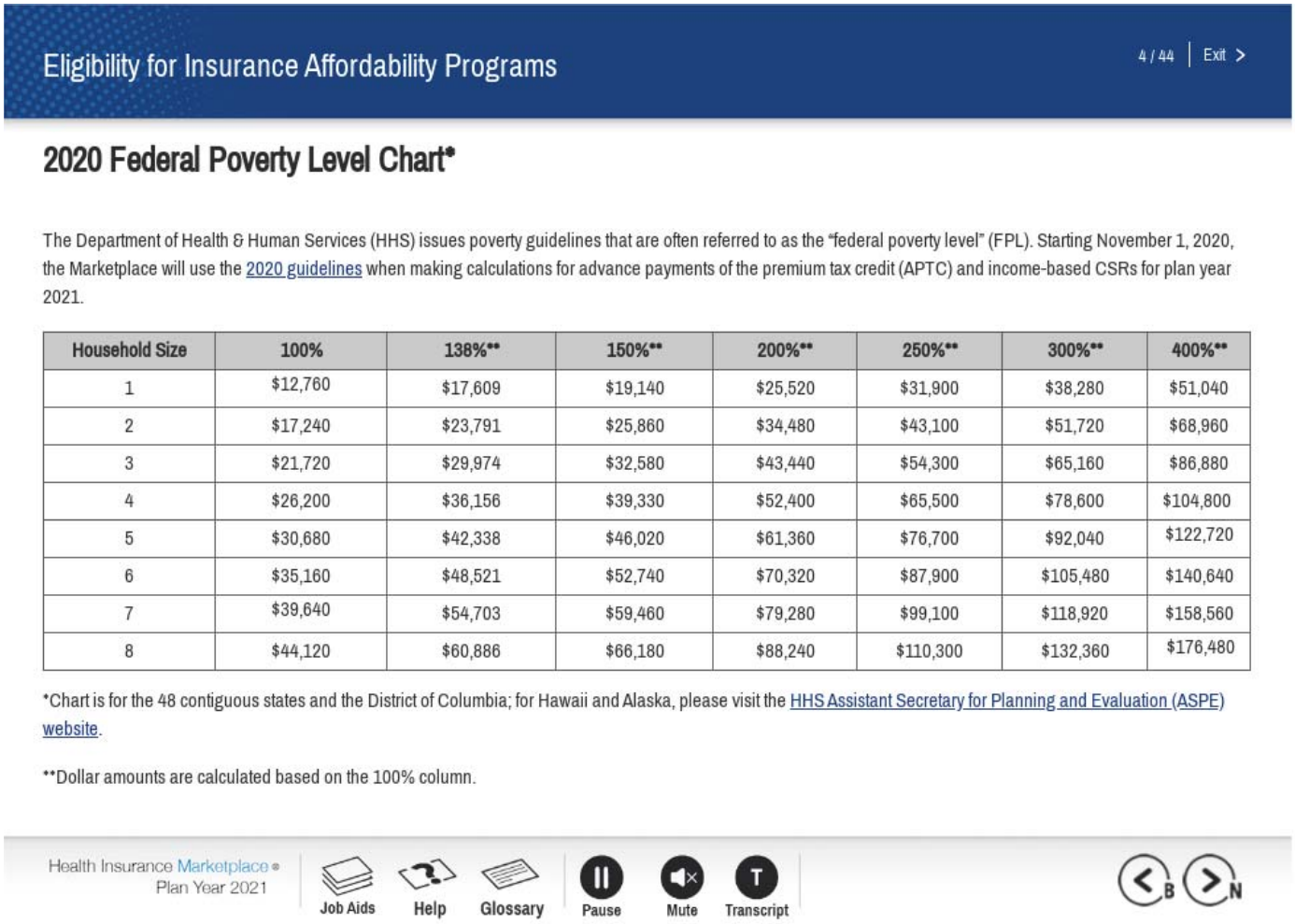
- Describe the premium tax credit, including the option for consumers to obtain the credit in advance
- Describe CSRs
- Describe Medicaid and CHIP

*The term "Health Insurance Marketplace®" is a registered trademark of the of the U.S. Department of Health & Human Services. When used in this document, the term "Health Insurance Marketplace®" or "Marketplace" refers to Federally-facilitated Marketplaces (FFMs), including FFMs where states perform plan management functions, and also refers to State-based Marketplaces on the Federal Platform (SBM-FPs).

Alt Text

A mother, father, and their young daughter sitting at a table across from an agent or broker

Page: 4 of 44: 2020 Federal Poverty Level Chart*



Page Text

The Department of Health & Human Services (HHS) issues poverty guidelines that are often referred to as the "federal poverty level" (FPL). Starting November 1, 2020, the Marketplace will use the 2020 guidelines when making calculations for advance payments of the premium tax credit (APTC) and income-based CSRs for plan year 2021.

Household Size 100% 138%** 150%** 200%** 250%** 300%** 400%** 1 $12,760 $17,609 $19,140 $25,520 $31,900 $38,280 $51,040 2 $17,240 $23,791 $25,860 $34,480 $43,100 $51,720 $68,960 3 $21,720 $29,974 $32,580 $43,440 $54,300 $65,160 $86,880 4 $26,200 $36,156 $39,330 $52,400 $65,500 $78,600 $104,800 5 $30,680 $42,338 $46,020 $61,360 $76,700 $92,040 $122,720 6 $35,160 $48,521 $52,740 $70,320 $87,900 $105,480 $140,640 7 $39,640 $54,703 $59,460 $79,280 $99,100 $118,920 $158,560 8 $44,120 $60,886 $66,180 $88,240 $110,300 $132,360 $176,480

*Chart is for the 48 contiguous states and the District of Columbia; for Hawaii and Alaska, please visit the HHS Assistant Secretary for Planning and Evaluation (ASPE) website. **Dollar amounts are calculated based on the 100% column.

Pop Up Text

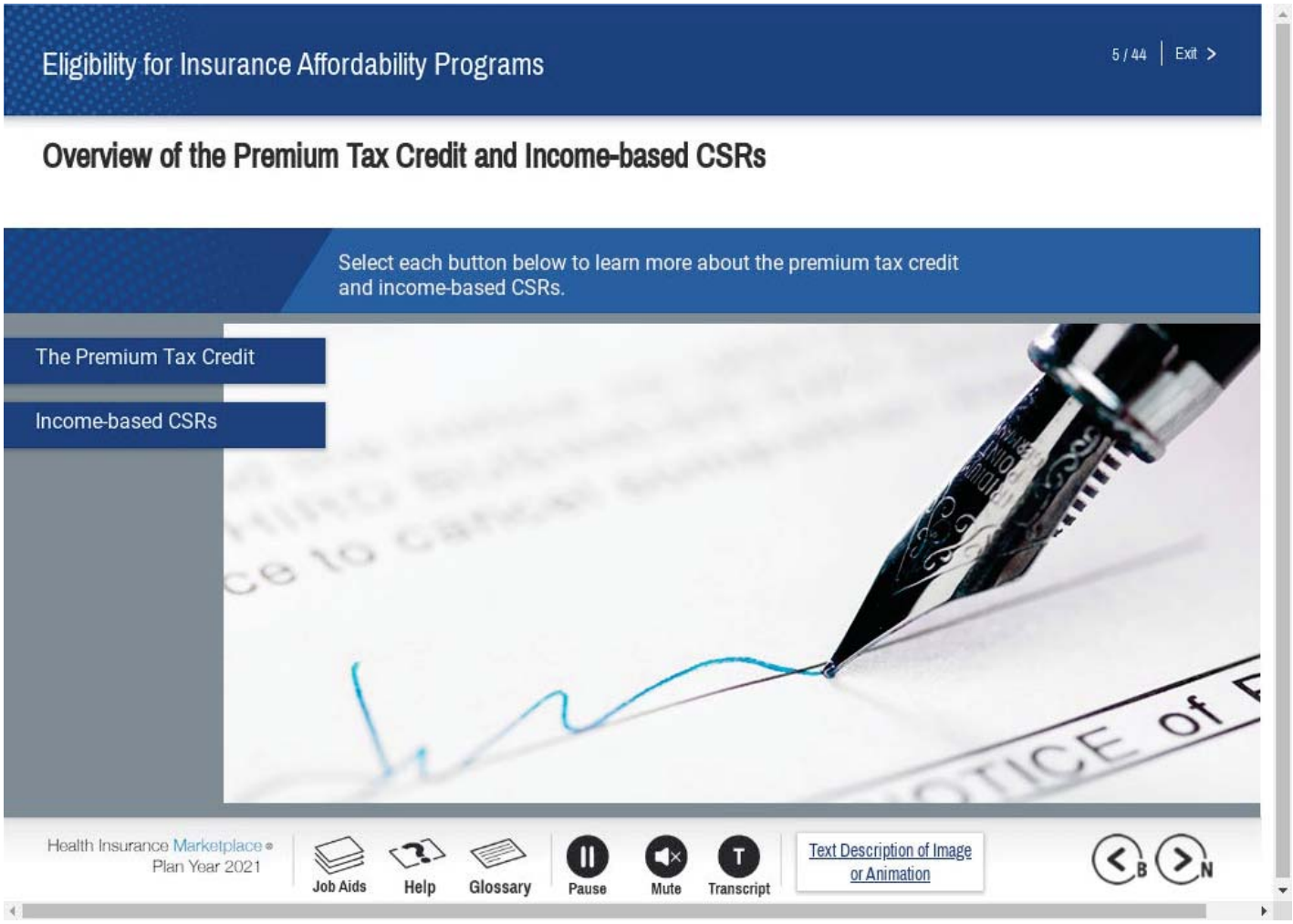
Plan Year 2020 Guidelines

For plan year 2021, beginning with the Open Enrollment period (November 1, 2020 through December 15, 2020), determinations of eligibility for APTC and income-based CSRs will be based on the 2020 FPL from HHS' 2020 Poverty Guidelines (https://aspe.hhs.gov/poverty-guidelines).

Note that Medicaid and CHIP assessments/determinations are currently based on the 2020 FPL from the HHS 2020 Poverty Guidelines until January or February 2021 when HHS releases the new guidelines for 2021.

The 2021 guidelines have not been released as of the date of publication of this training, but will be available on the HHS Assistant Secretary for Planning and Evaluation (ASPE) website.

Page: 5 of 44: Overview of the Premium Tax Credit and Income-based CSRs



Page Text

Long Description
Interactive graphic. The center of the screen is an image of a pen signing a check. There is instruction text at the top of the screen in a blue banner and white font. To the left of the image are two buttons that, when selected, pop-up boxes and accompanying text are displayed. Once a button is selected and the pop-up box is closed, the button turns from blue to green to indicate the action is complete.

Prompt text: Select each button below to learn more about the premium tax credit and income-based CSRs.

Pop Up Text
The Premium Tax Credit Text:

The premium tax credit helps eligible individuals and families afford health insurance coverage purchased through the Marketplace. After submitting an application to the Marketplace, an individual may be determined eligible to receive APTC. APTC is an amount paid to an individual's insurance company to reduce the amount the individual must pay each month for coverage in a qualified health plan (QHP). The amount of APTC for which an individual is eligible is based on an estimation of the premium tax credit the individual will be able to claim for the year of coverage. An individual may choose to apply some or all of the APTC for which he or she qualifies towards premium costs. Alternatively, if an individual chooses to forego APTC, he

or she will receive the full benefit of the premium tax credit by claiming it on his or her federal income tax return filed for the plan year.

APTC are paid on a monthly basis directly to the issuer offering the QHP.

The premium tax credit is not available for coverage purchased outside of the Marketplace or for an individual's Marketplace coverage if the individual chooses to be covered by an individual coverage Health Reimbursement Arrangement (HRA) or has an individual coverage HRA offer that is considered affordable. You will learn more about HRAs later in this module.

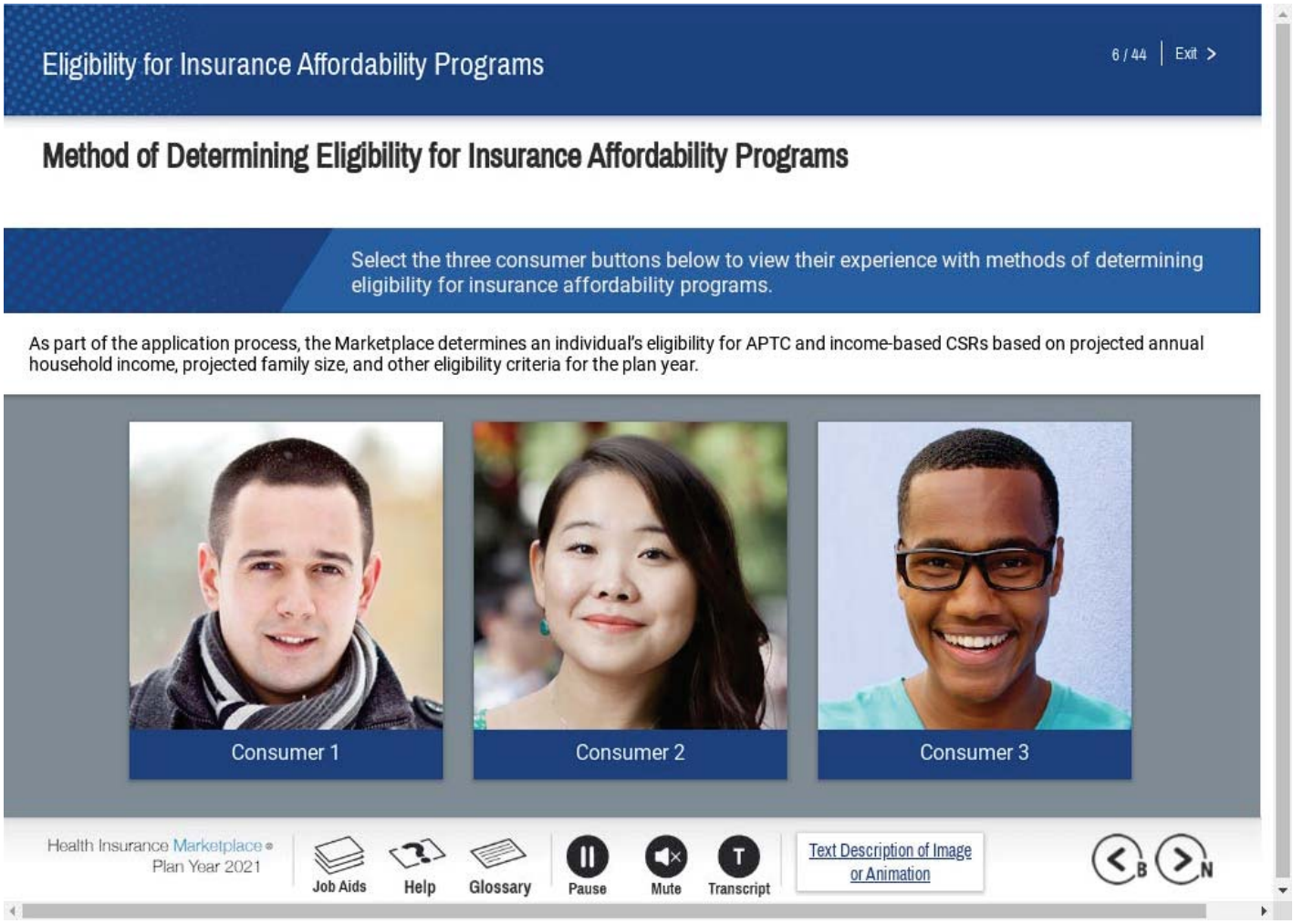
Income-based CSRs Text:

CSRs reduce out-of-pocket costs, such as deductibles, coinsurance, and copayments, but not balance billing, such as from an out-of-network provider or for non-covered services. Eligibility for income-based CSRs is based on household income and generally requires the individual or family to enroll in a Silver plan category and be eligible for APTC. However, consumers who are members of federally recognized tribes or shareholders in the Alaska Native Claims Settlement Act (ANCSA) Corporations may receive CSRs if they enroll in a plan in any plan category, and those who qualify for a limited cost-sharing plan do not have to be eligible for APTC.

CSRs are not available for coverage purchased outside of the Marketplace.

Generally, individuals and families with household incomes between 100% and 250% of the FPL may be eligible to receive income-based CSRs. Household income is determined by calculating a consumer's modified adjusted gross income (MAGI). Consumers who are members of federally recognized tribes or ANCSA Corporation shareholders may qualify for additional cost-sharing benefits.

Page: 6 of 44: Method of Determining Eligibility for Insurance Affordability Programs



Long Description
Interactive graphic representing consumers. Three equally sized profile images of consumers. From left to right under each image are the labels: Consumer 1, Consumer 2, and Consumer 3. When each consumer is selected, a pop-up box appears in the middle of the screen with related text.

Prompt Text: Select the three consumer buttons below to view his or her experience with methods of determining eligibility for insurance affordability programs.

Page Text:

As part of the application process, the Marketplace determines an individual's eligibility for APTC and income-based CSRs based on projected annual household income, projected family size, and other eligibility criteria for the coverage year.

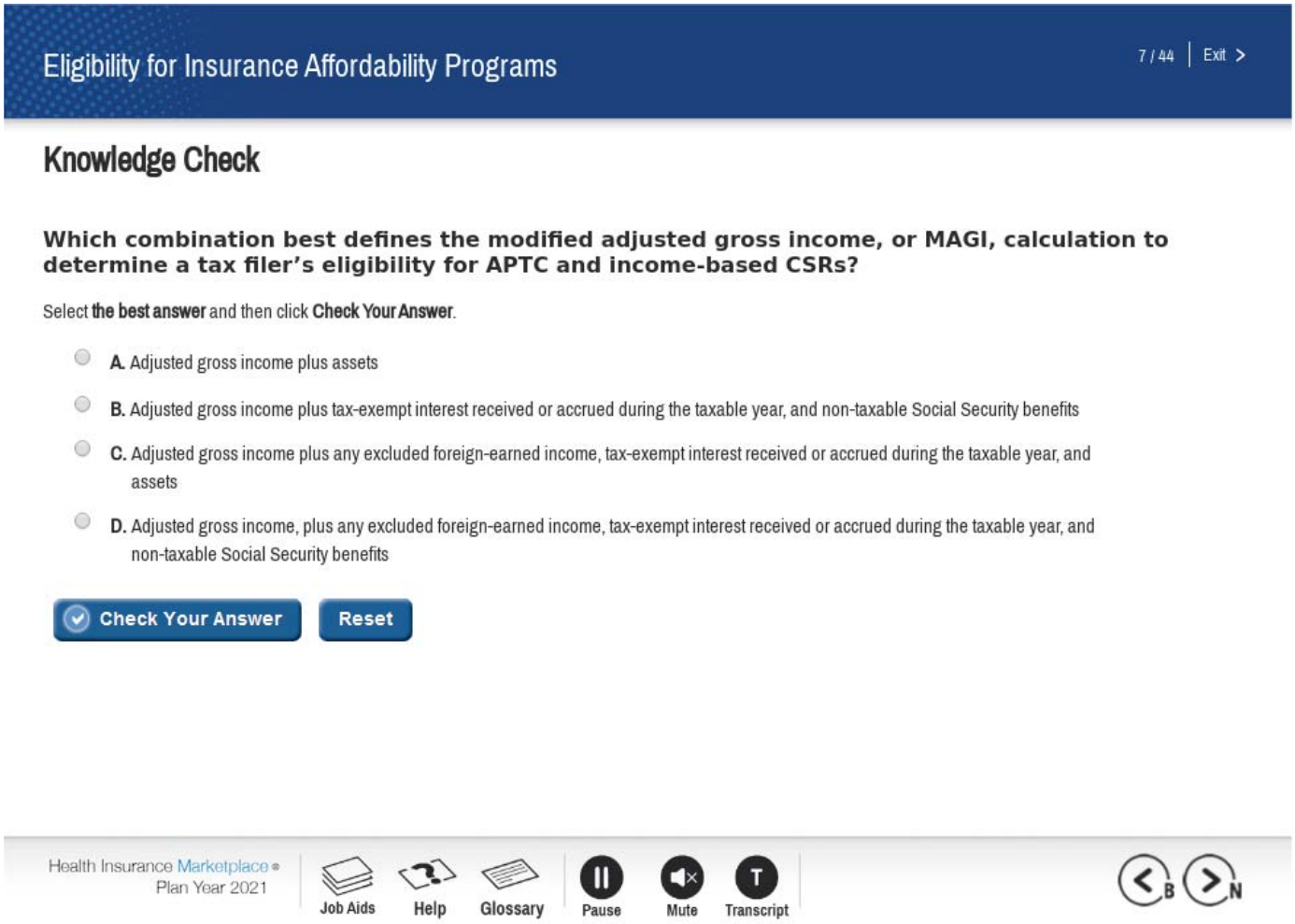
Pop Up Text

Consumer 1: The first thing I needed to know was how to calculate MAGI. MAGI is adjusted gross income on my federal income tax return, plus any excluded foreign-earned income, tax-exempt interest received or accrued during the taxable year, and non-taxable Social Security benefits. I thought I had to list my assets, but they are not considered in calculating MAGI or determining eligibility.

Consumer 2: My eligibility for insurance affordability programs is based on my annual household income, which is generally the sum of my MAGI, my spouse's MAGI if we file jointly, and the MAGI of my dependents who are required to file a federal income tax return. Medicaid and CHIP eligibility is primarily based on current monthly income, while eligibility for APTC and income-based CSRs is based on projected annual household income for the coverage year.

Consumer 3: The Patient Protection and Affordable Care Act requires all states and the Marketplace to determine eligibility for Medicaid and CHIP for most individuals (essentially, all non-disabled, non-elderly individuals) based on their MAGI. I wasn't aware that the Marketplace generally uses the same income methodology for determining eligibility for APTC and income-based CSRs as it does for determining eligibility for Medicaid and CHIP, with some exceptions.

Page: 7 of 44: Knowledge Check



Prompt
Select **the best answer** and then click **Check Your Answer**.

Question
Which combination best defines the modified adjusted gross income, or MAGI, calculation to determine a tax filer's eligibility for APTC and income-based CSRs?

Options

A. Adjusted gross income plus assets

B. Adjusted gross income plus tax-exempt interest received or accrued during the taxable year, and non-taxable Social Security benefits

C. Adjusted gross income plus any excluded foreign-earned income, tax-exempt interest received or accrued during the taxable year, and assets

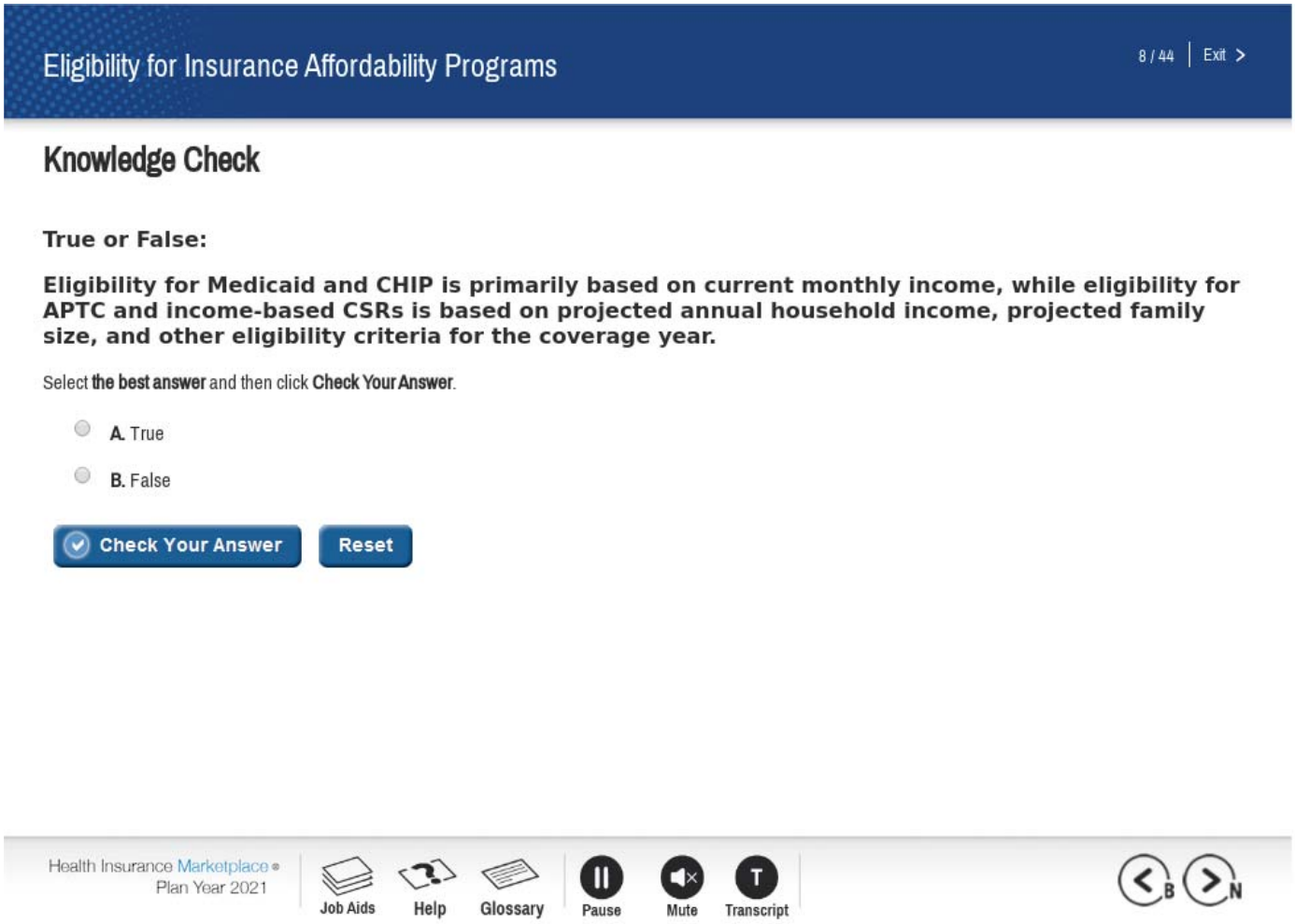
D. Adjusted gross income, plus any excluded foreign-earned income, tax-exempt interest received or accrued during the taxable year, and non-taxable Social Security benefits

Correct Answer
D

Positive Feedback
Correct! MAGI is adjusted gross income on the federal income tax return, plus any excluded foreign-earned income, tax-exempt interest received or accrued during the taxable year, and non-taxable Social Security benefits. Assets are not considered in determining eligibility.

