Marketplace Assister Essentials

Contents

Course Introduction
Who Must Take this Course?

Welcome to the Marketplace Assister Essentials course!

This course includes an overview of important information that will help you provide consumers in FFMs with eligibility and enrollment assistance or support them with exemptions and appeals.

For detailed information about topics covered in this course, we encourage you to reference the Assister's Standard Operating Procedures (SOP) Manual. Ready? Let's get started!

Disclaimers

Before we begin, you need to be aware of these training disclaimers.

Assister Training Content

The information provided in this training course is not intended to take the place of the statutes, regulations, and formal policy guidance that it is based upon. This course summarizes current policy and operations as of the date it was uploaded to the Marketplace Learning Management System. Links to certain source documents have been provided for your reference. We encourage persons taking the course to refer to the applicable statutes, regulations, CMS assister webinars, and other interpretive materials for complete and current information.

This course includes references and links to nongovernmental third-party websites. CMS offers these links for informational purposes only, and inclusion of these websites should not be construed as an endorsement of any third-party organization's programs or activities.

Coronavirus (COVID-19)

This training does not address COVID-19-related guidance or related requirements for assisters. CMS will communicate applicable information to assisters and assister organizations through separate channels.

- To learn more about how we're responding to coronavirus, visit HealthCare.gov/blog/coronavirus-marketplace-coverage/.
- For preventive practices and applicable state/local guidance, visit CDC.gov/coronavirus.

Individual Shared Responsibility Payment, Exemptions, and Catastrophic Coverage

This course includes references to the Patient Protection and Affordable Care Act's individual shared responsibility provision and exemptions from it. Under the Tax Cuts and Jobs Act, taxpayers must continue to report minimum essential coverage, qualify for an exemption, or pay an individual shared responsibility payment for tax years prior to 2019.

For tax year 2018 only (for which consumers generally filed taxes by April 2019), consumers do not have to fill out an application to get a hardship exemption certificate number (ECN). Consumers can claim the exemption without having to submit documentation about the hardship on their 2018 federal tax returns.

Beginning with tax year 2019, consumers do not need to make an individual shared responsibility payment or file Form 8965, Health Coverage Exemptions, with their tax returns if they don't have minimum essential coverage for part or all of the tax year.

For all tax years, as set forth in §155.305(h), individuals age 30 and above must continue to apply for, obtain, and report an exemption certificate number (ECN) for a Marketplace affordability or hardship exemption if they wish to purchase Catastrophic health coverage.

Standards Related to Essential Health Benefits

Navigators in FFMs must