Negative Feedback
Incorrect. The correct answer is D. MAGI is adjusted gross income on the federal income tax return, plus any excluded foreign-earned income, tax-exempt interest received or accrued during the taxable year, and non-taxable Social Security benefits. Assets are not considered in determining eligibility.

Page: 8 of 44: Knowledge Check



Prompt
Select **the best answer** and then click **Check Your Answer**.

Question
True or False: Eligibility for Medicaid and CHIP is primarily based on current monthly income, while eligibility for APTC and income-based CSRs is based on projected annual household income, projected family size, and other eligibility criteria for the coverage year.

Options

A. True

B. False

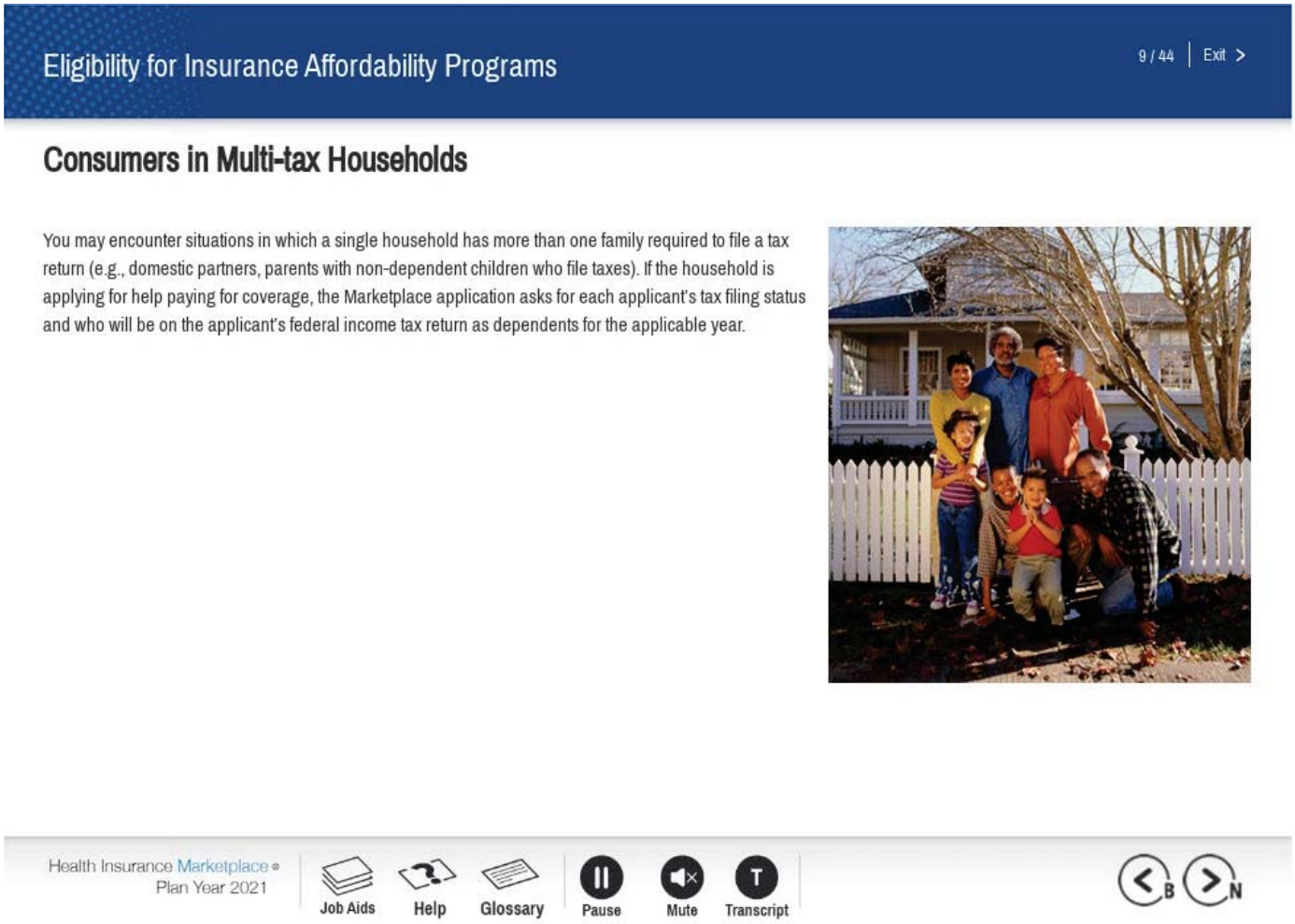
Correct Answer
A

Positive Feedback
Correct! You should recognize and advise your clients of the difference in this income calculation methodology.

Negative Feedback

Incorrect. The statement is true. You should recognize and advise your clients of the difference in this income calculation methodology.

Page: 9 of 44: Consumers in Multi-tax Households



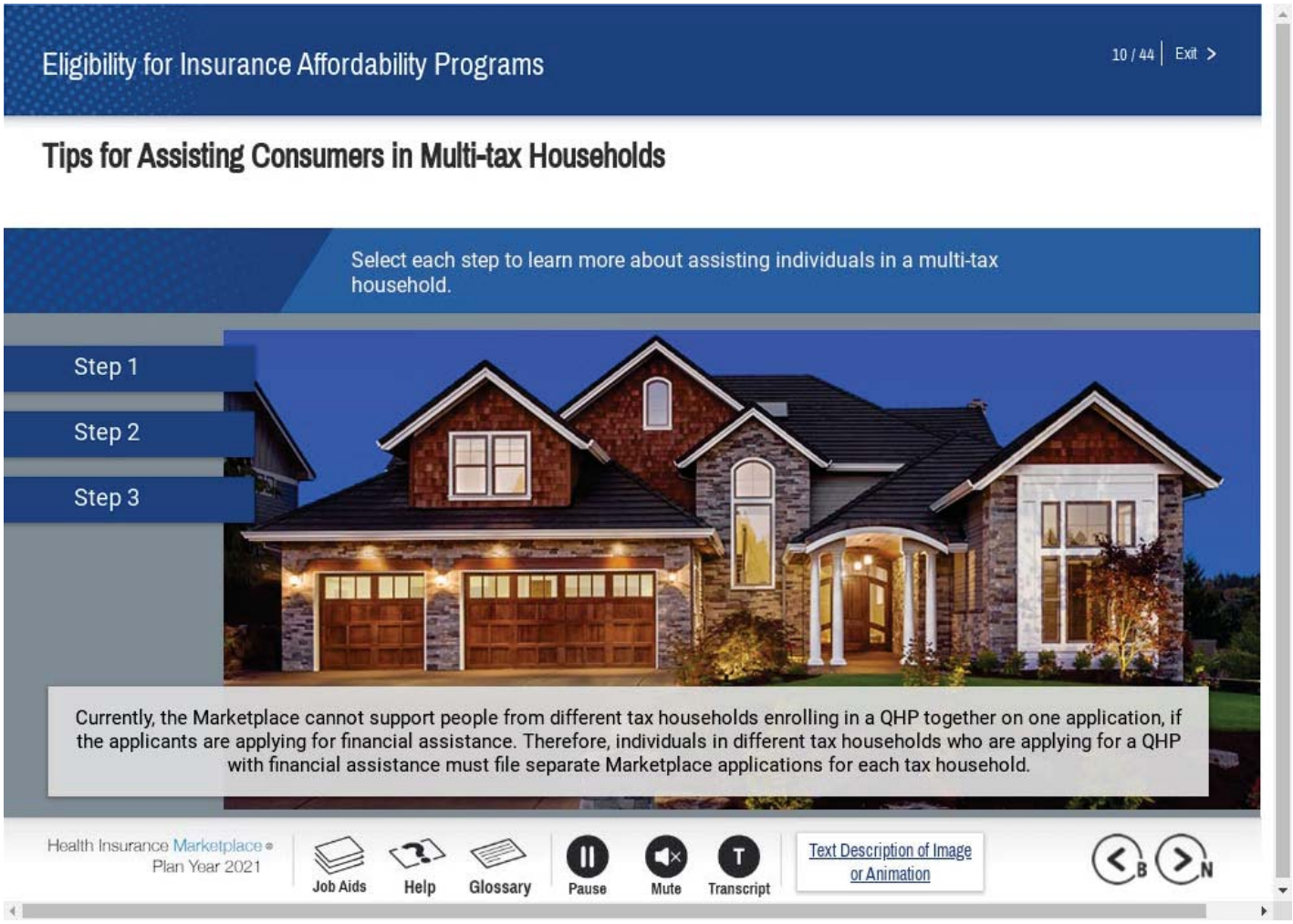
Page Text

You may encounter situations in which a single household has more than one family required to file a tax return (e.g., domestic partners, parents with non-dependent children who file taxes). If the household is applying for help paying for coverage, the Marketplace application asks for each applicant's tax filing status and who will be on the applicant's federal income tax return as dependents for the applicable year.

Alt Text

A multi-generational family with adults and children standing together in front of a house

Page: 10 of 44: Tips for Assisting Consumers in Multi-tax Households



Long Description
Interactive graphic showing a full-page image of a house with the lights on at night. To the left of the image are three buttons stacked on top of each other. From top to bottom the buttons are labeled Step 1, Step 2, and Step 3.

Prompt Text: Select each step to learn more about assisting individuals in a multi-tax household.

Page Text: Currently, the Marketplace cannot support people from different tax households enrolling in a QHP together on one application, if the applicants are applying for financial assistance. Therefore, individuals in different tax households applying for coverage through a Marketplace with financial assistance must file separate applications for each tax household.

Pop Up Text

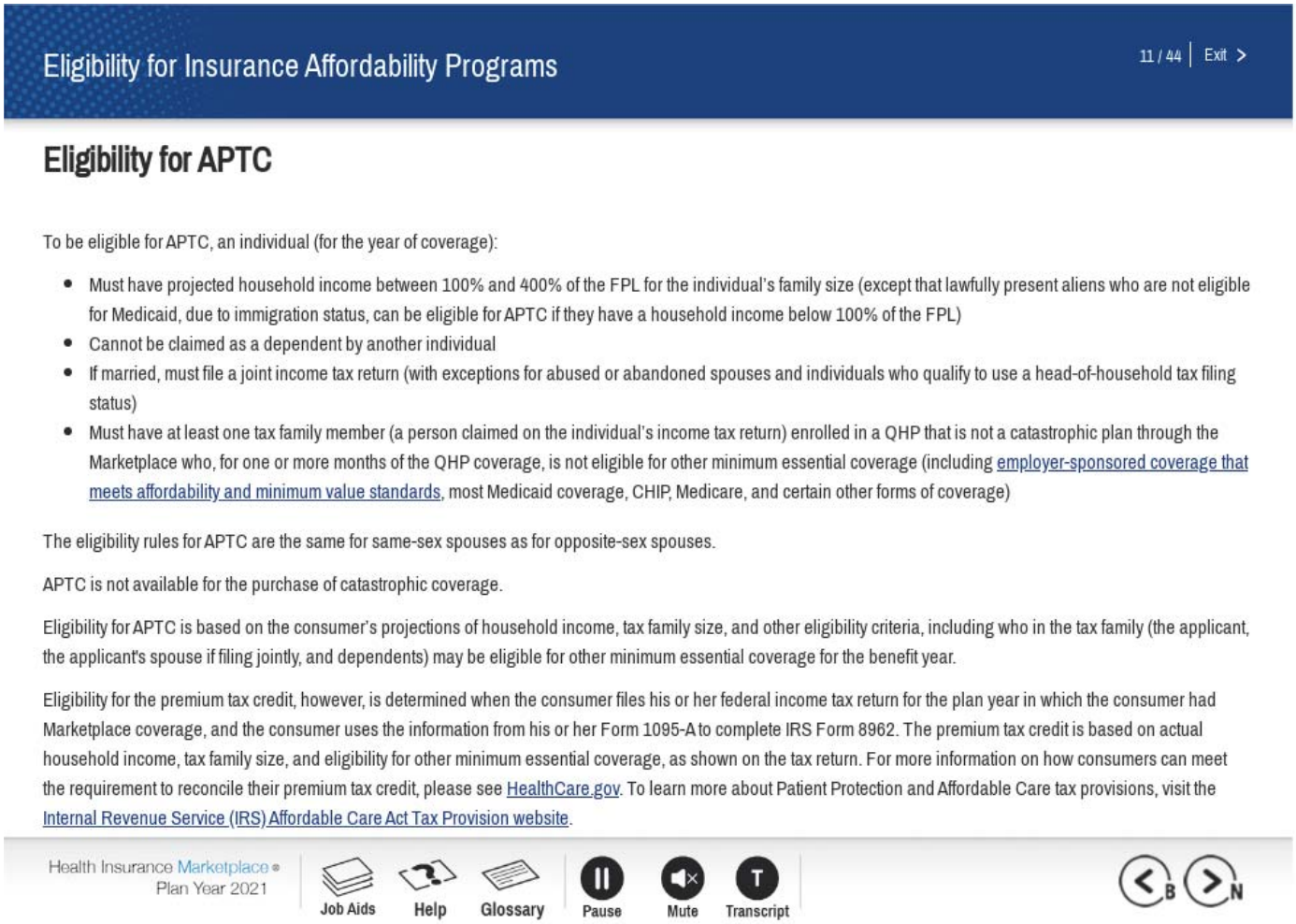
Step 1: Determine whether the application filer is applying for help paying for coverage. If no, then these instructions do not apply to the consumer you are assisting.

Step 2: Determine if the application includes members of more than one tax household, each filing a tax return. If no, then these instructions do not apply to the consumer you are assisting.

Step 3: Help these tax filers complete separate applications for each tax household or contact the Marketplace Call Center for help at 1-800-318-2596 (TTY: 1-855-889-4325).

- For each tax household, help the consumer list members of the tax household as applicants (applying for coverage) on only ONE application. The consumers should list the other household members as non-applicants (not applying for coverage) on the application.
- Each tax household application group will be on its own policy, but can still select the same plan.

Page: 11 of 44: Eligibility for APTC



Page Text

To be eligible for APTC, an individual (for the year of coverage):

- Must have projected household income between 100% and 400% of the FPL for the individual's family size (except that lawfully present aliens who are not eligible for Medicaid, due to immigration status, can be eligible for APTC if they have a household income below 100% of the FPL)
- Cannot be claimed as a dependent by another individual
- If married, must file a joint income tax return (with exceptions for abused or abandoned spouses and individuals who qualify to use a head-of-household tax filing status)
- Must have at least one tax family member (a person claimed on the individual's income tax return) enrolled in a QHP that is not a catastrophic plan through the Marketplace who, for one or more months of the QHP coverage, is not eligible for other minimum essential coverage (including employer-sponsored coverage that meets affordability and minimum value standards, most Medicaid coverage, CHIP, Medicare, and certain other forms of coverage)

The eligibility rules for APTC are the same for same-sex spouses as for opposite-sex spouses.

APTC is not available for the purchase of catastrophic coverage.

Eligibility for APTC is based on the consumer's projections of household income, tax family size, and other eligibility criteria, including who in the tax family (the applicant, the applicant's spouse if filing jointly, and dependents) may be eligible for other minimum essential coverage for the benefit year.

Eligibility for the premium tax credit, however, is determined when the consumer files his or her federal income tax return for the plan year in which the consumer had Marketplace coverage, and the consumer uses the information from his or her Form 1095-A to complete IRS Form 8962. The premium tax credit is based on actual household income, tax family size, and eligibility for other minimum essential coverage, as shown on the tax return. For more information on how consumers can meet the requirement to reconcile their premium tax credit, please see HealthCare.gov. To learn more about Patient Protection and Affordable Care tax provisions, visit the Internal Revenue Service (IRS) Affordable Care Act Tax Provision website.

Pop Up Text

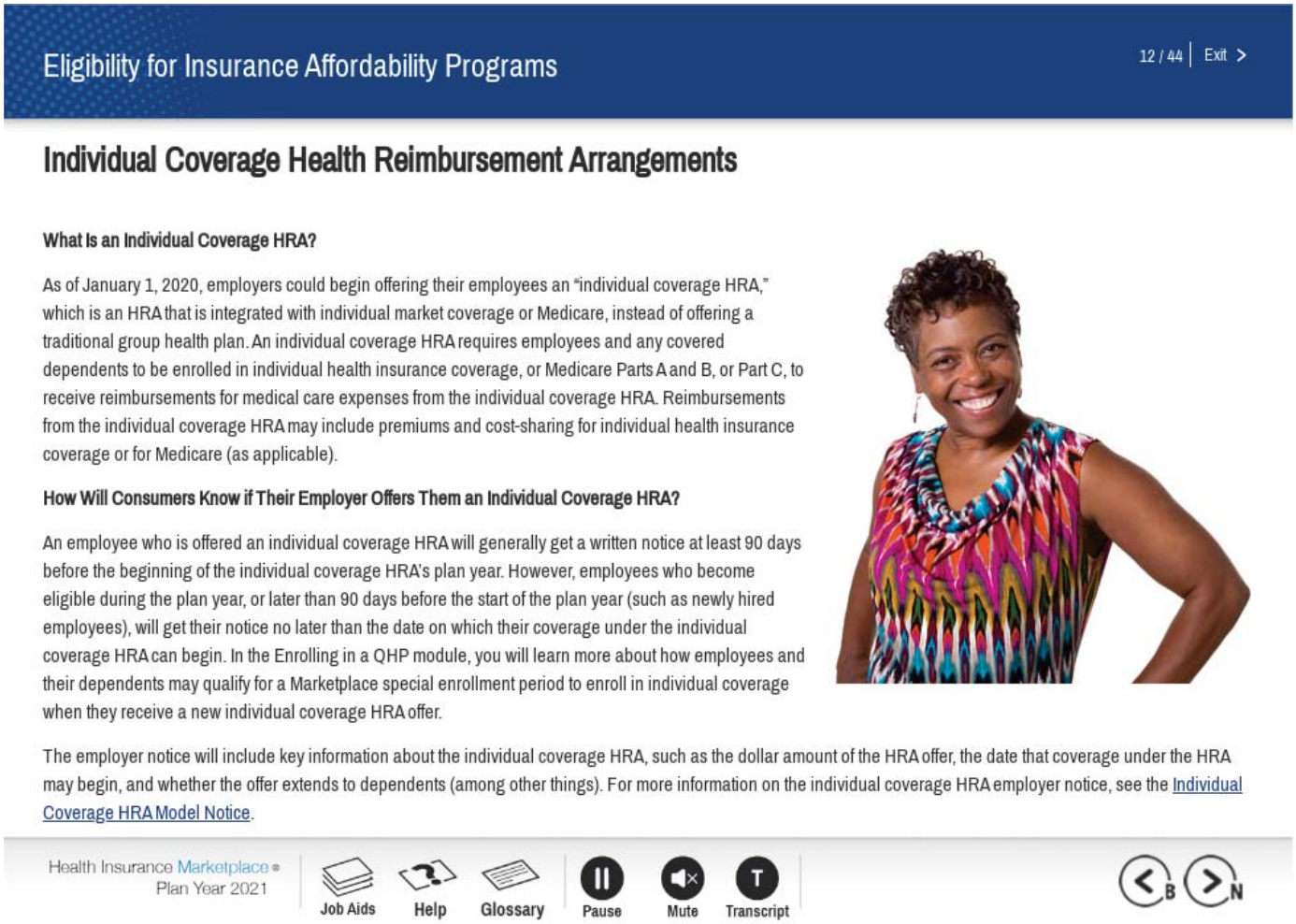
Standards for Employer-sponsored Insurance
Employer-sponsored insurance is considered unaffordable for an employee, and the employee's family members if they are also allowed to enroll in the coverage, if the amount the employee must pay for the lowest-cost self-only plan that meets the minimum value standard is more than a percentage of the worker's projected annual household income. The percentage is 9.78% for plan years beginning in 2020. The percentage for plan years beginning in 2021 is not available as of the publication date of this training.

A health plan meets the minimum value standard if both of the following apply:

- It is designed to pay at least 60% of the total cost of medical services for a standard population.
- Its benefits include substantial coverage of physician and inpatient hospital services.

If the employee and his or her family members actually enroll in the employer-sponsored insurance, the employee and family members are not allowed APTC for their Marketplace coverage regardless of whether the employer plan is affordable or provides minimum value.

Page: 12 of 44: Individual Coverage Health Reimbursement Arrangements



Page Text

What Is an Individual Coverage HRA?

As of January 1, 2020, employers could begin offering their employees an "individual coverage HRA," which is an HRA that is integrated with individual market coverage or Medicare, instead of offering a traditional group health plan. An individual coverage HRA requires employees and any covered dependents to be enrolled in individual health insurance coverage, or Medicare Parts A and B, or Part C, to receive reimbursements for medical care expenses from the individual coverage HRA. Reimbursements from the individual coverage HRA may include premiums and cost-sharing for individual health insurance coverage or for Medicare (as applicable).

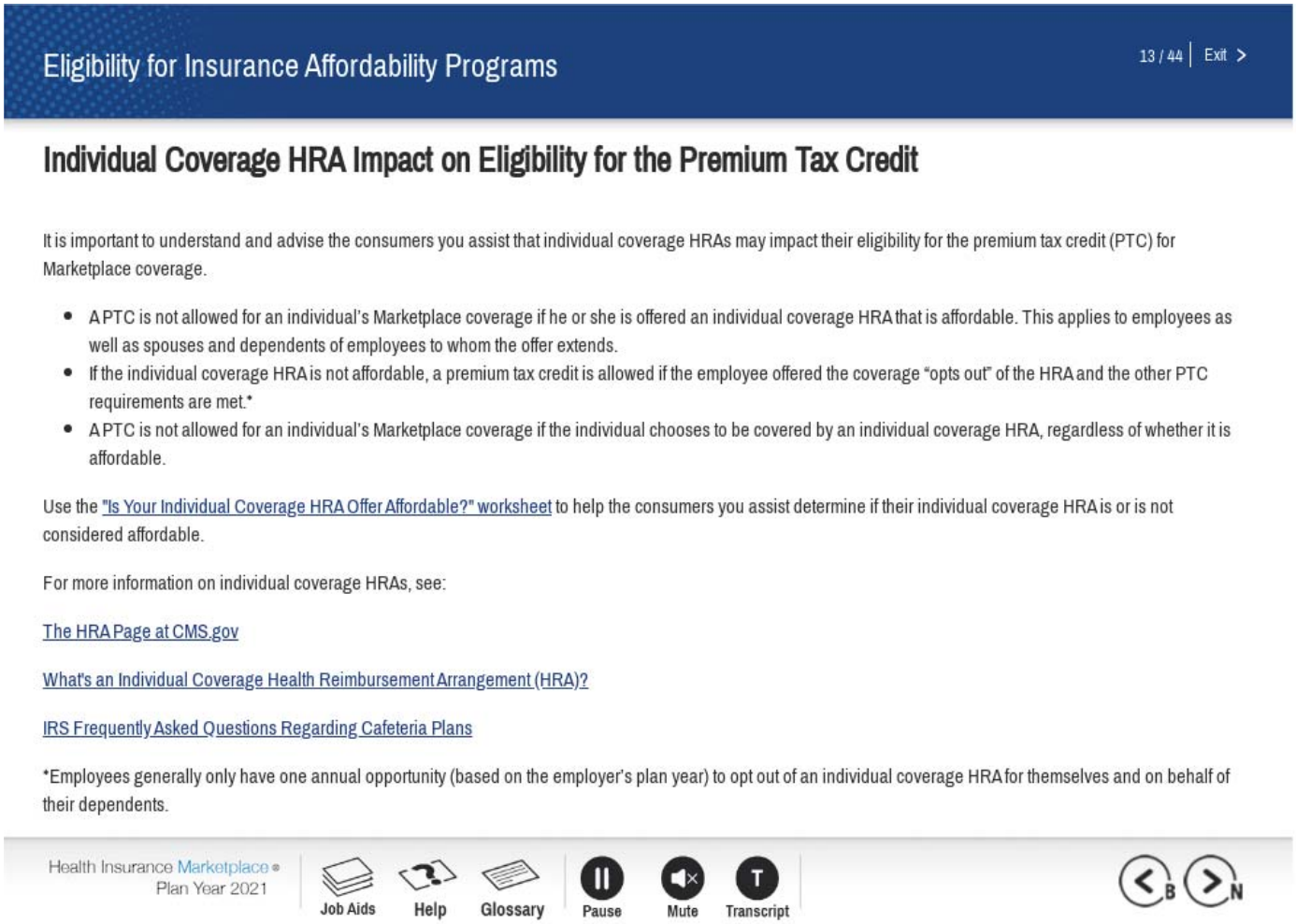
How Will Consumers Know if Their Employer Offers Them an Individual Coverage HRA?

An employee who is offered an individual coverage HRA will generally get a written notice at least 90 days before the beginning of the individual coverage HRA's plan year. However, employees who become eligible during the plan year, or later than 90 days before the start of the plan year (such as newly hired employees), will get their notice no later than the date on which their coverage under the individual coverage HRA can begin. In the Enrolling in a QHP module, you will learn more about how employees and their dependents may qualify for a Marketplace special enrollment period to enroll in individual coverage when they receive a new individual coverage HRA offer.

The employer notice will include key information about the individual coverage HRA, such as the dollar amount of the HRA offer, the date that coverage under the HRA may begin, and whether the offer extends to dependents (among other things). For more information on the individual coverage HRA employer notice, see the Individual Coverage HRA Model Notice.

Alt Text
A middle aged, female consumer

Page: 13 of 44: Individual Coverage HRA Impact on Eligibility for the Premium Tax Credit



Page Text

It is important to understand and advise the consumers you assist that individual coverage HRAs may impact their eligibility for the premium tax credit (PTC) for Marketplace coverage.

- A PTC is not allowed for an individual's Marketplace coverage if he or she is offered an individual coverage HRA that is affordable. This applies to employees as well as spouses and dependents of employees to whom the offer extends.
- If the individual coverage HRA is not affordable, a premium tax credit is allowed if the employee offered the coverage "opts out" of the HRA and the other PTC requirements are met.*
- A PTC is not allowed for an individual's Marketplace coverage if the individual chooses to be covered by an individual coverage HRA, regardless of whether it is affordable.

Use the "Is Your Individual Coverage HRA Offer Affordable?" worksheet to help the consumers you assist determine if their individual coverage HRA is or is not considered affordable.

For more information on individual coverage HRAs, see:

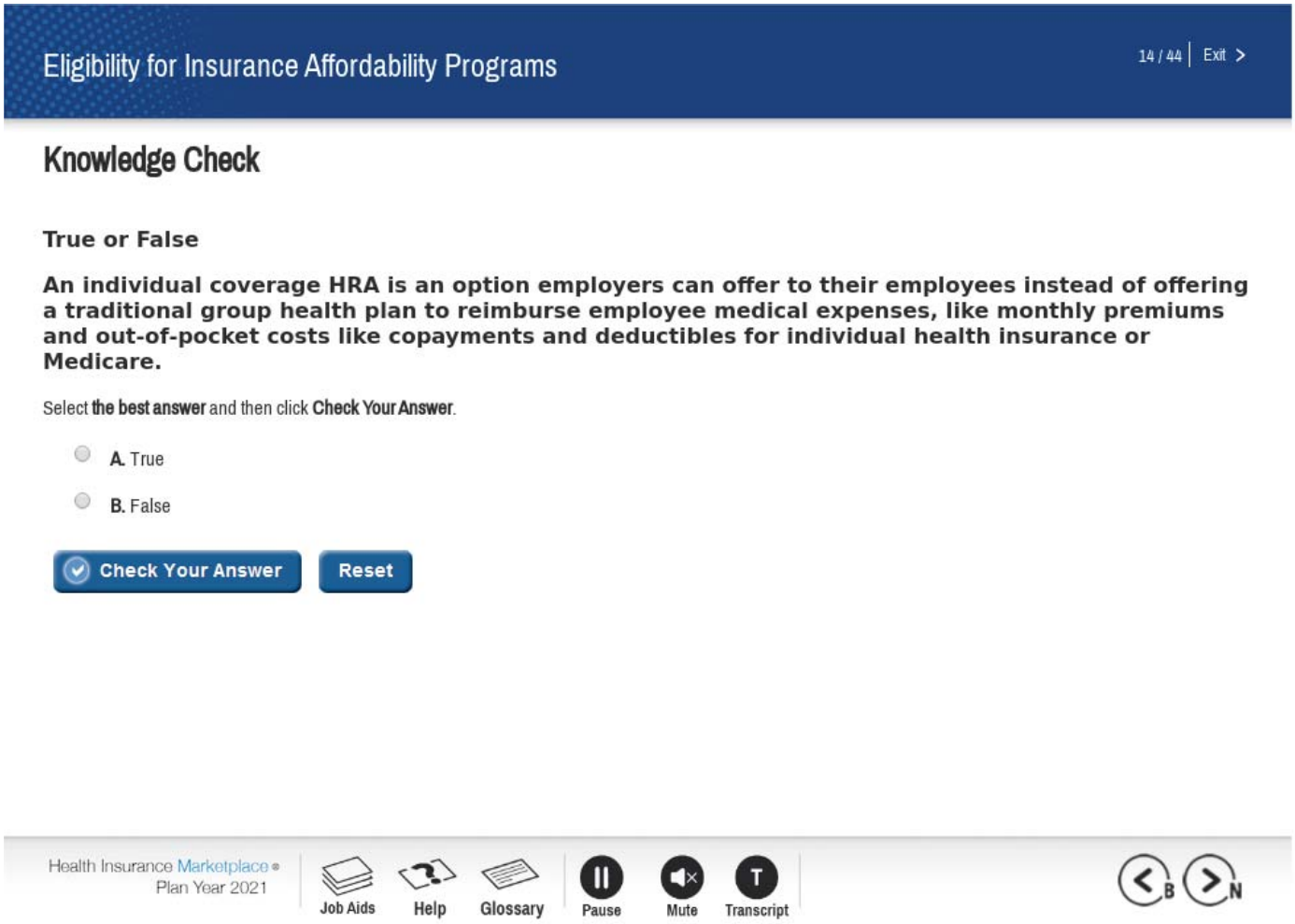
The HRA Page at CMS.gov

What's an Individual Coverage Health Reimbursement Arrangement (HRA)?

IRS Frequently Asked Questions Regarding Cafeteria Plans

*Employees generally only have one annual opportunity (based on the employer's plan year) to opt out of an individual coverage HRA for themselves and on behalf of their dependents.

Page: 14 of 44: Knowledge Check



Prompt
Select **the best answer** and then click **Check Your Answer**.

Question
True or False An individual coverage HRA is an option employers can offer to their employees instead of offering a traditional group health plan to reimburse employee medical expenses, like monthly premiums and out-of-pocket costs like copayments and deductibles for individual health insurance or Medicare.

Options

A. True

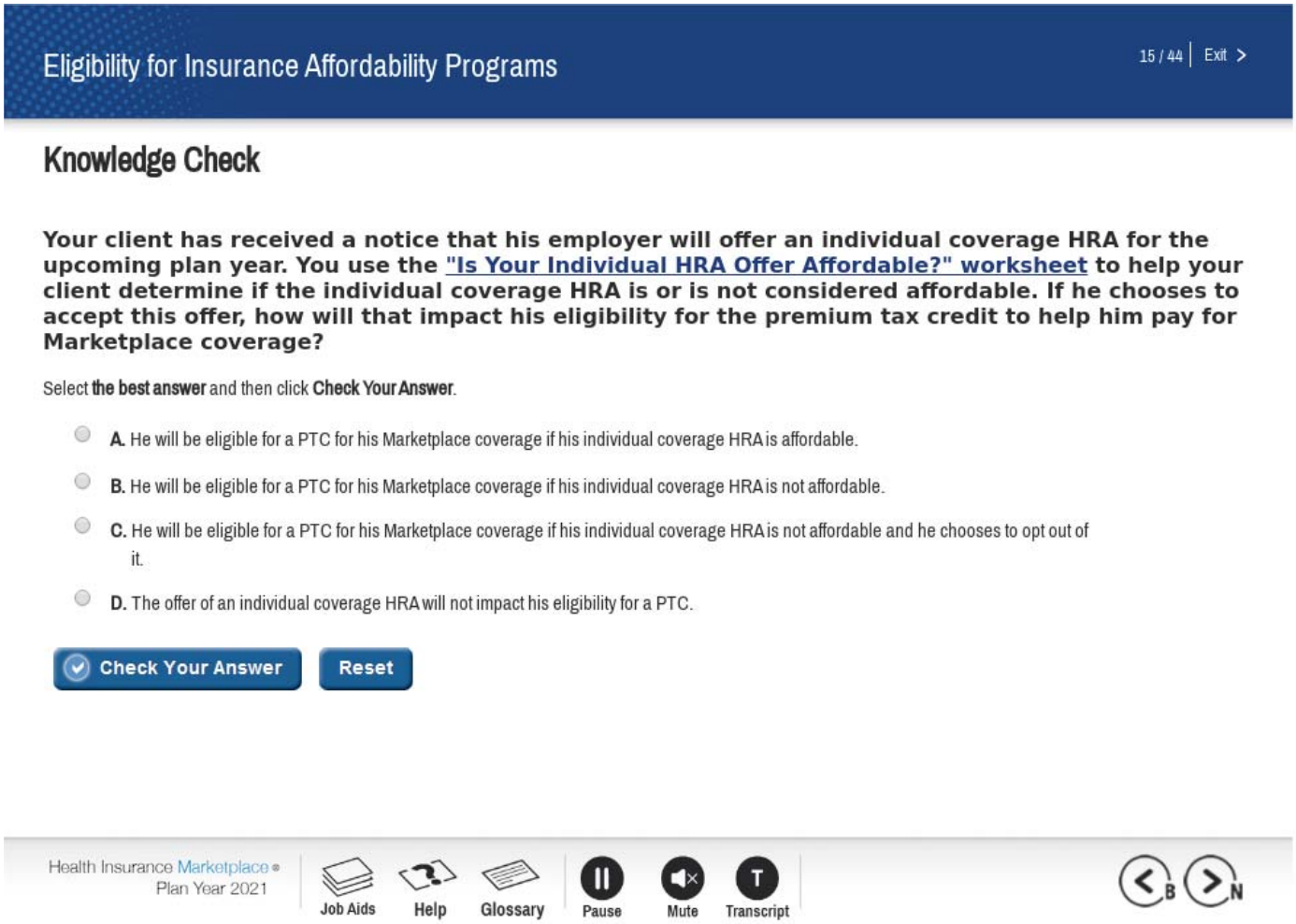
B. False

Correct Answer
A

Positive Feedback
Correct! You should learn how to help clients who wish to enroll in Marketplace coverage and who have an individual coverage HRA offer from an employer. See the Individual Coverage Health Reimbursement Arrangements: Pre-Open Enrollment Period training for additional individual coverage HRA information and consumer scenarios.

Negative Feedback
Incorrect. You should learn how to help clients who wish to enroll in Marketplace coverage and who have an individual coverage HRA offer from an employer. See the Individual Coverage Health Reimbursement Arrangements: Pre-Open Enrollment Period training for additional individual coverage HRA information and consumer scenarios.

Page: 15 of 44: Knowledge Check



Prompt

Select **the best answer** and then click **Check Your Answer**.

Question

Your client has received a notice that his employer will offer an individual coverage HRA for the upcoming plan year. You use the "Is Your Individual HRA Offer Affordable?" worksheet to help your client determine if the individual coverage HRA is or is not considered affordable. If he chooses to accept this offer, how will that impact his eligibility for the premium tax credit to help him pay for Marketplace coverage?

Options

A. He will be eligible for a PTC for his Marketplace coverage if his individual coverage HRA is affordable.

B. He will be eligible for a PTC for his Marketplace coverage if his individual coverage HRA is not affordable.

C. He will be eligible for a PTC for his Marketplace coverage if his individual coverage HRA is not affordable and he chooses to opt out of it.

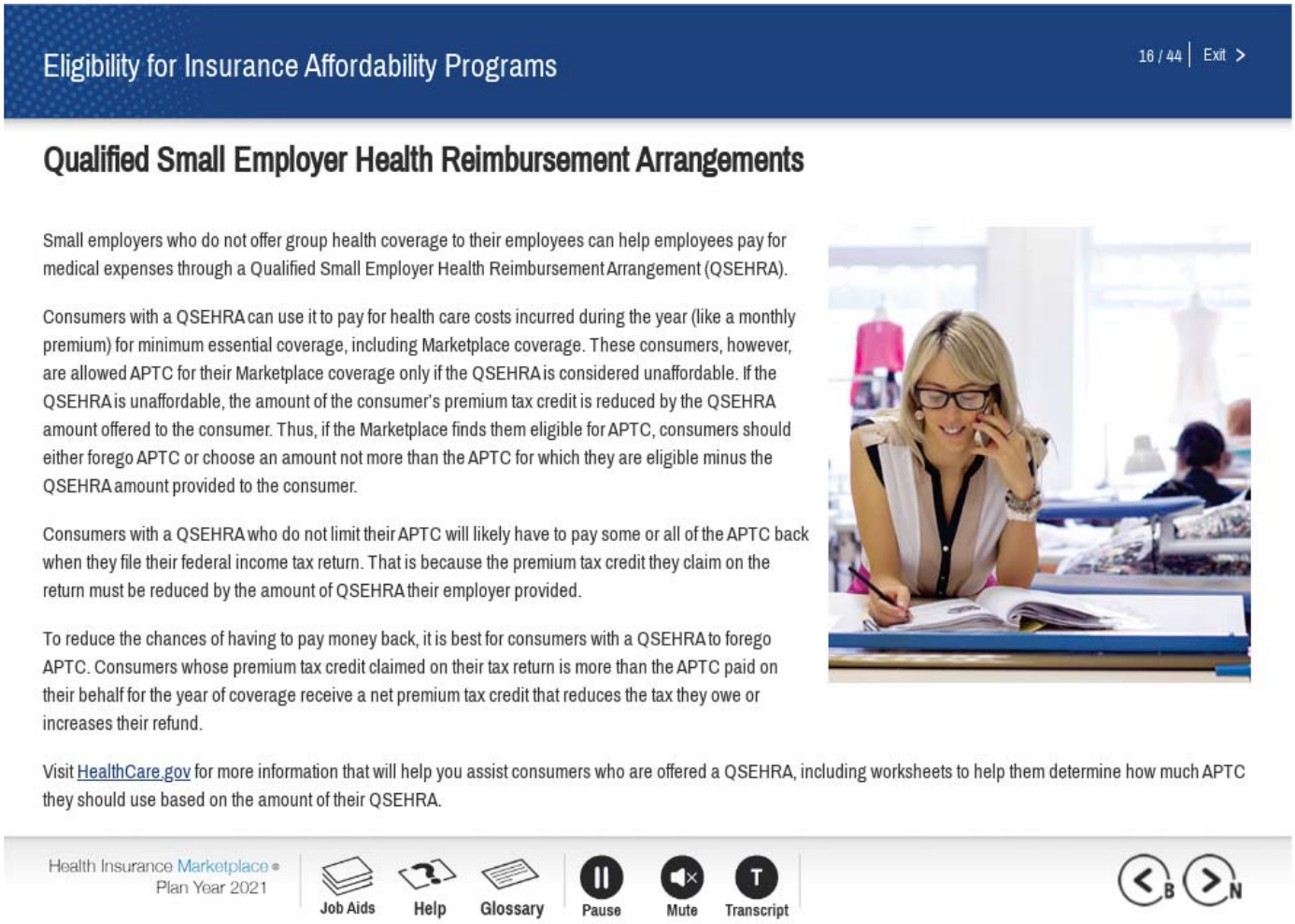
D. The offer of an individual coverage HRA will not impact his eligibility for a PTC.

Correct Answer
C

Positive Feedback
Correct! If your client does not opt out of his individual coverage HRA, he will not be eligible for a PTC for Marketplace coverage, even if the individual coverage HRA is not affordable. Remember, you can use the "Is Your Individual Coverage HRA Offer Affordable?" worksheet to help the consumers you assist determine if their individual coverage HRA is or is not considered affordable.

Negative Feedback
Incorrect. The correct answer is C. If your client does not opt out of his individual coverage HRA, he will not be eligible for a PTC for Marketplace coverage, even if the individual coverage HRA is not affordable. Remember, you can use the "Is Your Individual Coverage HRA Offer Affordable?" worksheet to help the consumers you assist determine if their individual coverage HRA is or is not considered affordable.

Page: 16 of 44: Qualified Small Employer Health Reimbursement Arrangements



Page Text

Small employers who do not offer group health coverage to their employees can help employees pay for medical expenses through a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA).

Consumers with a QSEHRA can use it to pay for health care costs incurred during the year (like a monthly premium) for minimum essential coverage, including Marketplace coverage. These consumers, however, are allowed APTC for their Marketplace coverage only if the QSEHRA is considered unaffordable. If the QSEHRA is unaffordable, the amount of the consumer's premium tax credit is reduced by the QSEHRA amount offered to the consumer. Thus, if the Marketplace finds them eligible for APTC, consumers should either forego APTC or choose an amount not more than the APTC for which they are eligible minus the QSEHRA amount provided to the consumer.

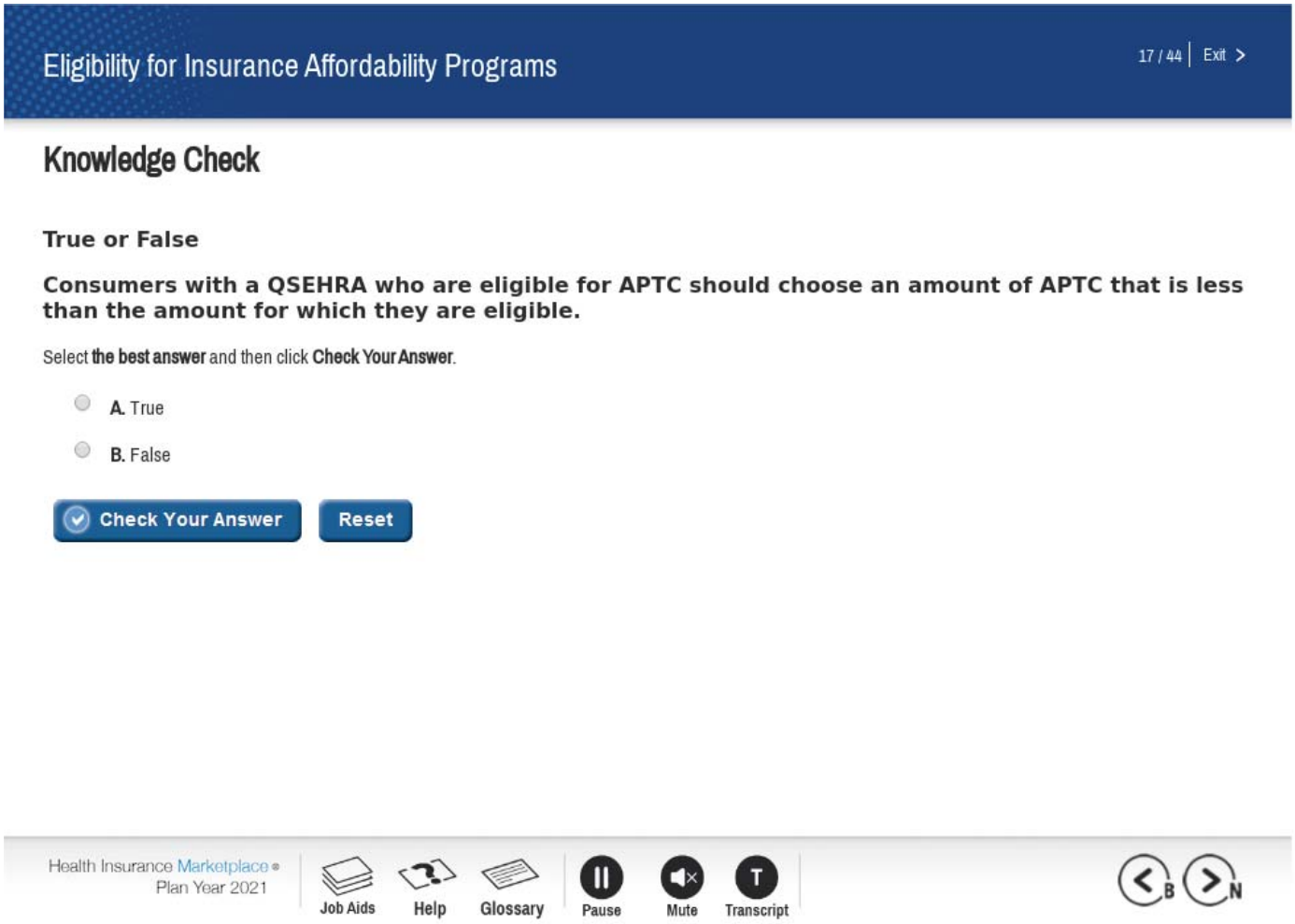
Consumers with a QSEHRA who do not limit their APTC will likely have to pay some or all of the APTC back when they file their federal income tax return. That is because the premium tax credit they claim on the return must be reduced by the amount of QSEHRA their employer provided.

To reduce the chances of having to pay money back, it is best for consumers with a QSEHRA to forego APTC. Consumers whose premium tax credit claimed on their tax return is more than the APTC paid on their behalf for the year of coverage receive a net premium tax credit that reduces the tax they owe or increases their refund.

Visit HealthCare.gov for more information that will help you assist consumers who are offered a QSEHRA, including worksheets to help them determine how much APTC they should use based on the amount of their QSEHRA.

Alt Text
A small business owner talking on her cell phone while working in her shop.

Page: 17 of 44: Knowledge Check



Prompt
Select **the best answer** and then click **Check Your Answer**.

Question
True or False Consumers with a QSEHRA who are eligible for APTC should choose an amount of APTC that is less than the amount for which they are eligible.

Options

A. True

B. False

Correct Answer
A

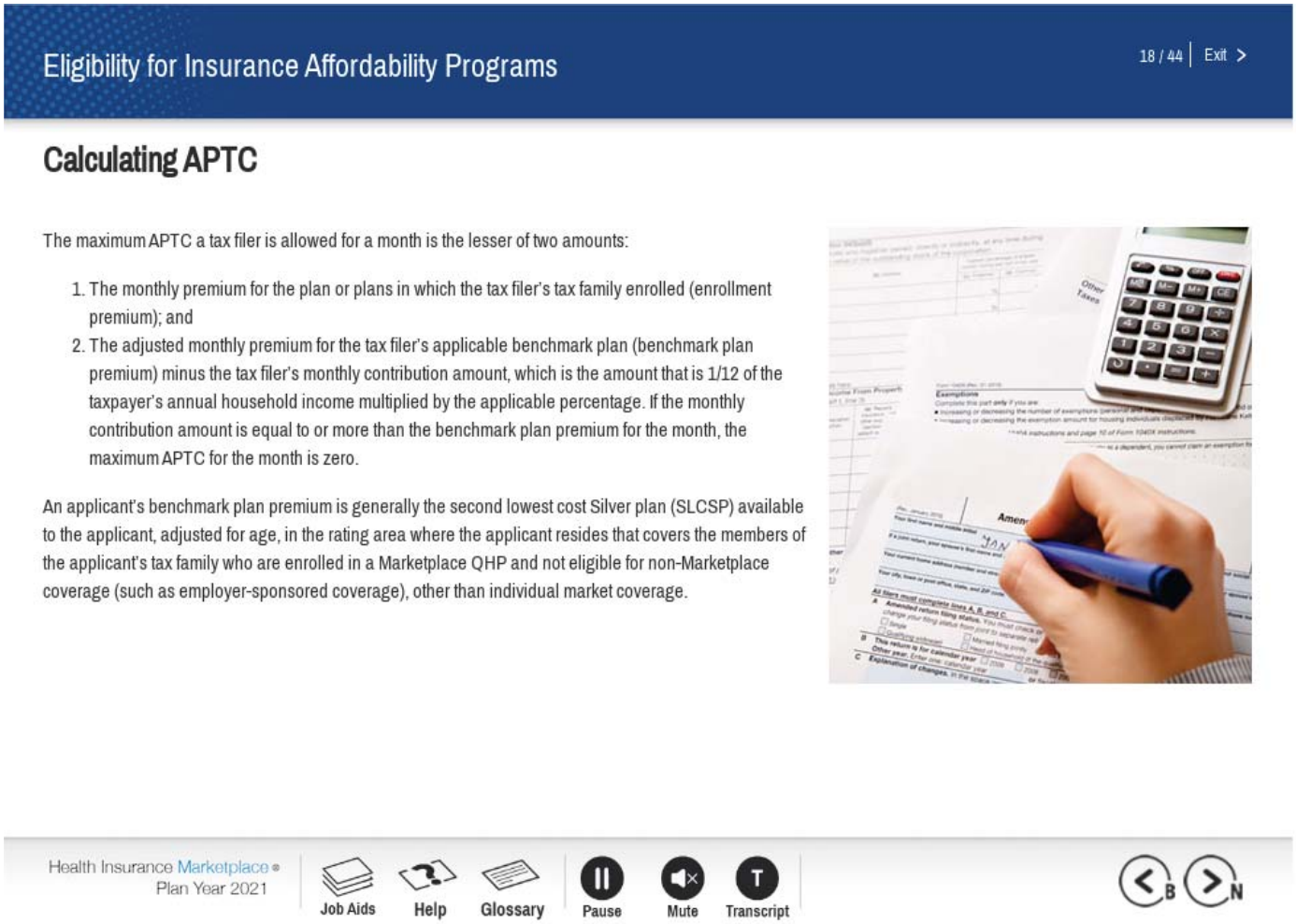
Positive Feedback
Correct! Consumers who have a QSEHRA and who do not limit their APTC will likely have to pay some or all of the APTC back when they reconcile it on their federal income tax returns. To reduce the chances of this happening, it is best for these consumers to either forego APTC or choose an amount not more than the APTC for which they are eligible minus the

QSEHRA amount offered to the consumer. Consumers whose premium tax credit claimed on the return is more than the APTC paid on their behalf for the year of coverage receive a net premium tax credit that reduces the tax they owe or increases their refund.

Negative Feedback

Incorrect. Consumers who have a QSEHRA and who do not limit their APTC will likely have to pay some or all of the APTC back when they reconcile it on their federal income tax returns. To reduce the chances of this happening, it is best for these consumers to either forego APTC or choose an amount not more than the APTC for which they are eligible minus the QSEHRA amount offered to the consumer. Consumers whose premium tax credit claimed on the return is more than the APTC paid on their behalf for the year of coverage receive a net premium tax credit that reduces the tax they owe or increases their refund.

Page: 18 of 44: Calculating APTC



Page Text

The maximum APTC a tax filer is allowed for a month is the lesser of two amounts:

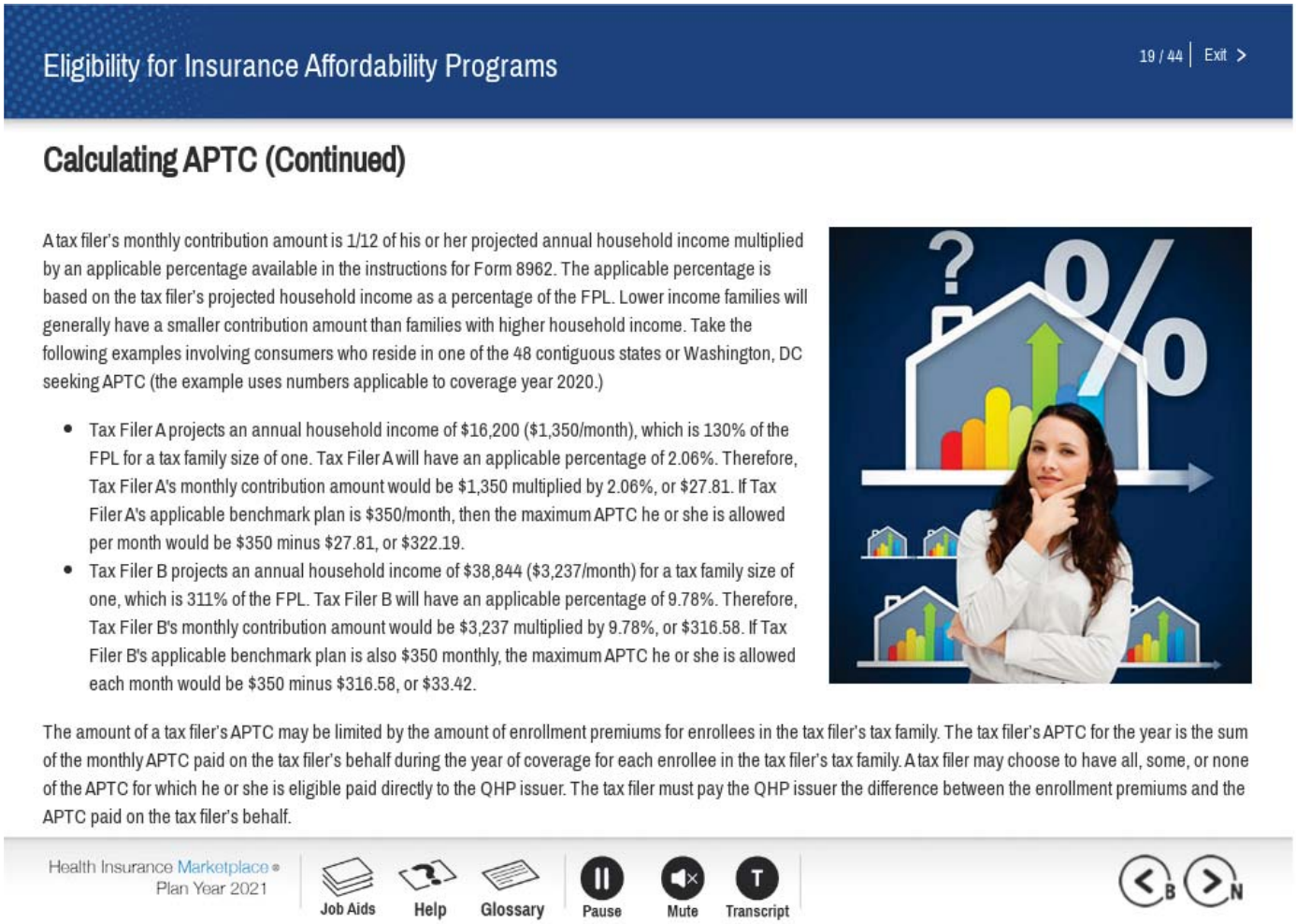
1. The monthly premium for the plan or plans in which the tax filer's tax family enrolled (enrollment premium); and
2. The adjusted monthly premium for the tax filer's applicable benchmark plan (benchmark plan premium) minus the tax filer's monthly contribution amount, which is the amount that is 1/12 of the taxpayer's annual household income multiplied by the applicable percentage. If the monthly contribution amount is equal to or more than the benchmark plan premium for the month, the maximum APTC for the month is zero.

An applicant's benchmark plan premium is generally the second lowest cost Silver plan (SLCSP) available to the applicant, adjusted for age, in the rating area where the applicant resides that covers the members of the applicant's tax family who are enrolled in a Marketplace QHP and not eligible for non-Marketplace coverage (such as employer-sponsored coverage), other than individual market coverage.

Alt Text

A hand holding a pen completing a tax form

Page: 19 of 44: Calculating APTC (Continued)



Page Text

A tax filer's monthly contribution amount is 1/12 of his or her projected annual household income multiplied by an applicable percentage available in the instructions for Form 8962. The applicable percentage is based on the tax filer's projected household income as a percentage of the FPL. Lower income families will generally have a smaller contribution amount than families with higher household income. Take the following examples involving consumers who reside in one of the 48 contiguous states or Washington, DC seeking APTC (the example uses numbers applicable to coverage year 2020.)

- Tax Filer A projects an annual household income of $16,200 ($1,350/month), which is 130% of the FPL for a tax family size of one. Tax Filer A will have an applicable percentage of 2.06%. Therefore, Tax Filer A's monthly contribution amount would be $1,350 multiplied by 2.06%, or $27.81. If Tax Filer A's applicable benchmark plan is $350/month, then the maximum APTC he or she is allowed per month would be $350 minus $27.81, or $322.19.
- Tax Filer B projects an annual household income of $38,844 ($3,237/month) for a tax family size of one, which is 311% of the FPL. Tax Filer B will have an applicable percentage of 9.78%. Therefore, Tax Filer B's monthly contribution amount would be $3,237 multiplied by 9.78%, or $316.58. If Tax Filer B's applicable benchmark plan is also $350 monthly, the maximum APTC he or she is allowed each month would be $350 minus $316.58, or $33.42.

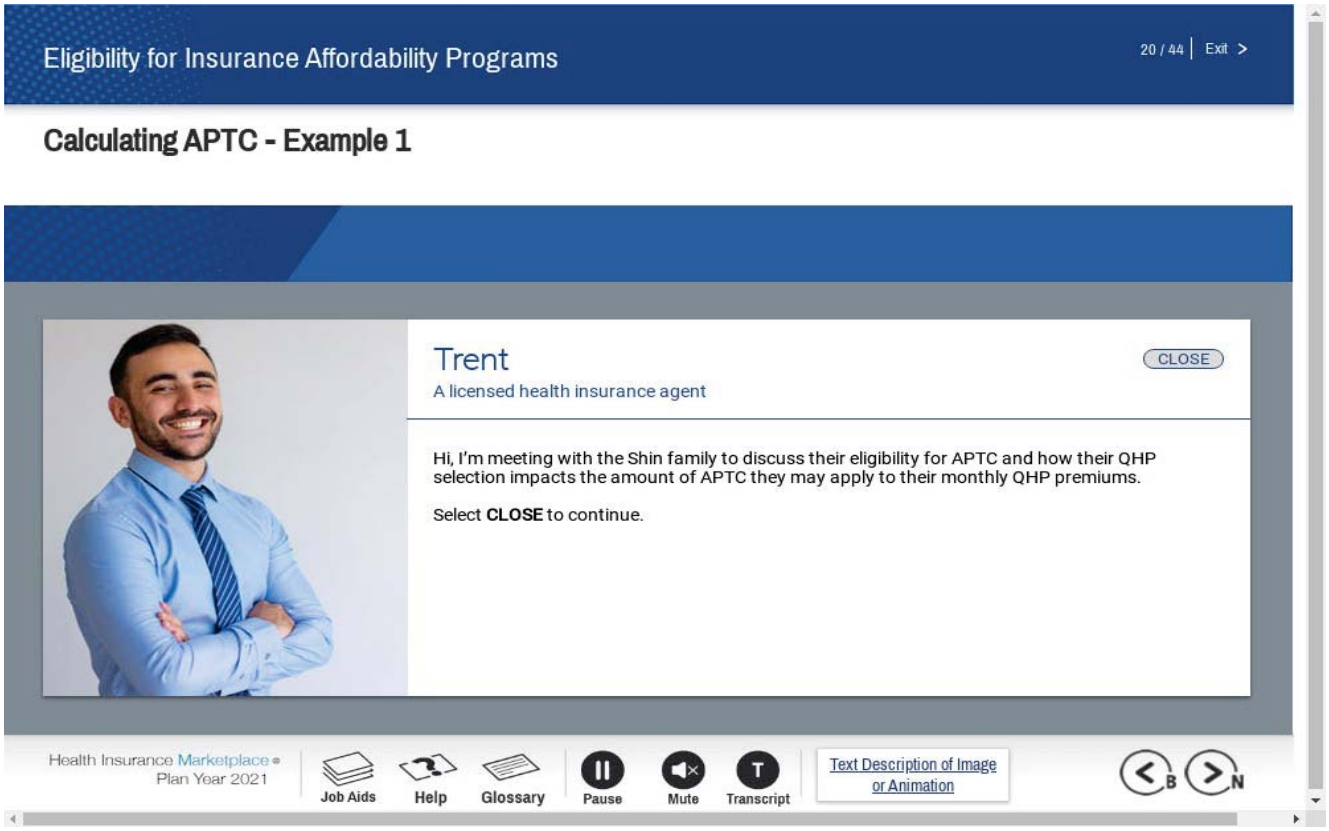
The amount of a tax filer's APTC may be limited by the amount of enrollment premiums for enrollees in the tax filer's tax family. The tax filer's APTC for the year is the sum of the monthly APTC paid on the tax filer's behalf during the year of coverage for each enrollee in the tax filer's tax family. A tax filer may choose to have all, some, or none of the APTC for which

he or she is eligible paid directly to the QHP issuer. The tax filer must pay the QHP issuer the difference between the enrollment premiums and the APTC paid on the tax filer's behalf.

Alt Text

A woman is standing in front of illustrated outlines of houses with various colored bar graphs inside; a question mark is above an outline of a house; a percentage symbol is in front of one of the house outlines and one house is underlined by an arrow pointing to the right.

Page: 20 of 44: Calculating APTC - Example 1



Long Description

Interactive graphic of 3 columns. In the foreground is an image of a man. To the right of him is prompt text. When the prompt text window is closed, the images are visible. When each image/column is selected, associated text appears. . When each image/column is selected, associated text appears. The column labels from left to right are Eligibility for APTC, Choosing a Plan, Premiums and Payments. Left Column Image: A couple sitting on a floor reading a book. Middle Column Image: Icon image of a clipboard with a medical form; a stethoscope; a calculator; and a shield Right Column Image: A calculator and a pen sitting on top of an invoice. Labels from Left to Right: Eligibility for APTC, Choosing a Plan, Premiums and Payments

Prompt Text: Hi, I'm meeting with the Shin family to discuss their eligibility for APTC and how their QHP selection impacts the amount of APTC they may apply to their monthly QHP premiums.

Pop Up Text

Eligibility for APTC

Cho Shin and his wife, Pei, are struggling financially and are interested in learning more about their eligibility for APTC. Cho and Pei file a joint income tax return.

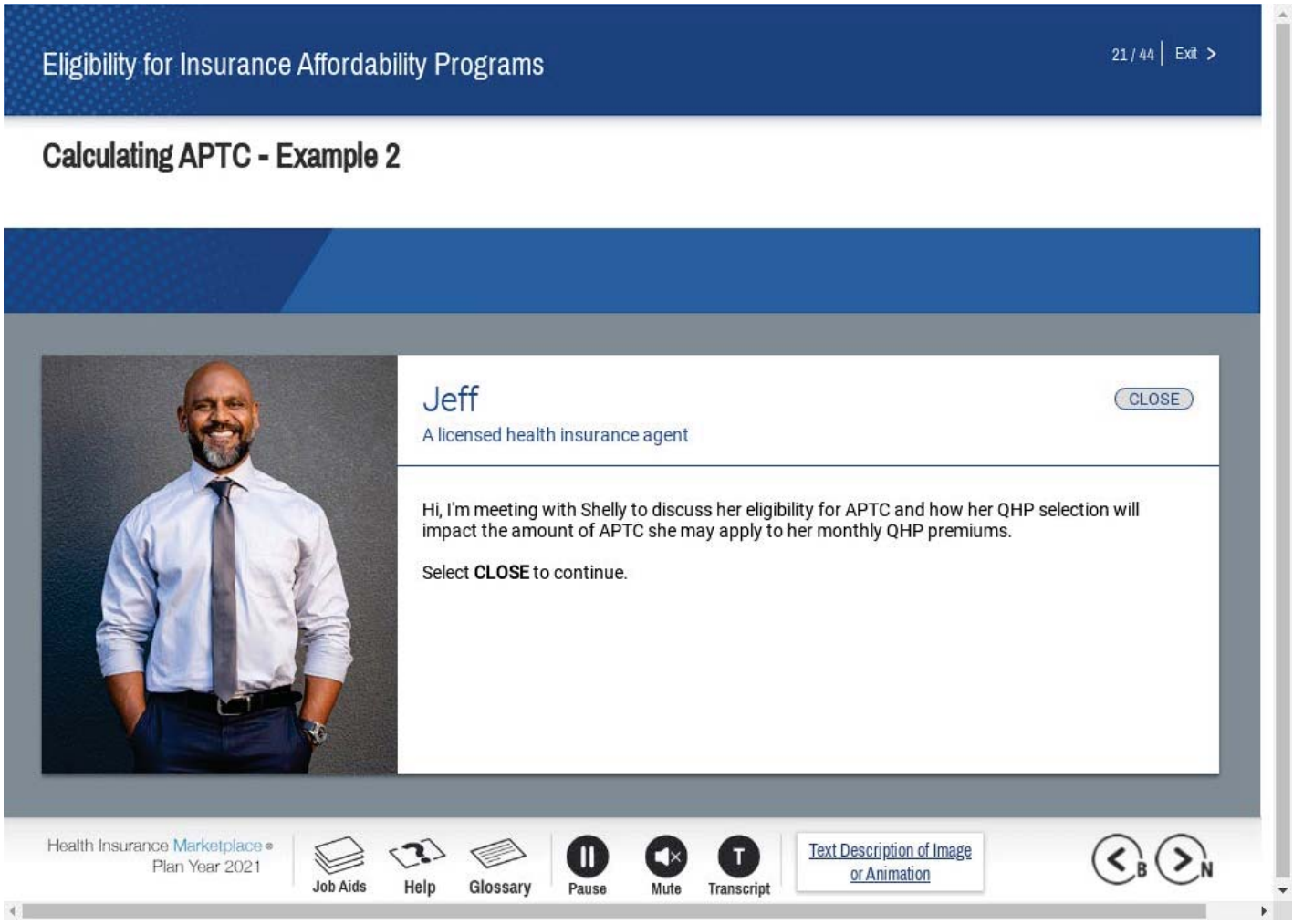
Choosing a Plan

Cho's employer does not offer health insurance, Pei is not employed, and neither Cho nor Pei is eligible for Medicare or Medicaid. The Marketplace determines that based on their projected household income, their family size of two, where they reside, and their SLCSP premium, they qualify for a maximum of $800 in APTC each month.

Premiums and Payments

Once you explain the options available to the Shins, they select a QHP with a monthly premium of $850 and apply the full amount of the APTC for which they are eligible. By choosing this option, the Shins will need to pay the remaining premium balance of $50 out of pocket each month.

Page: 21 of 44: Calculating APTC - Example 2



Long Description

Interactive graphic of 3 columns. In the foreground is an image of a man. To the right of him is prompt text. When the prompt text window is closed, the images and text above each image are visible. When each image/column is selected, associated text appears. Left Column Image: A woman smiling and holding a cup of coffee while checking her cell phone Middle Column Image: An icon image of a clip board with a medical form; a stethoscope; a calculator; and a shield Right Column Image: A calculator and pen sitting on top of an invoice. Labels from Left to Right: Choosing a Plan, Eligibility for APTC, Premiums and Payments

Prompt Text: Hi, I am Jeff, meeting with Shelly to discuss her eligibility for APTC and how her QHP selection will impact the amount of APTC she may apply to her monthly QHP premiums.

Pop Up Text

Eligibility for APTC

Shelly is single and needs to enroll in a QHP, but is not sure what type of coverage she can afford based on her salary. She is trying to choose a plan that best suits her needs.

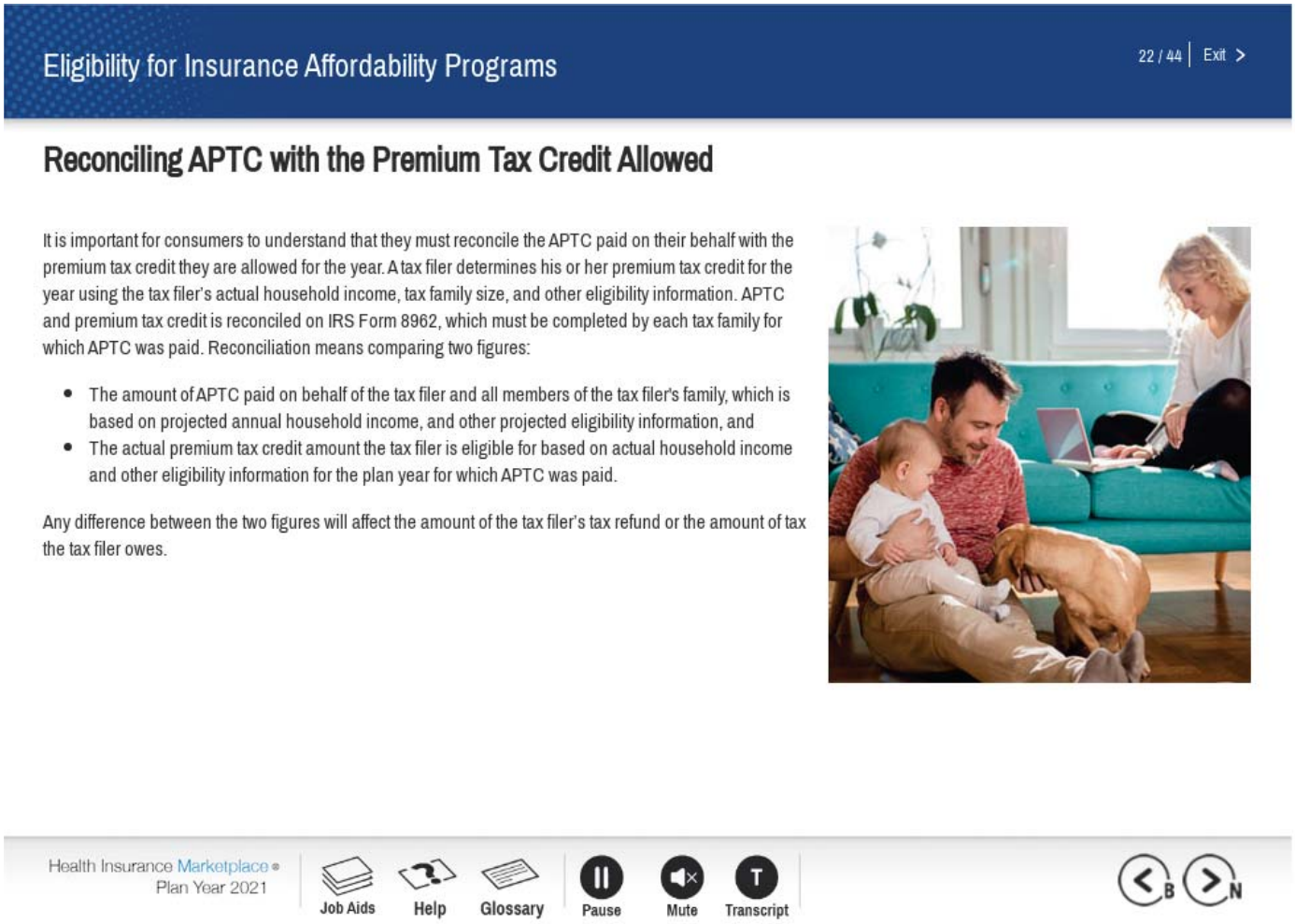
Choosing a Plan

You tell Shelly that only the Marketplace can determine her eligibility for APTC, but she may be eligible for a maximum of $400 in APTC per month. You explain her options to Shelly.

Premiums and Payments

She selects the plan that is best for her: a QHP with a premium of $400 or less, applying the full amount of APTC for which she is eligible. By choosing this option, Shelly will not have to make a monthly premium payment. If she selects a QHP with a premium of less than $400 (for example, a monthly premium of $350), all of her premium may be paid by APTC but she will NOT get a monthly payment of the difference between $400 and the monthly premium for the QHP she selects.

Page: 22 of 44: Reconciling APTC with the Premium Tax Credit Allowed



Page Text

It is important for consumers to understand that they must reconcile the APTC paid on their behalf with the premium tax credit they are allowed for the year. A tax filer determines his or her premium tax credit for the year using the tax filer's actual household income, tax family size, and other eligibility information. APTC and premium tax credit is reconciled on IRS Form 8962, which must be completed by each tax family for which APTC was paid. Reconciliation means comparing two figures:

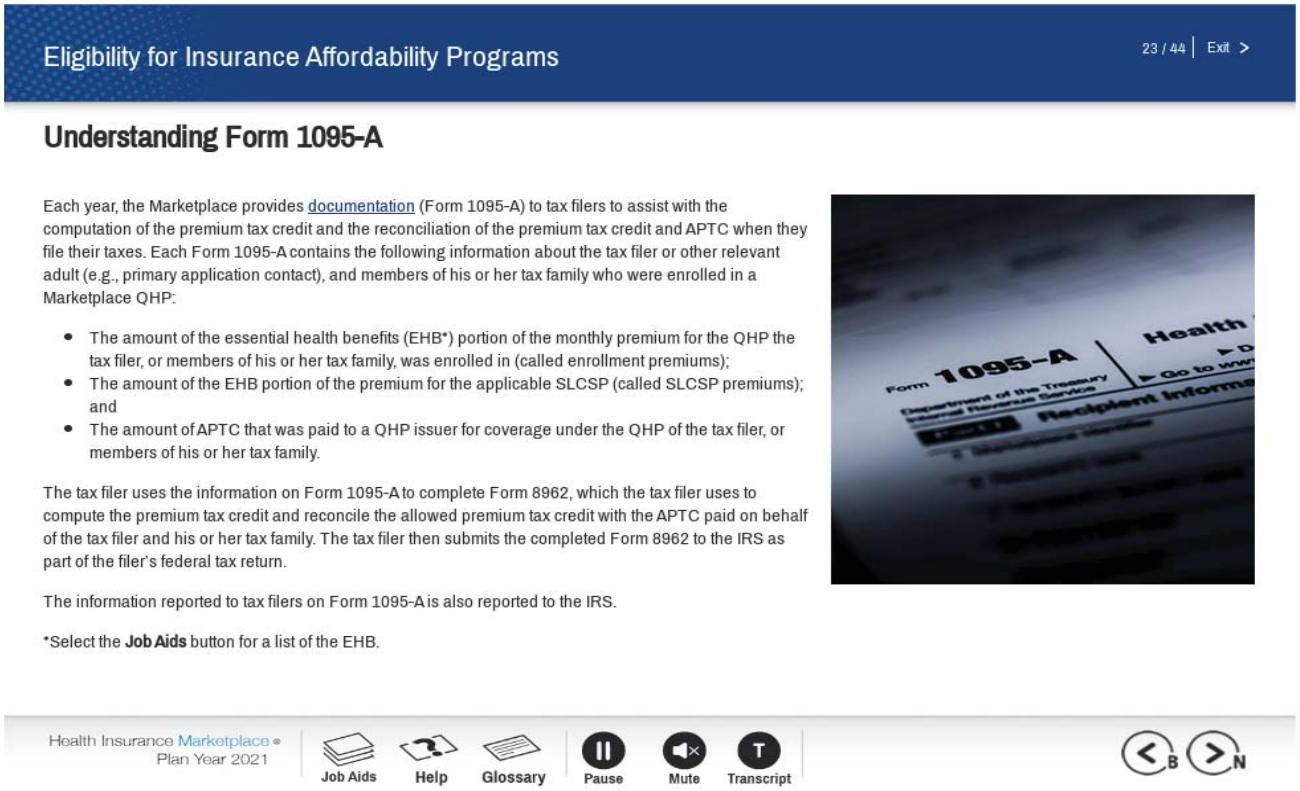
- The amount of APTC paid on behalf of the tax filer and all members of the tax filer's family, which is based on projected annual household income, and other projected eligibility information, and
- The actual premium tax credit amount the tax filer is eligible for based on actual household income and other eligibility information for the plan year for which APTC was paid.

Any difference between the two figures will affect the amount of the tax filer's tax refund or the amount of tax the tax filer owes.

Alt Text

A father holding a baby while petting a dog; the mother is sitting on the couch working on a laptop.

Page: 23 of 44: Understanding Form 1095-A



Page Text

Each year, the Marketplace provides documentation (Form 1095-A) to tax filers to assist with the computation of the premium tax credit and the reconciliation of the premium tax credit and APTC when they file their taxes. Each Form 1095-A contains the following information about the tax filer or other relevant adult (e.g., primary application contact), and members of his or her tax family who were enrolled in a Marketplace QHP:

- The amount of the essential health benefits (EHB*) portion of the monthly premium for the QHP the tax filer, or members of his or her tax family, was enrolled in (called enrollment premiums);
- The amount of the EHB portion of the premium for the applicable SLCSP (called SLCSP premiums); and
- The amount of APTC that was paid to a QHP issuer for coverage under the QHP of the tax filer, or members of his or her tax family.

The tax filer uses the information on Form 1095-A to complete Form 8962, which the tax filer uses to compute the premium tax credit and reconcile the allowed premium tax credit with the APTC paid on behalf of the tax filer and his or her tax family. The tax filer then submits the completed Form 8962 to the IRS as part of the filer's federal tax return.

The information reported to tax filers on Form 1095-A is also reported to the IRS.

*Select the **Job Aids** button for a list of the EHB.

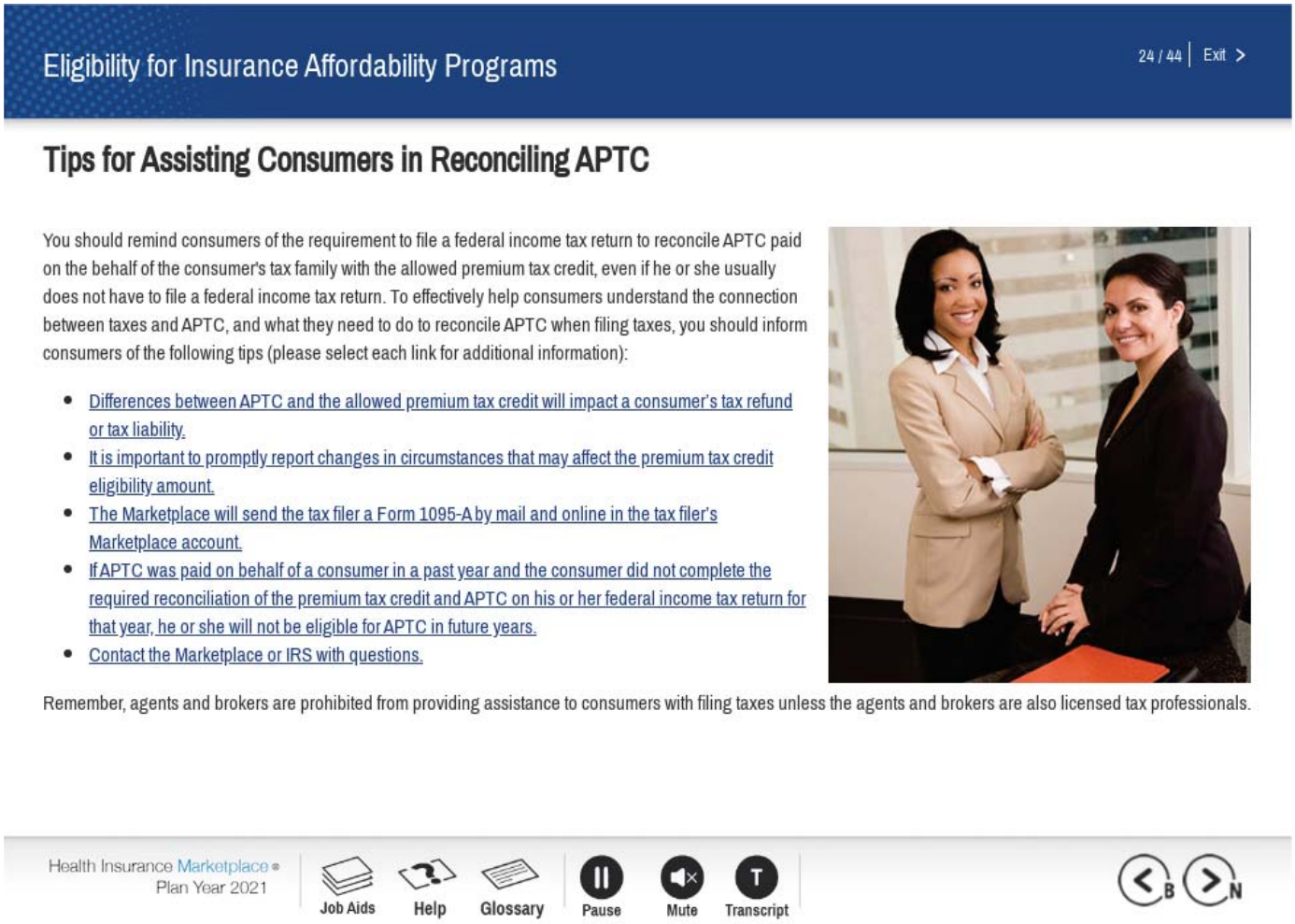
Pop Up Text

Documentation and Form 1095-A

The Marketplace provides the Form 1095-A by mail and online in the tax filer's Marketplace account. QHP issuers and web-brokers that are approved Direct Enrollment partners and offer the Enhanced Direct Enrollment (EDE) Pathway may provide agents and brokers the capability to download their clients' Form 1095-As through their client management portals. To find out more about specific Enhanced Direct Enrollment features, contact the issuer or web-broker directly. Use the Issuer & Direct Enrollment Partner Directory to find partners that are approved to offer the Enhanced Direct Enrollment Pathway in the states where you assist consumers with Marketplace enrollments.

Alt Text
Tax Form 1095-A

Page: 24 of 44: Tips for Assisting Consumers in Reconciling APTC



Page Text

You should remind consumers of the requirement to file a federal income tax return to reconcile APTC paid on the behalf of the consumer's tax family with the allowed premium tax credit, even if he or she usually does not have to file a federal income tax return. To effectively help consumers understand the connection between taxes and APTC, and what they need to do to reconcile APTC when filing taxes, you should inform consumers of the following tips (please select each link for additional information):

- Differences between APTC and the allowed premium tax credit will impact a consumer's tax refund or tax liability.
- It is important to promptly report changes in circumstances that may affect the premium tax credit eligibility amount.
- The Marketplace will send the tax filer a Form 1095-A by mail and online in the tax filer's Marketplace account.
- If APTC was paid on behalf of a consumer in a past year and the consumer did not complete the required reconciliation of the premium tax credit and APTC on his or her federal income tax return for that year, he or she will not be eligible for APTC in future years.
- Contact the Marketplace or IRS with questions.

Remember, agents and brokers are prohibited from providing assistance to consumers with filing taxes unless the agents and brokers are also licensed tax professionals.

Pop Up Text

Differences between APTC and the allowed premium tax credit will impact a consumer's taxes
Remind consumers of the impact of differences between APTC and the allowed premium tax credit based on actual, annual household income:

- If the amount of the allowed premium tax credit is more than the APTC, the difference (called "net premium tax credit") will increase the tax filer's refund or reduce his or her tax liability.
- If the tax filer's APTC is more than the allowed premium tax credit, excess APTC was paid on the tax filer's behalf and the tax filer will be required to repay all or a portion of the excess APTC when filing the tax return. (The excess APTC repayment amount may be limited for tax filers with actual annual household income below 400% of the FPL for the tax filer's family size.) The excess APTC repayment amount results in a decrease in the tax filer's refund or an increase in his or her tax liability.

It is important to promptly report changes in circumstances.

Encourage consumers to promptly report changes in circumstances to the Marketplace as they happen to allow the Marketplace to update the information used to determine eligibility for APTC and income-based CSRs and to adjust the APTC amount. This adjustment decreases the likelihood of a significant difference between the tax filer's APTC and his or her allowed premium tax credit. Changes in circumstances that can affect the amount of the actual premium tax credit include: increases or decreases in household income, marriage, divorce, birth or adoption of a child, other changes in household composition, gaining or losing eligibility for government-sponsored programs or employer-sponsored health care coverage, and change of address.

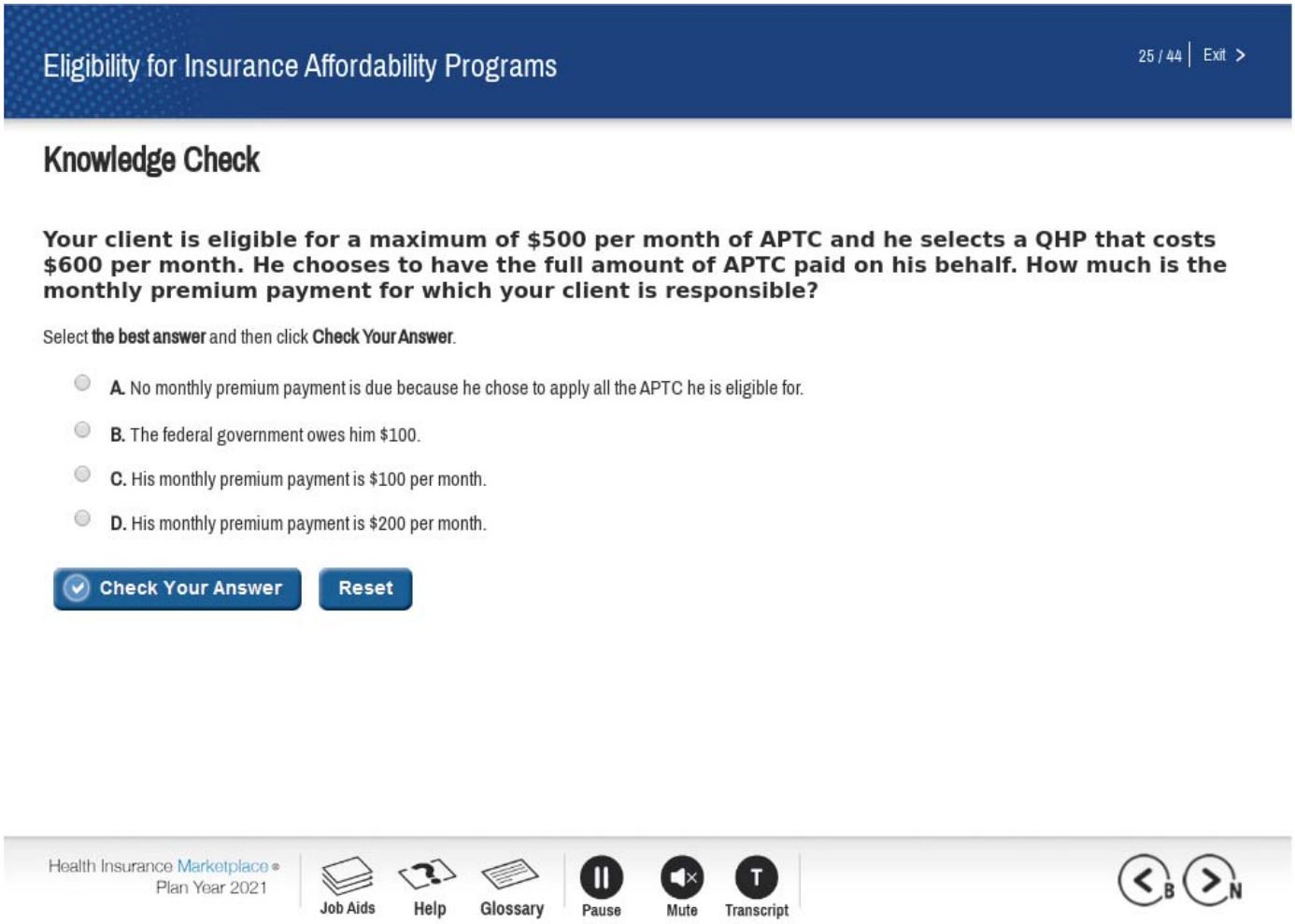
The Marketplace will send the tax filer a Form 1095-A.
Advise consumers to look for an envelope in the mail labeled "Important Tax or Health Coverage Information Inside," which contains the paper copy of Form 1095-A, and/or explain how to access their Form 1095-As by logging in to their Marketplace accounts.

Consumers must reconcile APTC paid on their behalf.
Remind consumers that in order to be eligible for APTC and income-based CSRs in future coverage years, a tax filer must file a federal income tax return and reconcile APTC with allowed premium tax credit for any past year APTC was paid on his or her behalf.

Contact the Marketplace or IRS with questions.
Direct consumers to the Marketplace for questions about Form 1095-A, or the IRS (IRS.gov or (800) 829-1040) for questions about the premium tax credit, Form 8962, or tax filing.

Alt Text
Two business women smiling; one is standing with her arms folded over her chest; the other is sitting on a desk.

Page: 25 of 44: Knowledge Check



Prompt
Select **the best answer** and then click **Check Your Answer**.

Question
Your client is eligible for a maximum of $500 per month of APTC and he selects a QHP that costs $600 per month. He chooses to have the full amount of APTC paid on his behalf. How much is the monthly premium payment for which your client is responsible?

Options

A. No monthly premium payment is due because he chose to apply all the APTC he is eligible for.

B. The federal government owes him $100.

C. His monthly premium payment is $100 per month.

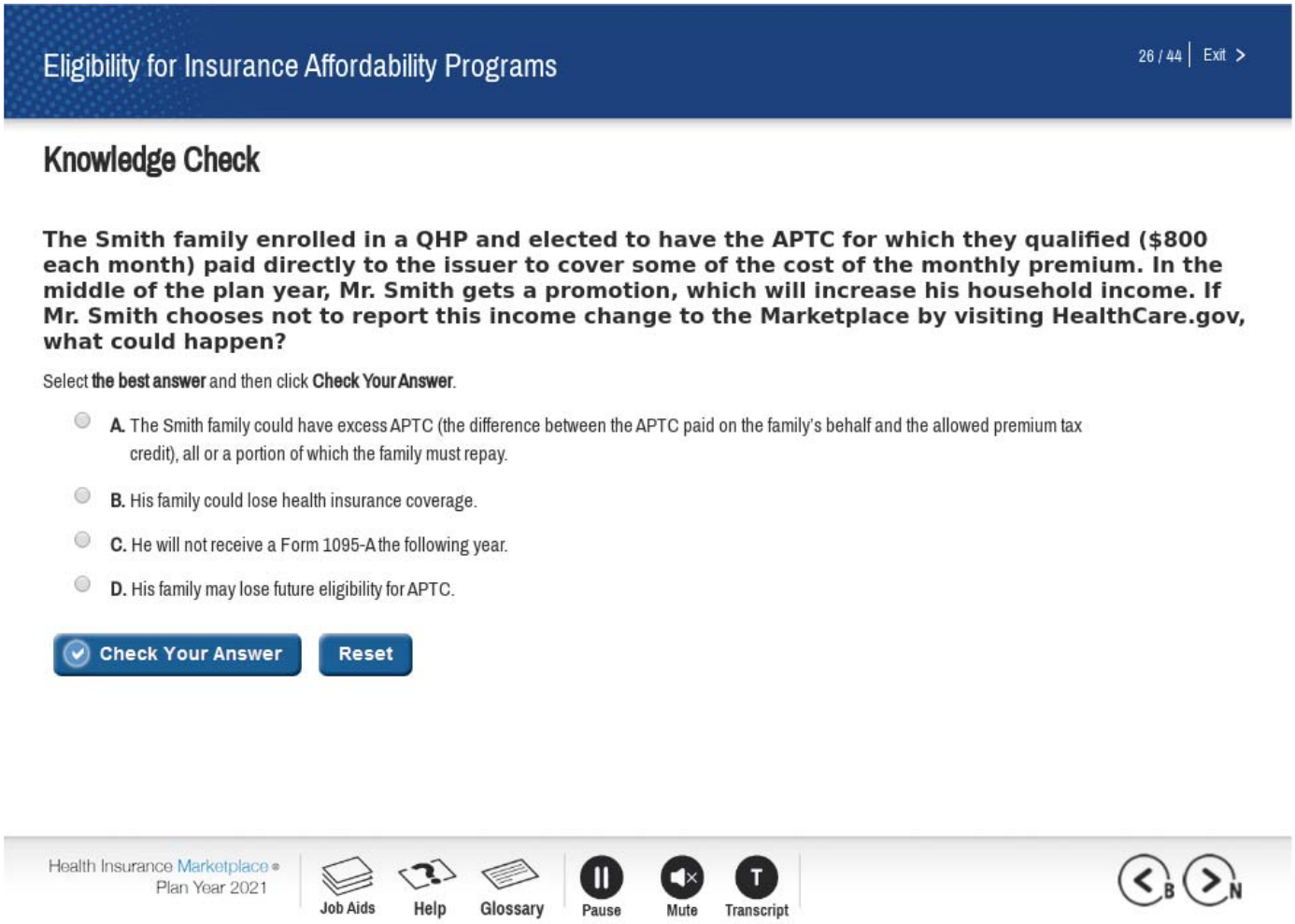
D. His monthly premium payment is $200 per month.

Correct Answer
C

Positive Feedback
Correct! Your client must pay $100 per month. The total monthly premium is $600 and $500 of APTC is paid directly to the QHP issuer, leaving your client responsible for the remaining $100.

Negative Feedback
Incorrect. The correct answer is C. Your client must pay $100 per month. The total monthly premium is $600 and $500 of APTC is paid directly to the QHP issuer, leaving your client responsible for the remaining $100.

Page: 26 of 44: Knowledge Check



Prompt

Select **the best answer** and then click **Check Your Answer**.

Question

The Smith family enrolled in a QHP and elected to have the APTC for which they qualified ($800 each month) paid directly to the issuer to cover some of the cost of the monthly premium. In the middle of the plan year, Mr. Smith gets a promotion, which will increase his household income. If Mr. Smith chooses not to report this income change to the Marketplace by visiting HealthCare.gov, what could happen?

Options

A. The Smith family could have excess APTC (the difference between the APTC paid on the family's behalf and the allowed premium tax credit), all or a portion of which the family must repay.

B. His family could lose health insurance coverage.

C. He will not receive a Form 1095-A the following year.

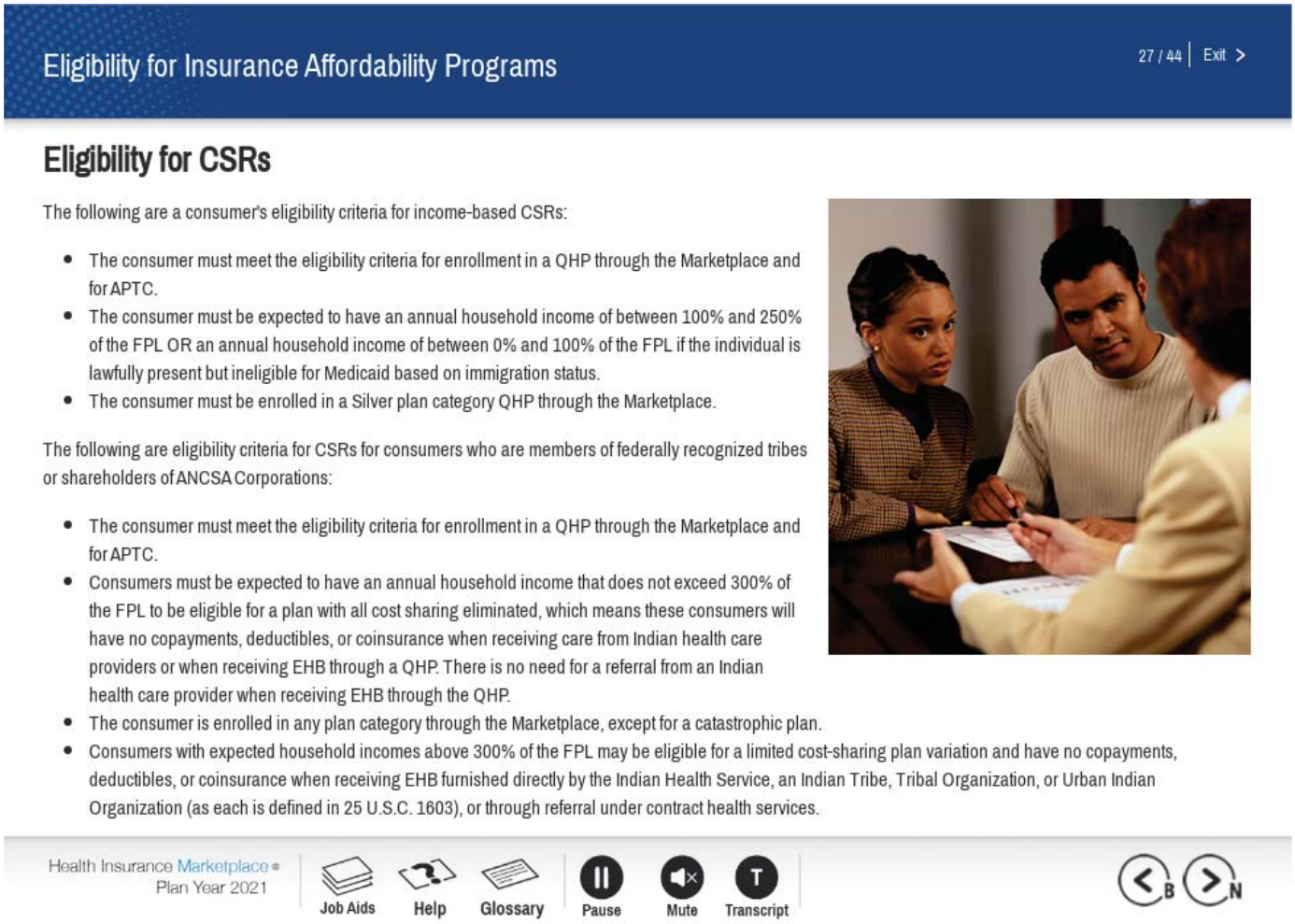
D. His family may lose future eligibility for APTC.

Correct Answer
A

Positive Feedback
Correct! The premium tax credit amount will likely be different from the amount of APTC if a person's household income increases or decreases from what was projected at enrollment. In this case, Mr. Smith's household income increased and, therefore, the amount of allowed premium tax credit will likely be less than the amount of APTC paid. Promptly reporting the change will reduce the likelihood that the Smith family will have a large amount of excess APTC (the amount by which the APTC exceeds the allowed premium tax credit). Tax filers must repay all or a portion of the excess APTC on their tax returns for the year.

Negative Feedback
Incorrect. The correct answer is A. The premium tax credit amount will likely be different from the amount of APTC if a person's household income increases or decreases from what was projected at enrollment. In this case, Mr. Smith's household income increased and, therefore, the amount of allowed premium tax credit will likely be less than the amount of APTC paid. Promptly reporting the change will reduce the likelihood that the Smith family will have a large amount of excess APTC (the amount by which the APTC exceeds the allowed premium tax credit). Tax filers must repay all or a portion of the excess APTC on their tax returns for the year.

Page: 27 of 44: Eligibility for CSRs



Page Text

The following are a consumer's eligibility criteria for income-based CSRs:

- The consumer must meet the eligibility criteria for enrollment in a QHP through the Marketplace and for APTC.
- The consumer must be expected to have an annual household income of between 100% and 250% of the FPL OR an annual household income of between 0% and 100% of the FPL if the individual is lawfully present but ineligible for Medicaid based on immigration status.
- The consumer must be enrolled in a Silver plan category QHP through the Marketplace.

The following are eligibility criteria for CSRs for consumers who are members of federally recognized tribes or shareholders of ANCSA Corporations:

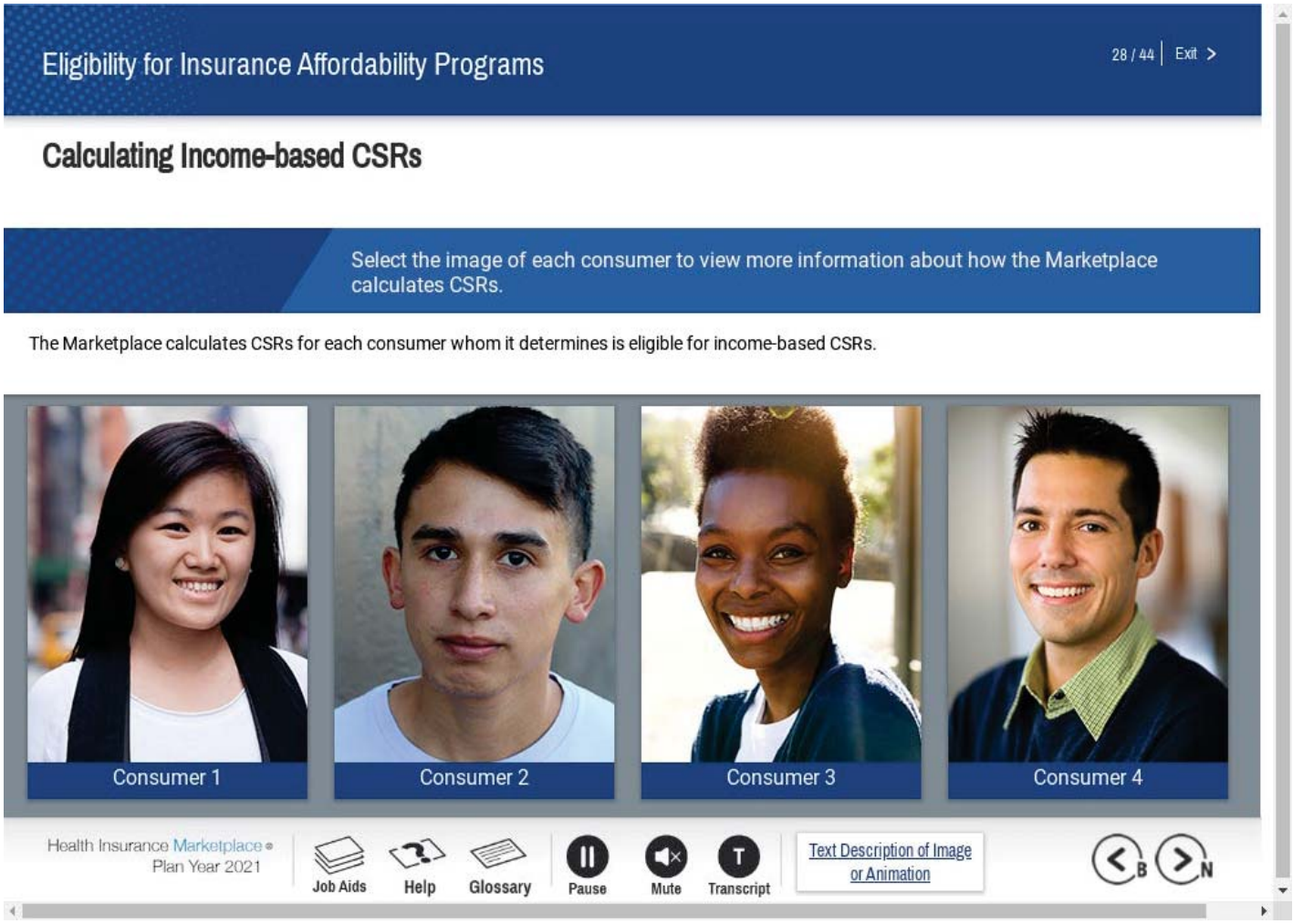
- The consumer must meet the eligibility criteria for enrollment in a QHP through the Marketplace and for APTC.
- Consumers must be expected to have an annual household income that does not exceed 300% of the FPL to be eligible for a plan with all cost sharing eliminated, which means these consumers will have no copayments, deductibles, or coinsurance when receiving care from Indian health care providers or when receiving EHB through a QHP. There is no need for a referral from an Indian health care provider when receiving EHB through the QHP.
- The consumer is enrolled in any plan category through the Marketplace, except for a catastrophic plan.

- Consumers with expected household incomes above 300% of the FPL may be eligible for a limited cost-sharing plan variation and have no copayments, deductibles, or coinsurance when receiving EHB furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as each is defined in 25 U.S.C. 1603), or through referral under contract health services.

Alt Text

A couple sitting next to each other listening to a person speak

Page: 28 of 44: Calculating Income-based CSRs



Long Description
Interactive graphic representing consumers and calculating CSRs. There are 4 images positioned left to right on the screen. All images are the same size. From left to right, each image is labeled; Consumer 1, Consumer 2, Consumer 3, Consumer 4. When you select an image, a pop-up box appears in the middle of the screen with related text.

Prompt Text: Select the image of each consumer to view more information about how the Marketplace calculates CSRs.

Page Text: The Marketplace calculates CSRs for each consumer whom it determines is eligible for income-based CSRs.

Pop Up Text

Consumer 1

Income-based CSRs limit certain out-of-pocket costs for EHB for individuals and families with household income between 100-250% of the FPL (or 0-100% of the FPL if lawfully present but ineligible for Medicaid based on immigration status) and enrolled in a Silver plan category QHP through the Individual Marketplace.

Consumer 2

Consumers who are members of federally recognized tribes or ANCSA Corporation shareholders may be eligible for additional CSRs and are not required to enroll in a Silver plan category QHP to receive them.

Consumer 3

Federal regulations set the reduced maximum annual limitation on cost sharing* for individuals and families eligible for CSRs based on income; however, reductions on cost sharing for specific benefits and services may vary based on a QHP issuer's specific plan design.

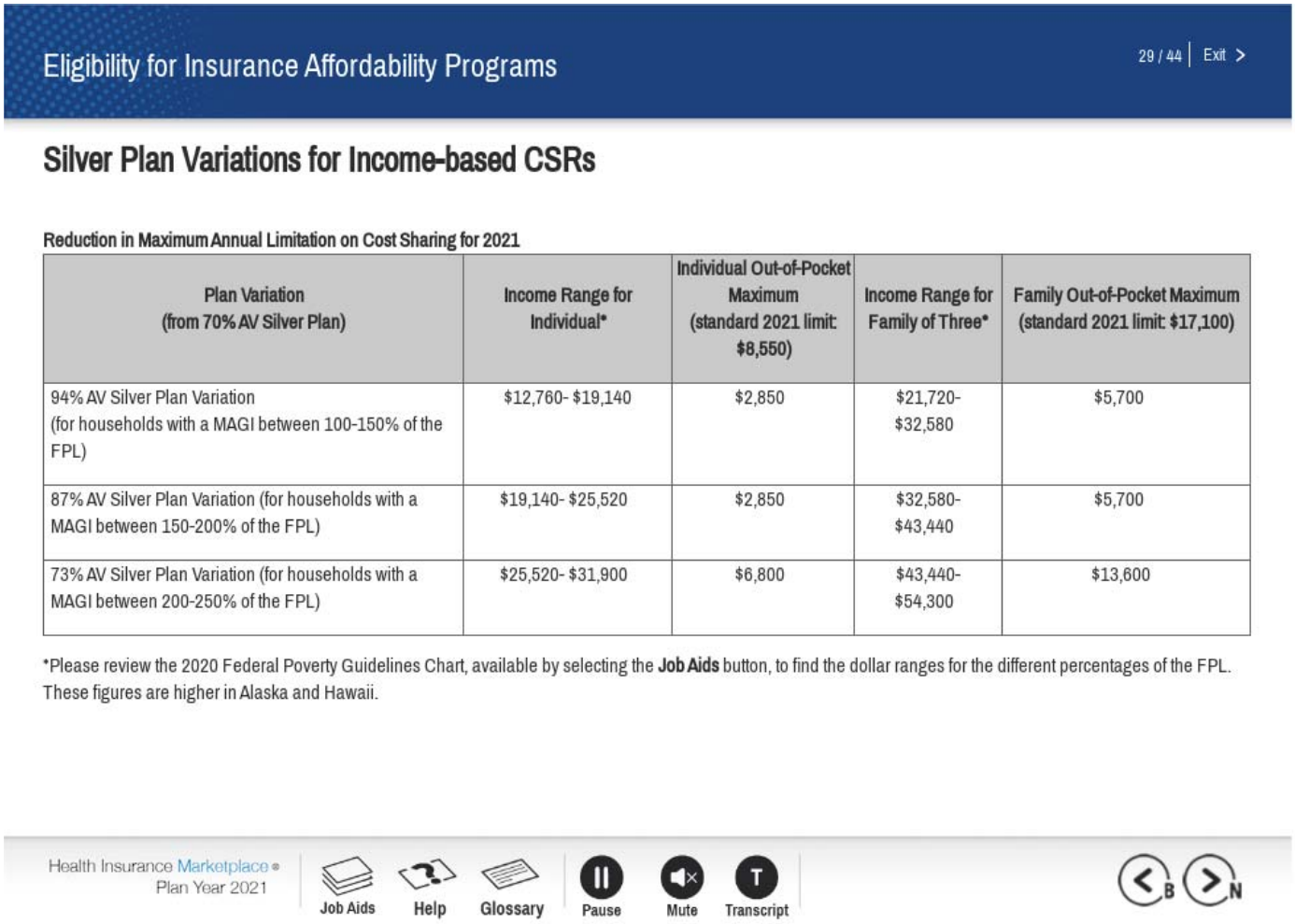
*Cost sharing refers to the costs enrollees must pay for services that their plan covers before their plan begins to pay, such as deductibles, coinsurance, or copayments. Cost sharing does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

Consumer 4

Under federal regulations, a family that is eligible for different kinds of CSRs can only enroll together in the most generous plan coverage level for which all members of the family are eligible.

For example, if a tax household includes one member who is eligible for income-based CSRs and another member who is eligible for CSRs based on membership in a federally recognized tribe or status as an ANCSA Corporation shareholder, and the tax household enrolls in a Silver plan category QHP as one enrollment group, then both members will be determined eligible for income-based CSRs. Note: Only consumers in a household who are members of federally recognized tribes or shareholders in ANCSA Corporations are eligible to receive the cost sharing that applies to consumers who are members of federally recognized tribes or shareholders in ANCSA Corporations.

Page: 29 of 44: Silver Plan Variations for Income-based CSRs



Page Text

Reduction in Maximum Annual Limitation on Cost Sharing for 2021

Plan Variation (from 70% AV Silver Plan) Income Range for Individual* Individual Out-of-Pocket Maximum (standard 2021 limit: $8,550) Income Range for Family of Three* Family Out-of-Pocket Maximum (standard 2021 limit: $17,100) 94% AV Silver Plan Variation (for households with a MAGI between 100-150% of the FPL) $12,760- $19,140 $2,850 $21,720- $32,580 $5,700 87% AV Silver Plan Variation (for households with a MAGI between 150-200% of the FPL) $19,140- $25,520 $2,850 $32,580- $43,440 $5,700 73% AV Silver Plan Variation (for households with a MAGI between 200-250% of the FPL) $25,520- $31,900 $6,800 $43,440- $54,300 $13,600

*Please review the 2020 Federal Poverty Guidelines Chart, available by selecting the **Job Aids** button, to find the dollar ranges for the different percentages of the FPL. These figures are higher in Alaska and Hawaii.

Page: 30 of 44: Overview of Medicaid and CHIP

Long Description
Graphic of adults and children standing together in a line with their hands held high. To the left of the graphic are three buttons stacked on top of each other. From top to bottom the buttons are labeled: Overview of Medicaid and CHIP, Medicaid, and CHIP. When each button is selected, related text appears in the middle of the screen.

Prompt Text: Select each of the three buttons below for an overview of Medicaid and CHIP.

Pop Up Text

Overview of Medicaid and CHIP

Medicaid and CHIP are federal and state partnership programs designed to provide health care coverage to lower-income adults and children. These programs provide safety net coverage for the country's lowest-income populations. These programs vary by state. An individual who is eligible for Medicaid or CHIP that qualifies as minimum essential coverage* is not eligible for APTC or income-based CSRs to help pay for Marketplace coverage.

As you learned in the Individual Marketplace Eligibility for Enrolling in a QHP module, new regulations apply to the definition and factors for "public charge" status. For children under age 21 and pregnant women, enrollment in Medicaid or CHIP will not

be considered to be a public benefit under the public charge rule. But for some foreign national adults, enrollment in Medicaid may be considered a negative factor in a public charge inadmissibility determination.

If you are assisting a consumer who may be impacted by this new regulation, the consumer should visit the USCIS website or contact the U.S. Citizenship and Immigration Services (USCIS) directly before continuing his or her Marketplace application. For more information on what it means to be a public charge, visit USCIS's website or call U.S. Citizenship and Immigration Services at 1-800-375-5283.

*Most Medicaid is considered minimum essential coverage. Some forms of Medicaid cover limited benefits (like Medicaid that only covers emergency care, family planning, or pregnancy-related services) and are not considered minimum essential coverage. For more information on which Medicaid programs are considered minimum essential coverage, visit HealthCare.gov.

Medicaid

Medicaid is a federal and state partnership to provide coverage for some people with lower incomes, older people, people with disabilities, and some families and children. To qualify for Medicaid, an individual must be part of a covered group – children, pregnant women, parents or caretaker relatives, the elderly, the disabled, or other non-elderly adults who are not eligible for or enrolled in Medicare – and must meet financial eligibility requirements. To be eligible for Medicaid, individuals generally need to satisfy federal and state requirements regarding residency; citizenship or immigration status; household income; and, in some cases, financial resources.

Medicaid is jointly funded with federal and state dollars, but is administered at the state level. State-based Medicaid programs often have different names in each state, like "MassHealth" in Massachusetts and "SoonerCare" in Oklahoma. States expanding their Medicaid programs must provide the 10 categories of EHB to people newly eligible for Medicaid. All states are required to provide EHB to certain other groups of people eligible for Medicaid. It is important to be familiar with the program in every state in which you operate.

Visit Medicaid.gov to find Medicaid information by state.

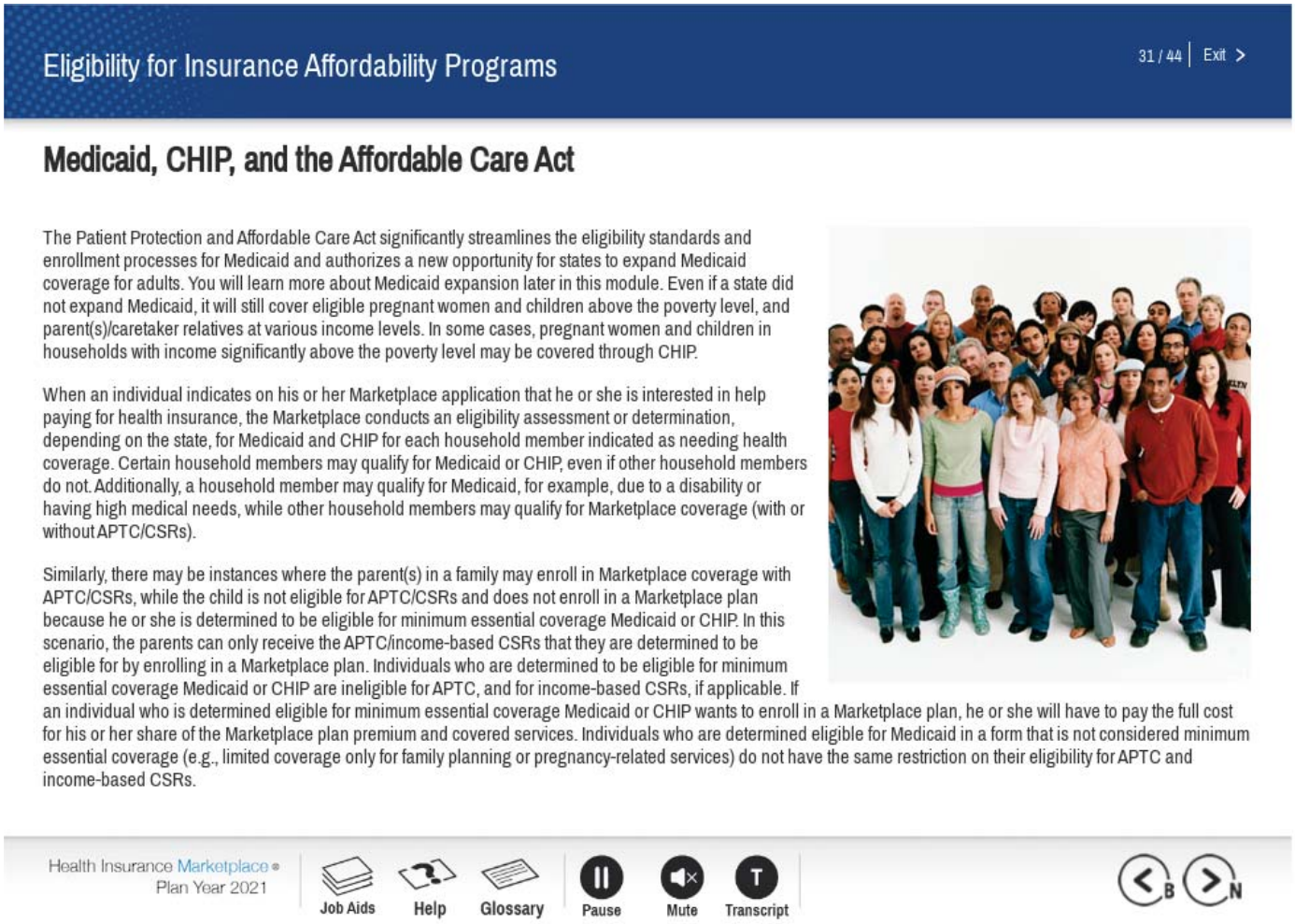
CHIP

CHIP provides no-cost or low-cost health insurance coverage to children under age 19 in families with qualifying incomes that are too high to qualify for Medicaid coverage. It also covers pregnant women in some states. Like Medicaid, the costs for CHIP are shared by the federal government and state governments, but the program is administered at the state level. CHIP programs operate under different names in each state, such as "BadgerCare" in Wisconsin and "Washington Apple Health for Kids" in the state of Washington.

CHIP provides comprehensive benefits, often through insurance companies.

To find CHIP information by state, visit InsureKidsNow.gov.

Page: 31 of 44: Medicaid, CHIP, and the Affordable Care Act



Page Text

The Patient Protection and Affordable Care Act significantly streamlines the eligibility standards and enrollment processes for Medicaid and authorizes a new opportunity for states to expand Medicaid coverage for adults. You will learn more about Medicaid expansion later in this module. Even if a state did not expand Medicaid, it will still cover eligible pregnant women and children above the poverty level, and parent(s)/caretaker relatives at various income levels. In some cases, pregnant women and children in households with income significantly above the poverty level may be covered through CHIP.

When an individual indicates on his or her Marketplace application that he or she is interested in help paying for health insurance, the Marketplace conducts an eligibility assessment or determination, depending on the state, for Medicaid and CHIP for each household member indicated as needing health coverage. Certain household members may qualify for Medicaid or CHIP, even if other household members do not. Additionally, a household member may qualify for Medicaid, for example, due to a disability or having high medical needs, while other household members may qualify for Marketplace coverage (with or without APTC/CSRs).

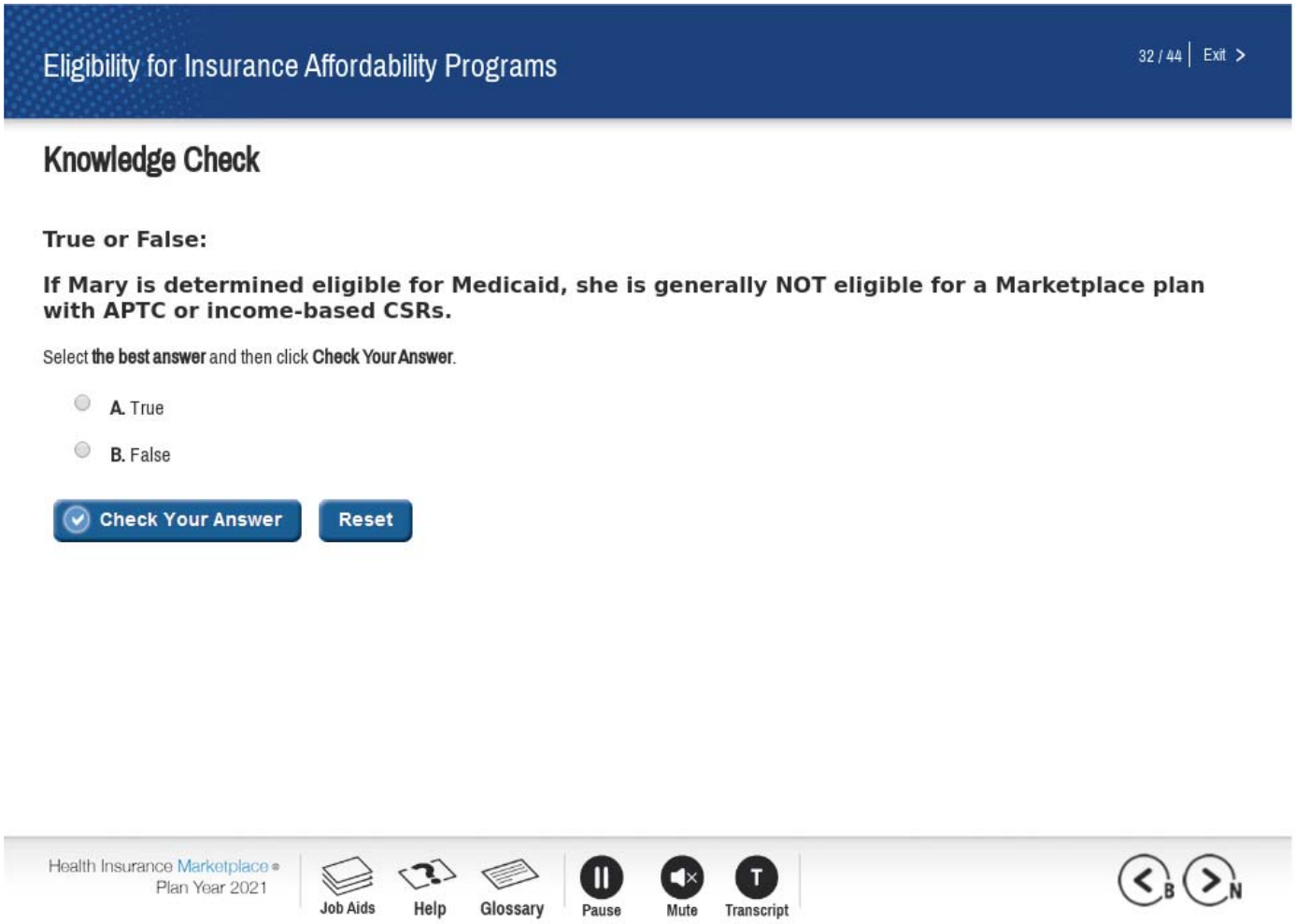
Similarly, there may be instances where the parent(s) in a family may enroll in Marketplace coverage with APTC/CSRs, while the child is not eligible for APTC/CSRs and does not enroll in a Marketplace plan because he or she is determined to be eligible for minimum essential coverage Medicaid or CHIP. In this scenario, the parents can only receive the APTC/income-based CSRs that they are determined to be eligible for by enrolling in a Marketplace plan. Individuals who are determined to be eligible for minimum essential coverage Medicaid or CHIP are ineligible for APTC, and for income-based CSRs, if

applicable. If an individual who is determined eligible for minimum essential coverage Medicaid or CHIP wants to enroll in a Marketplace plan, he or she will have to pay the full cost for his or her share of the Marketplace plan premium and covered services. Individuals who are determined eligible for Medicaid in a form that is not considered minimum essential coverage (e.g., limited coverage only for family planning or pregnancy-related services) do not have the same restriction on their eligibility for APTC and income-based CSRs.

Alt Text

A large group of people standing in a room

Page: 32 of 44: Knowledge Check



Prompt
Select **the best answer** and then click **Check Your Answer**.

Question
True or False: If Mary is determined eligible for Medicaid, she is generally NOT eligible for a Marketplace plan with APTC or income-based CSRs.

Options

A. True

B. False

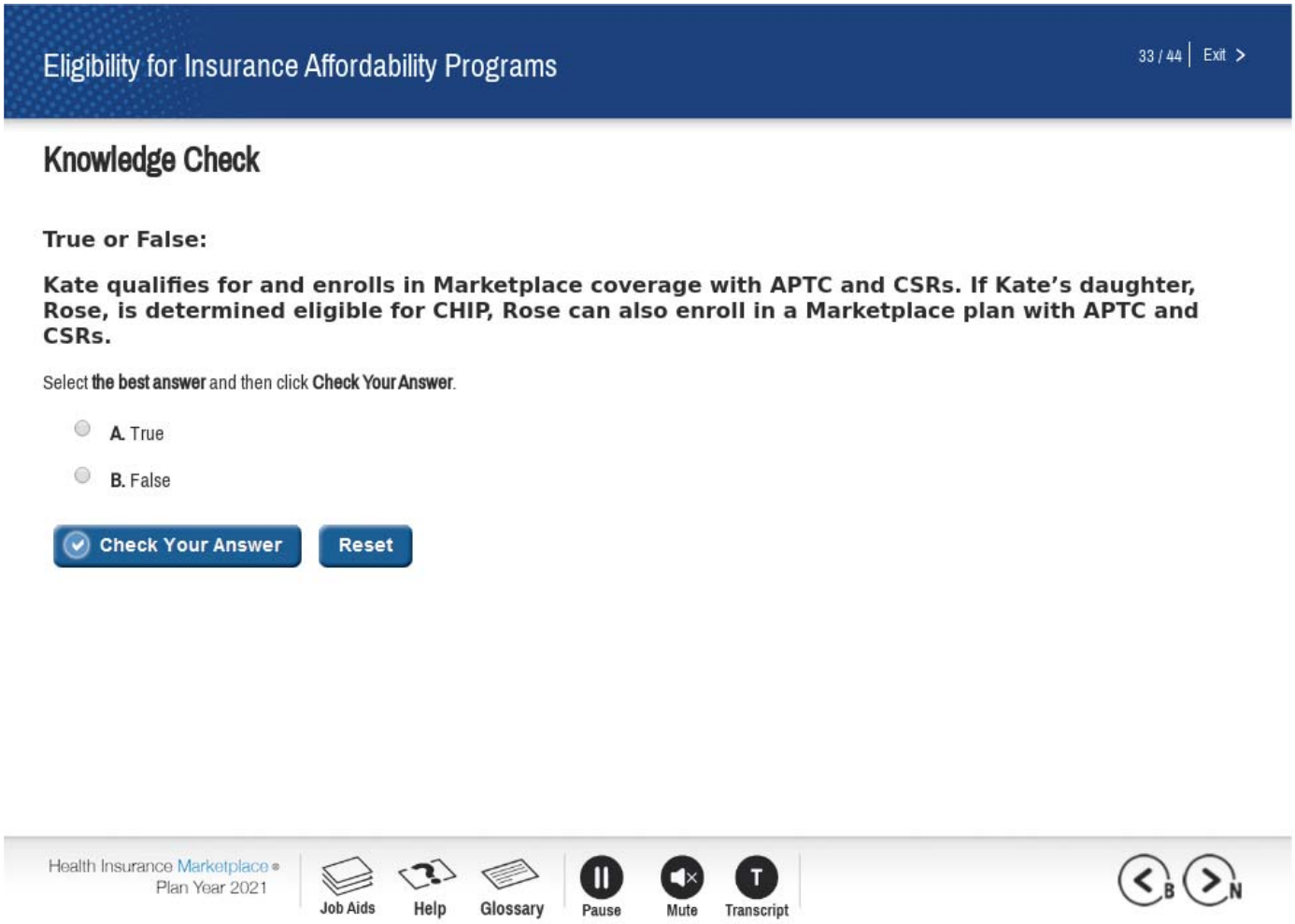
Correct Answer
A

Positive Feedback
Correct! Individuals determined eligible for minimum essential coverage Medicaid or CHIP can enroll in Marketplace coverage if otherwise eligible, but will have to pay full cost for their share of the Marketplace plan premium and covered services, as they are ineligible for APTC and for income-based CSRs, if applicable. Individuals who are determined eligible for Medicaid in a

form that is not considered minimum essential coverage (e.g., limited coverage only for family planning or pregnancy-related services) do not have the same restriction on their eligibility for APTC and income-based CSRs.

Negative Feedback
Incorrect. The statement is true. Individuals determined eligible for minimum essential coverage Medicaid or CHIP can enroll in Marketplace coverage if otherwise eligible, but will have to pay full cost for their share of the Marketplace plan premium and covered services, as they are ineligible for APTC and for income-based CSRs, if applicable. Individuals who are determined eligible for Medicaid in a form that is not considered minimum essential coverage (e.g., limited coverage only for family planning or pregnancy-related services) do not have the same restriction on their eligibility for APTC and income-based CSRs.

Page: 33 of 44: Knowledge Check



Prompt
Select **the best answer** and then click **Check Your Answer**.

Question
True or False: Kate qualifies for and enrolls in Marketplace coverage with APTC and CSRs. If Kate's daughter, Rose, is determined eligible for CHIP, Rose can also enroll in a Marketplace plan with APTC and CSRs.

Options

A. True

B. False

Correct Answer
B

Positive Feedback
Correct! If Rose is determined eligible for CHIP, she can enroll in Marketplace coverage if otherwise eligible, but will have to pay the full cost for her share of the Marketplace plan premium and covered services, as she is not eligible for APTC or for income-based CSRs, if applicable.

Negative Feedback
Incorrect. The statement is false. If Rose is determined eligible for CHIP, she can enroll in Marketplace coverage if otherwise eligible, but will have to pay the full cost for her share of the Marketplace plan premium and covered services, as she is not eligible for APTC or for income-based CSRs, if applicable.

Page: 34 of 44: Medicaid and Children's Health Insurance Program Eligibility

Long Description

Interactive graphic with two equally sized images positioned horizontally from left to right. The left image is of a grandfather playing in the grass with his grandson. The right image is a close up of a map of the city of Pittsburgh. There is a yellow pin drop next to Pittsburgh. From left to right, the images are labeled Medicaid and CHIP Eligibility Determinations and State Differences in Medicaid and CHIP Eligibility. When selected, a pop-up box appears with related text.

Prompt Text: Select each image below for additional information on the process and responsibilities for determining eligibility for Medicaid and CHIP.

Page Text: When an individual indicates on his or her Marketplace application that he or she wants to apply for help paying for health insurance, the Marketplace conducts an eligibility assessment or determination, depending on the state, for Medicaid and CHIP for each household member that indicates that he or she needs health coverage.

Pop Up Text

Medicaid and CHIP Eligibility Determinations

For households applying through the Marketplace for health coverage and help paying for it, the Marketplace evaluates each applicant's eligibility for Medicaid and CHIP.

In some states, known as determination states, the Marketplace may also make the final eligibility determinations for Medicaid and CHIP coverage, consistent with Medicaid and CHIP regulations and state-specific policies.

In other states, known as assessment states, the Marketplace makes preliminary assessments of eligibility for Medicaid and CHIP coverage; state Medicaid/CHIP agencies make the final eligibility determinations, consistent with Medicaid and CHIP regulations and state-specific policies. In assessment states, there is a possibility that the Marketplace will assess an individual potentially eligible for Medicaid/CHIP, and then the state Medicaid/CHIP agency may determine the individual ineligible for Medicaid/CHIP. In this case, the state agency will notify the individual of the determination, and send the updated application information to the Marketplace via a secure transaction.

Upon receiving the application information from the state agency, the Marketplace will start the individual's Marketplace application, and notify him or her (see sample notice here) that he or she should complete and submit the Marketplace application if the individual would like to see if he or she or someone on the individual's application qualifies to get Marketplace coverage and help paying for health coverage and services through a tax credit, and health plans specifically designed to lower out-of-pocket costs.
The decision as to whether a state is an assessment or determination state is made by the state Medicaid/CHIP agency, and applies to all applications for coverage and financial assistance that are submitted to the Marketplace for that state.

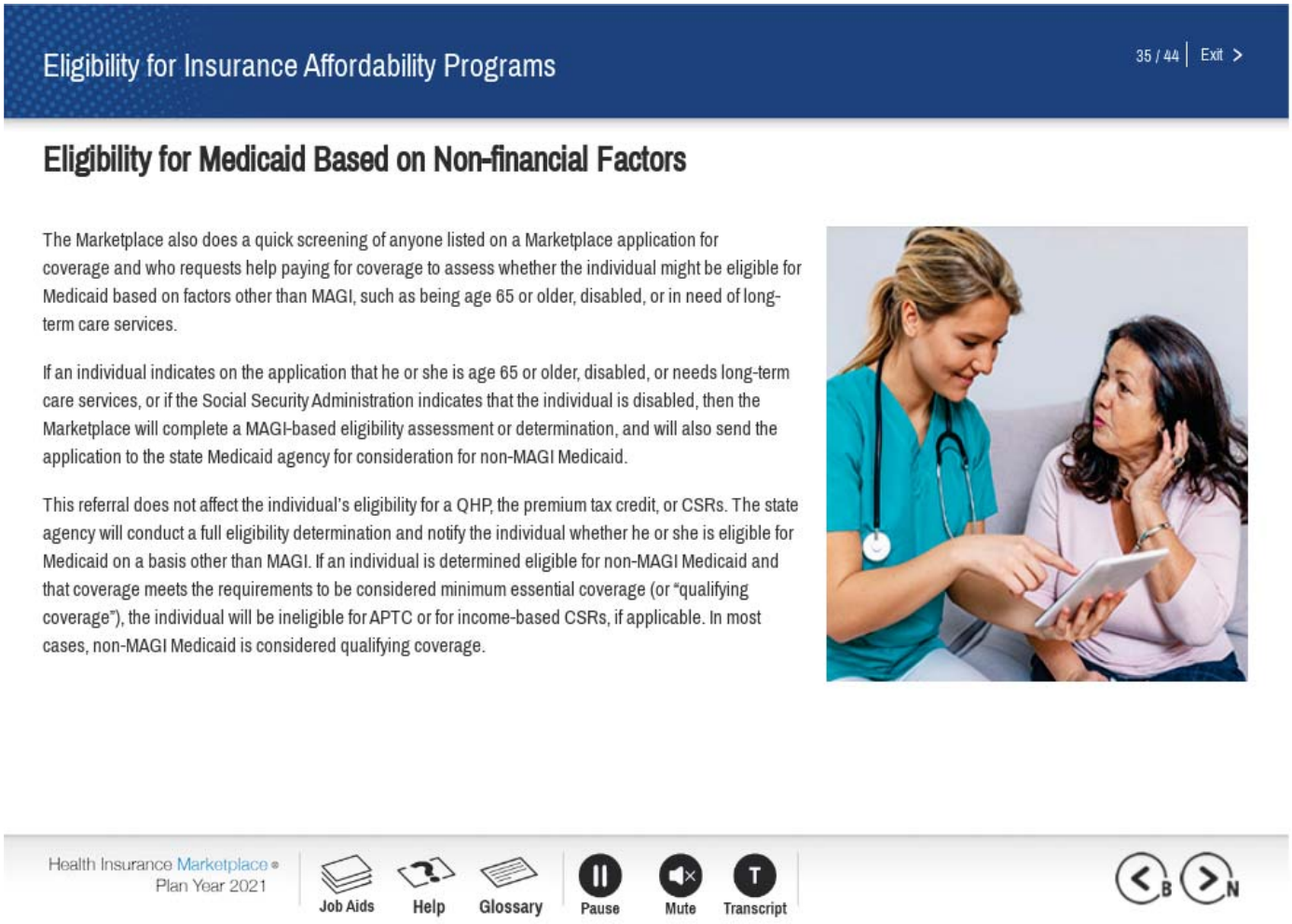
For households applying for Marketplace coverage and financial assistance, if applicants are not assessed/determined by the Marketplace as Medicaid/CHIP eligible, they will be evaluated for eligibility for Marketplace coverage with APTC/CSRs. Eligibility determinations may result in household members qualifying for and enrolling in different coverage/programs. For example, an application may include parents who enroll in a Marketplace plan with APTC/CSRs and a child who is eligible for Medicaid or CHIP.

State Differences in Medicaid and CHIP Eligibility

Assessments and determinations for Medicaid and CHIP eligibility are made based on each state's applicable Medicaid MAGI-based income standards; other eligibility requirements, like rules regarding citizenship and immigration status; and verification rules and procedures, consistent with federal regulations.

Since Medicaid and CHIP programs vary by state, you should familiarize yourself with the Medicaid and CHIP programs for the state(s) in which you operate as an agent or broker. Additional information is available through your state Medicaid and CHIP agencies; or to learn more about a state Medicaid or CHIP program and other available options, use the insurance and coverage finder at HealthCare.gov or visit Medicaid.gov or InsureKidsNow.gov.

Page: 35 of 44: Eligibility for Medicaid Based on Non-financial Factors



Page Text

The Marketplace also does a quick screening of anyone listed on a Marketplace application for coverage and who requests help paying for coverage to assess whether the individual might be eligible for Medicaid based on factors other than MAGI, such as being age 65 or older, disabled, or in need of long-term care services.

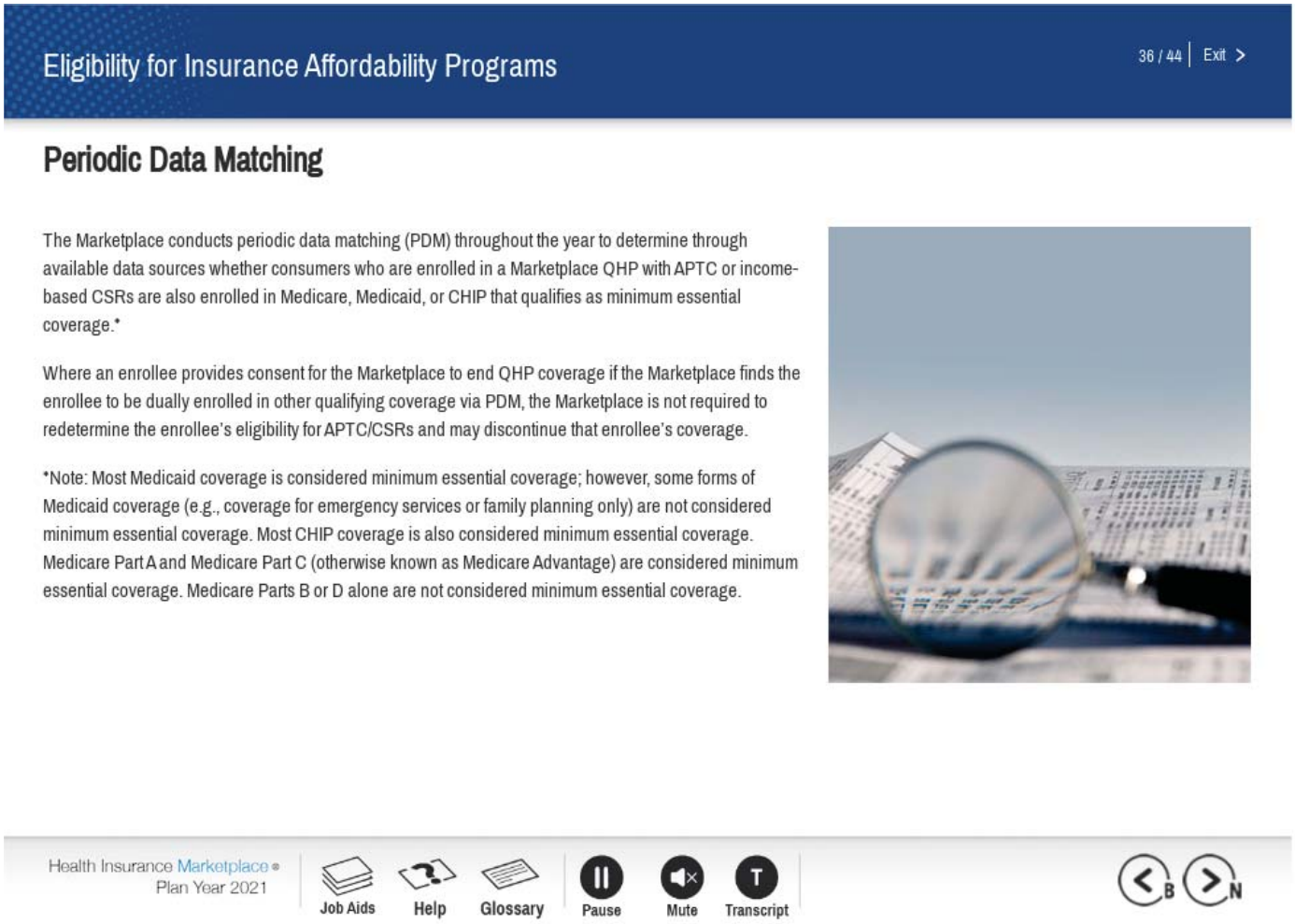
If an individual indicates on the application that he or she is age 65 or older, disabled, or needs long-term care services, or if the Social Security Administration indicates that the individual is disabled, then the Marketplace will complete a MAGI-based eligibility assessment or determination, and will also send the application to the state Medicaid agency for consideration for non-MAGI Medicaid.

This referral does not affect the individual's eligibility for a QHP, the premium tax credit, or CSRs. The state agency will conduct a full eligibility determination and notify the individual whether he or she is eligible for Medicaid on a basis other than MAGI. If an individual is determined eligible for non-MAGI Medicaid and that coverage meets the requirements to be considered minimum essential coverage (or "qualifying coverage"), the individual will be ineligible for APTC or for income-based CSRs, if applicable. In most cases, non-MAGI Medicaid is considered qualifying coverage.

Alt Text

A nurse is sitting next to an older woman and pointing to her tablet screen.

Page: 36 of 44: Periodic Data Matching



Page Text

The Marketplace conducts periodic data matching (PDM) throughout the year to determine through available data sources whether consumers who are enrolled in a Marketplace QHP with APTC or income-based CSRs are also enrolled in Medicare, Medicaid, or CHIP that qualifies as minimum essential coverage.*

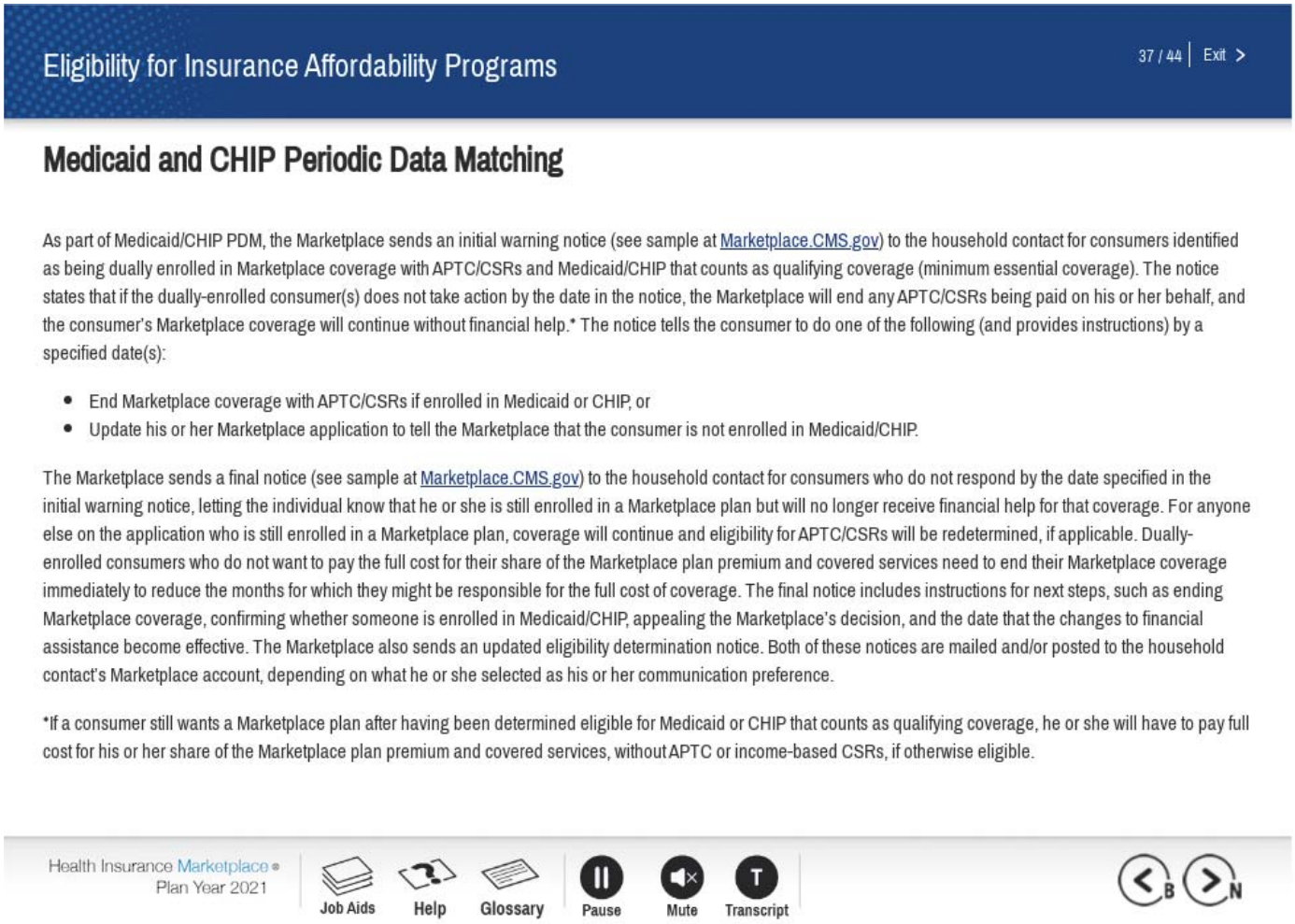
Where an enrollee provides consent for the Marketplace to end QHP coverage if the Marketplace finds the enrollee to be dually enrolled in other qualifying coverage via PDM, the Marketplace is not required to redetermine the enrollee's eligibility for APTC/CSRs and may discontinue that enrollee's coverage.

*Note: Most Medicaid coverage is considered minimum essential coverage; however, some forms of Medicaid coverage (e.g., coverage for emergency services or family planning only) are not considered minimum essential coverage. Most CHIP coverage is also considered minimum essential coverage. Medicare Part A and Medicare Part C (otherwise known as Medicare Advantage) are considered minimum essential coverage. Medicare Parts B or D alone are not considered minimum essential coverage.

Alt Text

Magnifying glass laying on a paper

Page: 37 of 44: Medicaid and CHIP Periodic Data Matching



Page Text

As part of Medicaid/CHIP PDM, the Marketplace sends an initial warning notice (see sample at Marketplace.CMS.gov) to the household contact for consumers identified as being dually enrolled in Marketplace coverage with APTC/CSRs and Medicaid/CHIP that counts as qualifying coverage (minimum essential coverage). The notice states that if the dually-enrolled consumer(s) does not take action by the date in the notice, the Marketplace will end any APTC/CSRs being paid on his or her behalf, and the consumer's Marketplace coverage will continue without financial help.* The notice tells the consumer to do one of the following (and provides instructions) by a specified date(s):

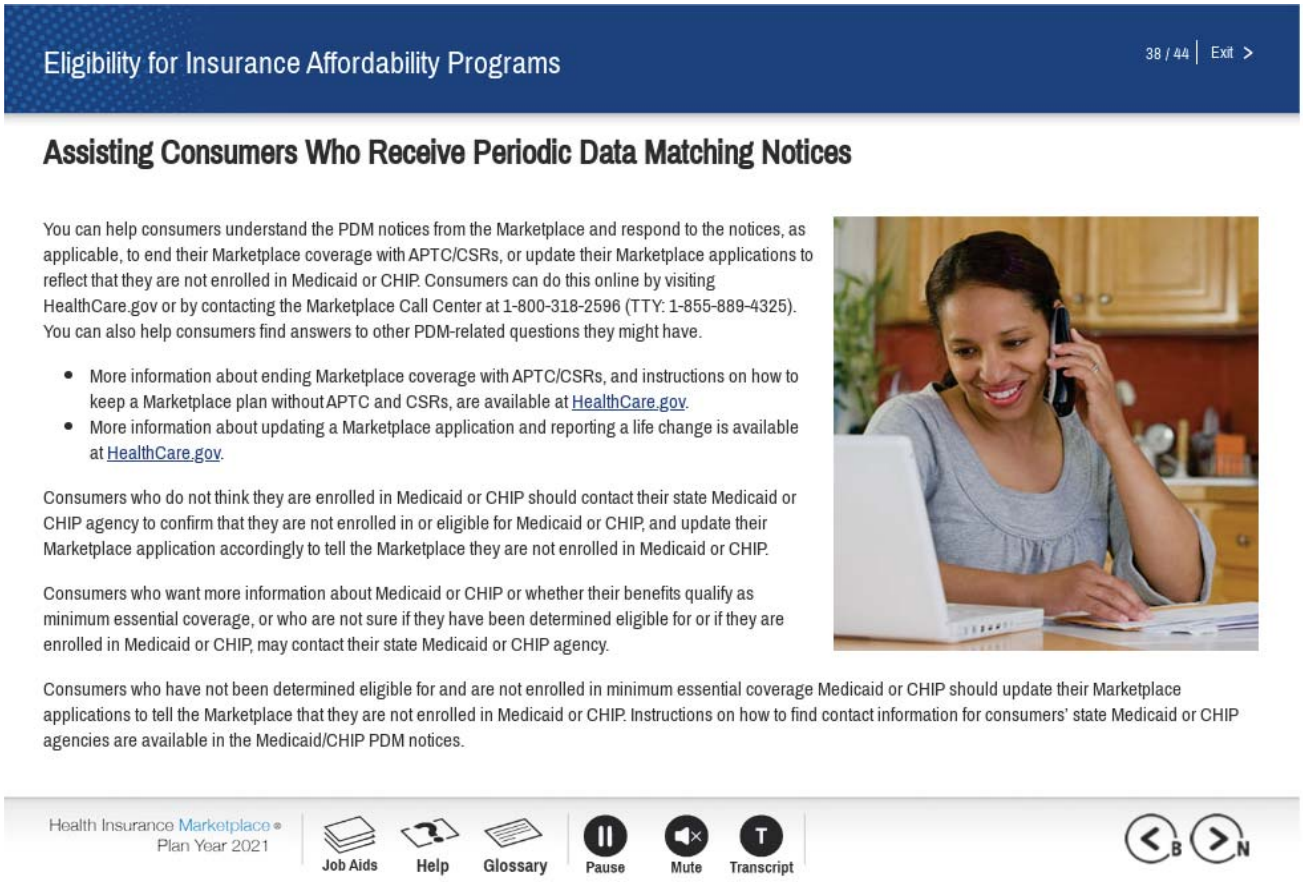
- End Marketplace coverage with APTC/CSRs if enrolled in Medicaid or CHIP, or
- Update his or her Marketplace application to tell the Marketplace that the consumer is not enrolled in Medicaid/CHIP.

The Marketplace sends a final notice (see sample at Marketplace.CMS.gov) to the household contact for consumers who do not respond by the date specified in the initial warning notice, letting the individual know that he or she is still enrolled in a Marketplace plan but will no longer receive financial help for that coverage. For anyone else on the application who is still enrolled in a Marketplace plan, coverage will continue and eligibility for APTC/CSRs will be redetermined, if applicable. Dually-enrolled consumers who do not want to pay the full cost for their share of the Marketplace plan premium and covered services need to end their Marketplace coverage immediately to reduce the months for which they might be responsible for the full cost of coverage. The final notice includes instructions for next steps, such as ending Marketplace coverage, confirming whether someone is enrolled in Medicaid/CHIP, appealing the Marketplace's decision, and the date that the changes to financial

assistance become effective. The Marketplace also sends an updated eligibility determination notice. Both of these notices are mailed and/or posted to the household contact's Marketplace account, depending on what he or she selected as his or her communication preference.

*If a consumer still wants a Marketplace plan after having been determined eligible for Medicaid or CHIP that counts as qualifying coverage, he or she will have to pay full cost for his or her share of the Marketplace plan premium and covered services, without APTC or income-based CSRs, if otherwise eligible.

Page: 38 of 44: Assisting Consumers Who Receive Periodic Data Matching Notices



Page Text

You can help consumers understand the PDM notices from the Marketplace and respond to the notices, as applicable, to end their Marketplace coverage with APTC/CSRs, or update their Marketplace applications to reflect that they are not enrolled in Medicaid or CHIP. Consumers can do this online by visiting HealthCare.gov or by contacting the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325). You can also help consumers find answers to other PDM-related questions they might have.

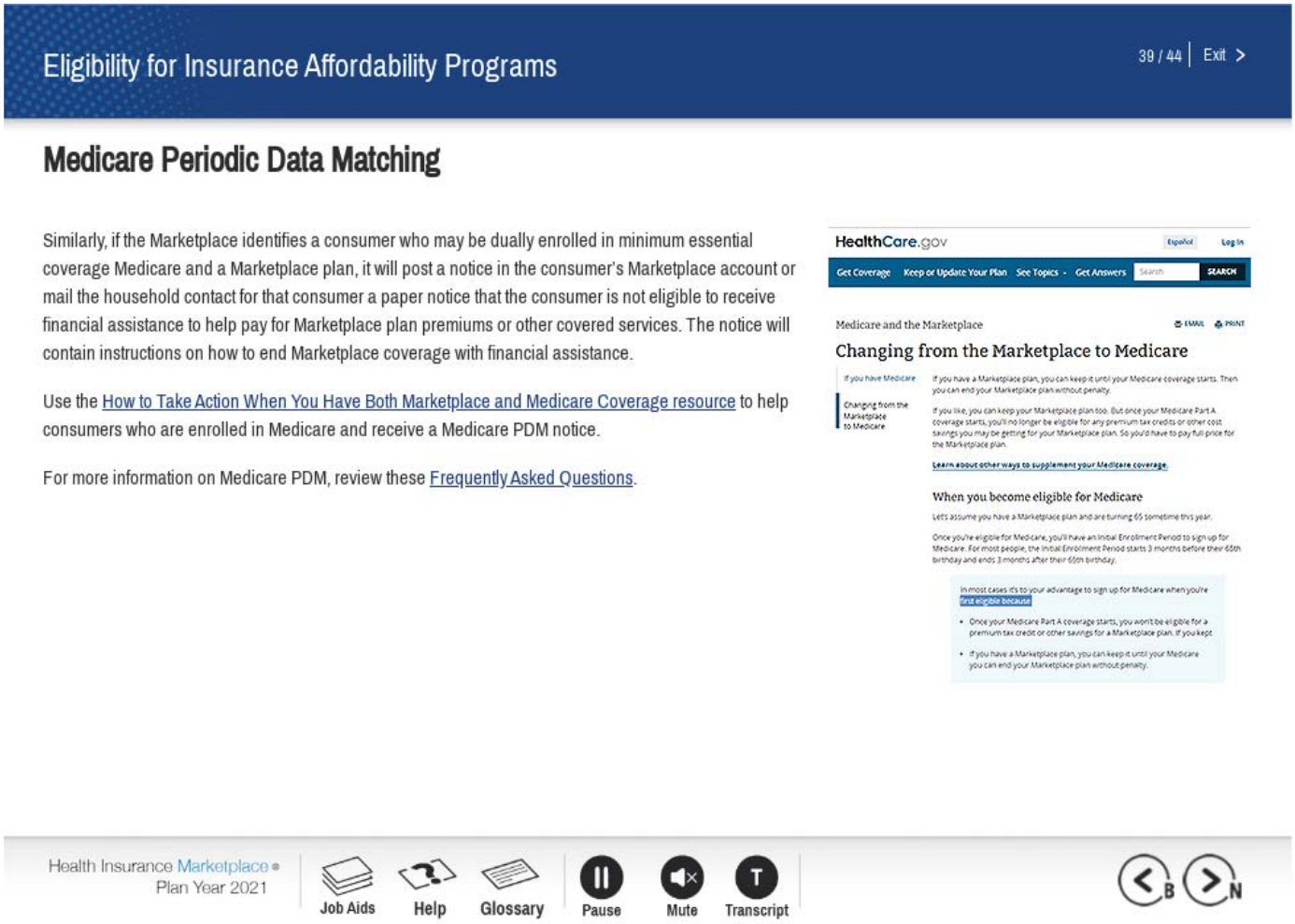
- More information about ending Marketplace coverage with APTC/CSRs, and instructions on how to keep a Marketplace plan without APTC and CSRs, are available at HealthCare.gov.
- More information about updating a Marketplace application and reporting a life change is available at HealthCare.gov.

Consumers who do not think they are enrolled in Medicaid or CHIP should contact their state Medicaid or CHIP agency to confirm that they are not enrolled in or eligible for Medicaid or CHIP, and update their Marketplace application accordingly to tell the Marketplace they are not enrolled in Medicaid or CHIP. Consumers who want more information about Medicaid or CHIP or whether their benefits qualify as minimum essential coverage, or who are not sure if they have been determined eligible for or if they are enrolled in Medicaid or CHIP, may contact their state Medicaid or CHIP agency. Consumers who have not been determined eligible for and are not enrolled in minimum essential coverage Medicaid or CHIP should update their Marketplace applications to tell the Marketplace that they are not enrolled in Medicaid or CHIP. Instructions on how to find contact information for consumers' state Medicaid or CHIP agencies are available in the Medicaid/CHIP PDM notices.

Alt Text

A woman sitting at a desk in her kitchen holding the phone while looking at her laptop screen

Page: 39 of 44: Medicare Periodic Data Matching



Page Text

Similarly, if the Marketplace identifies a consumer who may be dually enrolled in minimum essential coverage Medicare and a Marketplace plan, it will post a notice in the consumer's Marketplace account or mail the household contact for that consumer a paper notice that the consumer is not eligible to receive financial assistance to help pay for Marketplace plan premiums or other covered services. The notice will contain instructions on how to end Marketplace coverage with financial assistance.

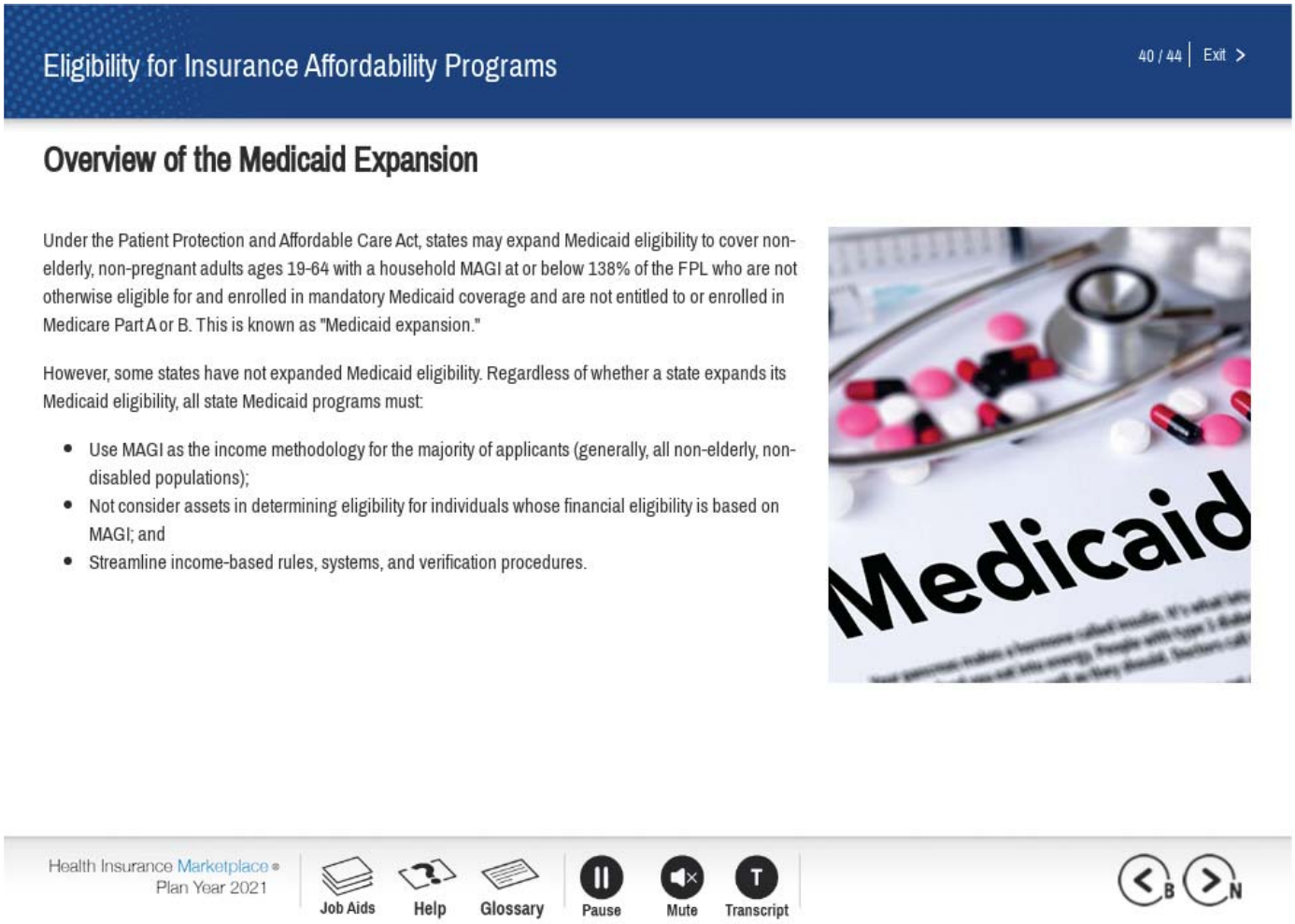
Use the How to Take Action When You Have Both Marketplace and Medicare Coverage resource to help consumers who are enrolled in Medicare and receive a Medicare PDM notice.

For more information on Medicare PDM, review these Frequently Asked Questions.

Alt Text

Screenshot from HealthCare.gov titled "Changing from the Marketplace to Medicare"

Page: 40 of 44: Overview of the Medicaid Expansion



Page Text

Under the Patient Protection and Affordable Care Act, states may expand Medicaid eligibility to cover non-elderly, non-pregnant adults ages 19-64 with a household MAGI at or below 138% of the FPL who are not otherwise eligible for and enrolled in mandatory Medicaid coverage and are not entitled to or enrolled in Medicare Part A or B. This is known as "Medicaid expansion."

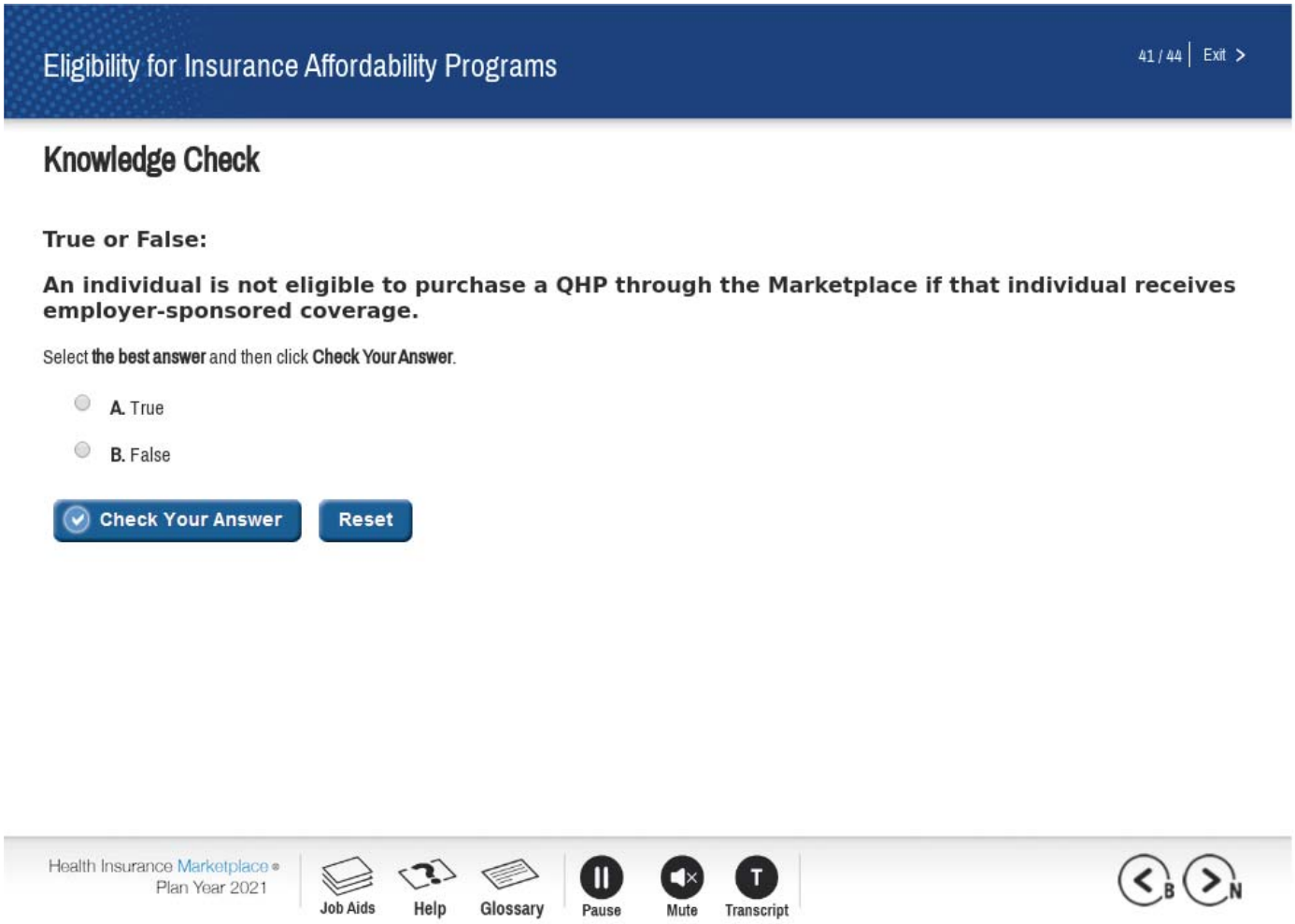
However, some states have not expanded Medicaid eligibility. Regardless of whether a state expands its Medicaid eligibility, all state Medicaid programs must:

- Use MAGI as the income methodology for the majority of applicants (generally, all non-elderly, non-disabled populations);
- Not consider assets in determining eligibility for individuals whose financial eligibility is based on MAGI; and
- Streamline income-based rules, systems, and verification procedures.

Alt Text

A close-up picture of a form with the word Medicaid on it; laying on top of the form are medications and a stethoscope.

Page: 41 of 44: Knowledge Check



Prompt
Select **the best answer** and then click **Check Your Answer**.

Question
True or False: An individual is not eligible to purchase a QHP through the Marketplace if that individual receives employer-sponsored coverage.

Options

A. True

B. False

Correct Answer
B

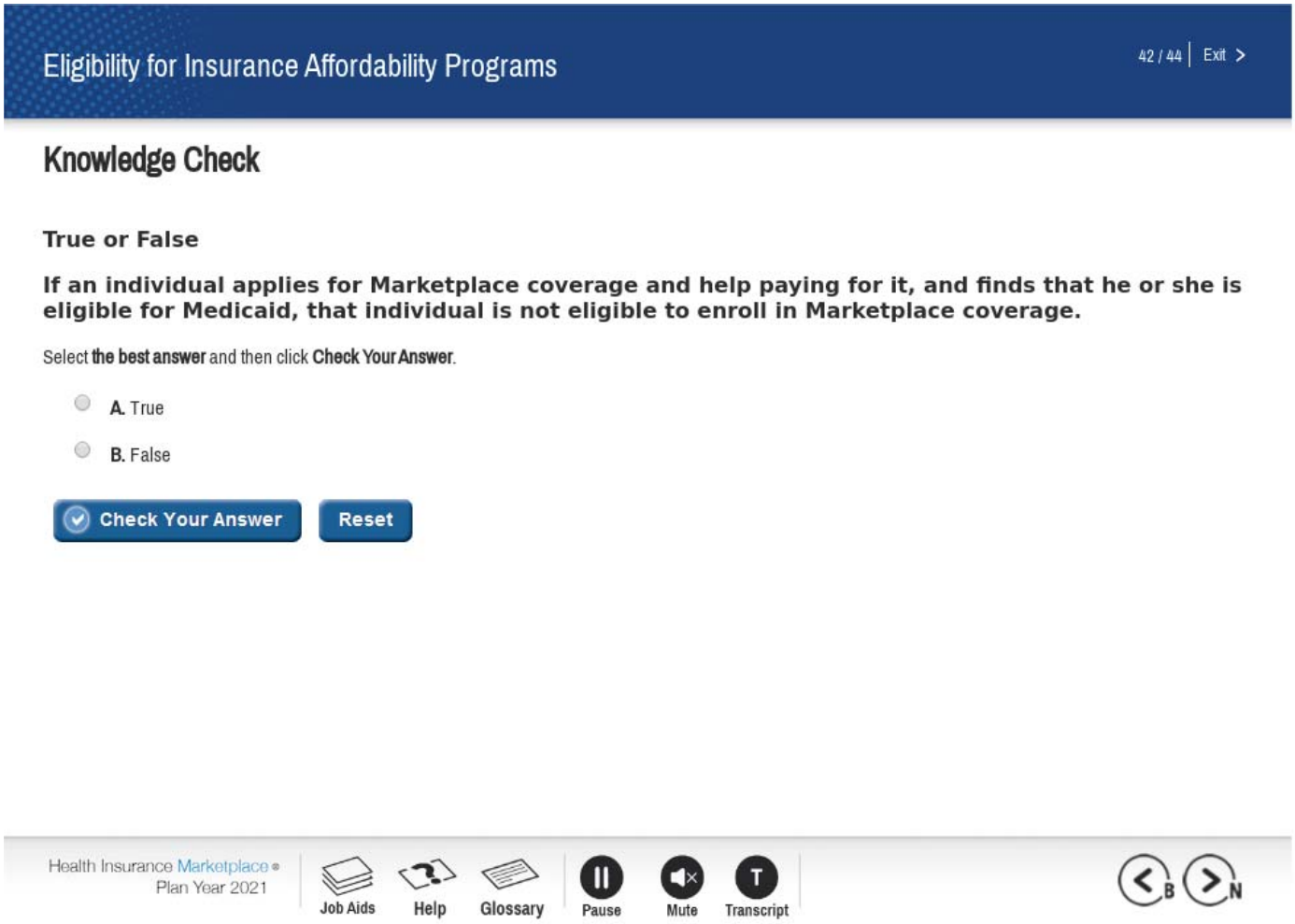
Positive Feedback
Correct! Individuals receiving employer-sponsored coverage may purchase a QHP through the Marketplace as long as they meet the eligibility criteria (i.e., the person: is a resident of the state in which he/she applies for and enrolls in a QHP; is a United States citizen or national or lawfully present non-citizen; and is not incarcerated, other than incarceration pending the

disposition of charges). However, individuals who are enrolled in employer-sponsored coverage, or are eligible for employer-sponsored coverage that is affordable and meets the minimum value standard, are NOT eligible for APTC and income-based CSRs. Further, if an individual has access to affordable and minimum value employer-sponsored coverage, he or she likely does not need to obtain health insurance coverage through a QHP.

Negative Feedback

Incorrect. The statement is false. Individuals receiving employer-sponsored coverage may purchase a QHP through the Marketplace as long as they meet the eligibility criteria (i.e., the person: is a resident of the state in which he/she applies for and enrolls in a QHP; is a United States citizen or national or lawfully present non-citizen; and is not incarcerated, other than incarceration pending the disposition of charges). However, individuals who are enrolled in employer-sponsored coverage, or are eligible for employer-sponsored coverage that is affordable and meets the minimum value standard, are NOT eligible for APTC and income-based CSRs. Further, if an individual has access to affordable and minimum value employer-sponsored coverage, he or she likely does not need to obtain health insurance coverage through a QHP.

Page: 42 of 44: Knowledge Check



Prompt
Select **the best answer** and then click **Check Your Answer**.

Question
True or False If an individual applies for Marketplace coverage and help paying for it, and finds that he or she is eligible for Medicaid, that individual is not eligible to enroll in Marketplace coverage.

Options

A. True

B. False

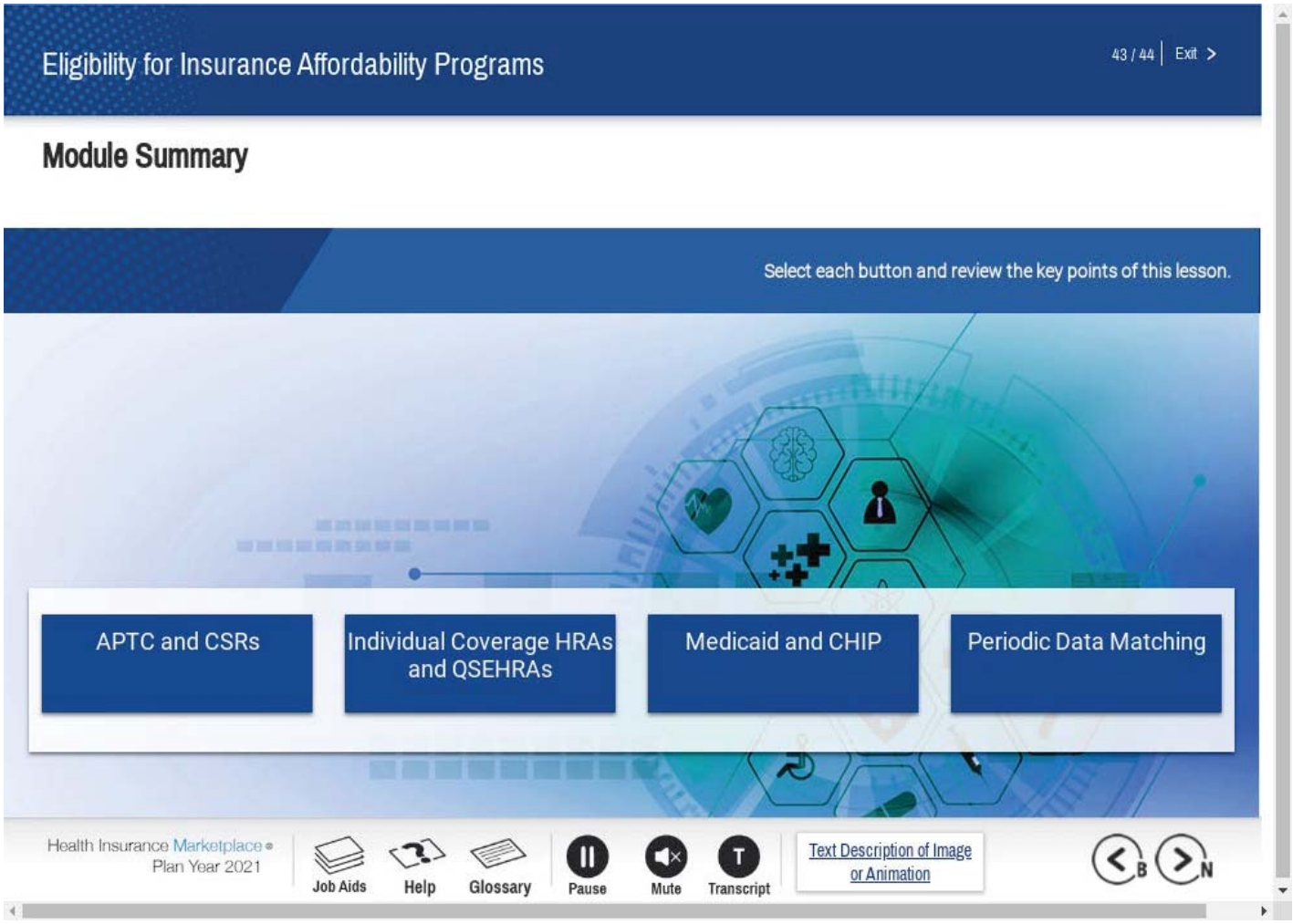
Correct Answer
B

Positive Feedback
Correct! Individuals who are determined to be eligible for minimum essential coverage Medicaid can enroll in Marketplace coverage, if otherwise eligible; however, they will have to pay the full cost for their share of the Marketplace plan premium and covered services, as they are ineligible for APTC, and for income-based CSRs, if applicable.

Negative Feedback

Incorrect. The statement is false. Individuals who are determined to be eligible for minimum essential coverage Medicaid can enroll in Marketplace coverage, if otherwise eligible; however, they will have to pay the full cost for their share of the Marketplace plan premium and covered services, as they are ineligible for APTC, and for income-based CSRs, if applicable.

Page: 43 of 44: Module Summary



Long Description

Interactive graphic: A collage of icons representing module-specific concepts is displayed; three equally-sized rectangular buttons are shown from left to right across the bottom of the page. Each rectangular button has a label that corresponds to a key module topic or concept. When each button is selected a pop-up box appears and displays accompanying text.

Pop Up Text

APTC and CSRs

- The premium tax credit is an income tax provision to help eligible individuals and families afford health insurance coverage purchased through the Marketplace. APTC are paid on a monthly basis directly to the insurance company offering the QHP and in which the individual(s) is enrolled.
- CSRs are subsidies that reduce the amount of certain out-of-pocket expenses, such as deductibles or coinsurance, that an individual is responsible for as part of his or her Marketplace QHP coverage.
- An individual may choose to apply some or all of the APTC he or she is determined eligible to receive towards Marketplace QHP premiums – with reconciliation at the end of the year – or to receive the credit on his or her federal tax return filed for the plan year.
- The Marketplace uses MAGI to determine a consumer's eligibility for APTC and income-based CSRs and for assessing or determining eligibility for Medicaid and CHIP. It also screens for potential eligibility for Medicaid on other bases.

Individual Coverage HRAs and QSEHRAs

- Employers can offer their employees an individual coverage HRA instead of a traditional group health plan to reimburse employee medical expenses, like monthly premiums and out-of-pocket costs like copayments and deductibles for individual health coverage or Medicare.
- Small employers can offer their employees an individual coverage HRA or can provide a QSEHRA that employees can use to pay for their health care costs.
- An offer of an individual coverage HRA may impact a consumer's eligibility for the premium tax credit for Marketplace coverage. If the consumer does not opt out of the offered individual coverage HRA, he or she will not be eligible for a premium tax credit for Marketplace coverage, even if the individual coverage HRA is not affordable. Use the "Is Your Individual Coverage HRA Offer Affordable?" worksheet to help the consumers you assist determine if their individual coverage HRA is or is not considered affordable.
- Consumers with a QSEHRA are allowed APTC for their Marketplace coverage only if the QSEHRA is considered unaffordable. However, consumers in this situation should either forego APTC or choose an amount not more than the APTC for which they are eligible minus the QSEHRA amount provided to the consumer; otherwise they will likely have to pay some or all of the APTC back when they file their federal income tax return.

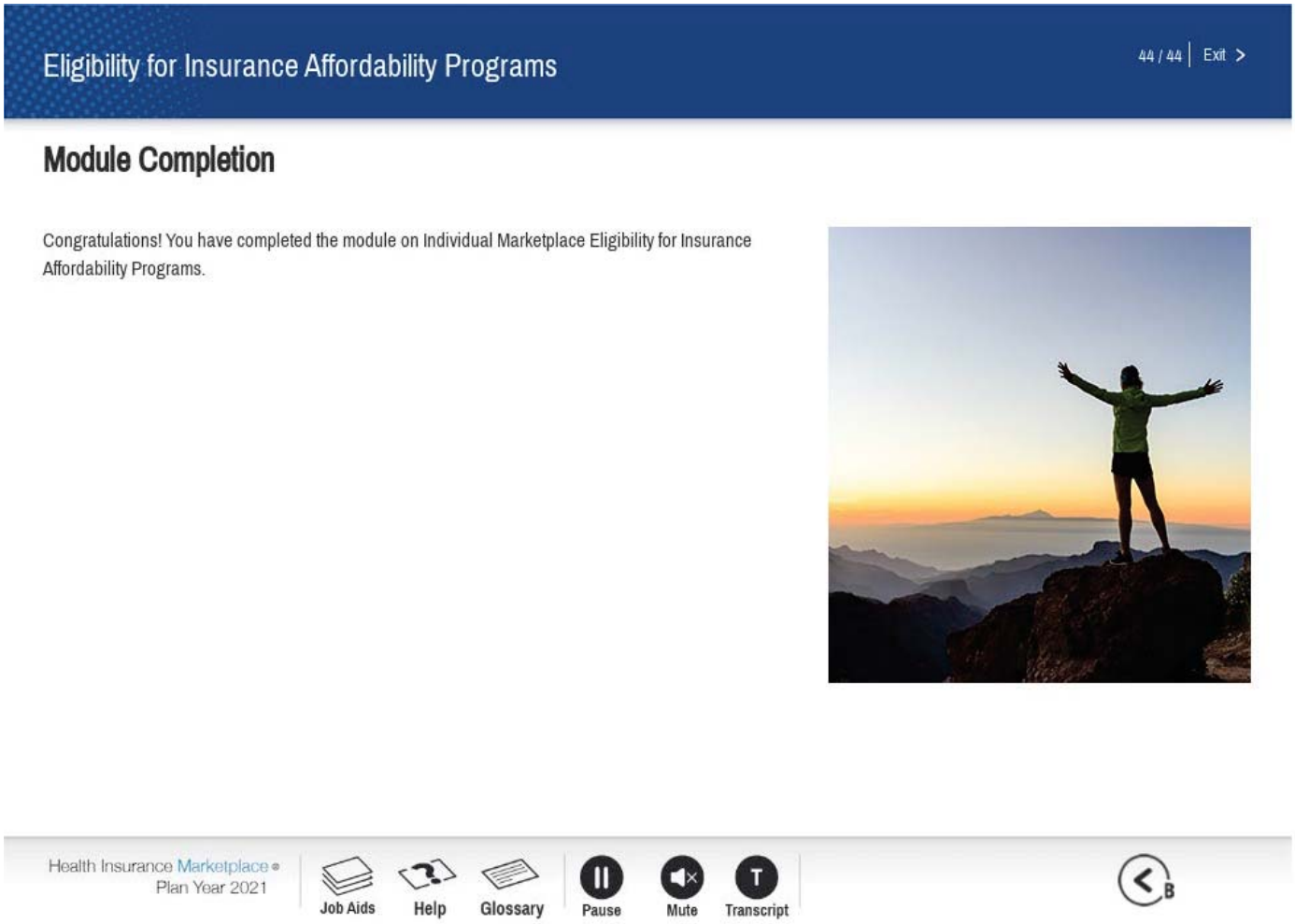
Medicaid and CHIP

- Medicaid is a federal and state partnership to provide health care coverage for eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities among other populations.
- CHIP provides no-cost or low-cost health insurance coverage to children under age 19 who are in families with qualifying incomes that are too high to qualify for Medicaid coverage.
- Individuals eligible for Medicaid or CHIP that qualifies as minimum essential coverage may enroll in Marketplace coverage if otherwise eligible; however, they will have to pay the full cost for their share of the Marketplace plan premium and covered services, as they are ineligible for APTC, and for income-based CSRs, if applicable.
- Household members may be covered by different health plans; certain household members may qualify for coverage through Medicaid or CHIP, while others may obtain health insurance through the Marketplace.

Periodic Data Matching

The Marketplace sends periodic data matching notices to consumers who are enrolled in a Marketplace QHP with APTC or income-based CSRs and who are also enrolled in Medicare, Medicaid, or CHIP that qualifies as minimum essential coverage. Notices inform and instruct those dually enrolled how to end their Marketplace coverage with APTC/CSRs, or update their Marketplace applications to reflect that they are not enrolled in Medicare, Medicaid, or CHIP.

Page: 44 of 44: Module Completion



Page Text

Congratulations! You have completed the module on Individual Marketplace Eligibility for Insurance Affordability Programs.

Alt Text

A person standing on top of a mountain peak with arms outstretched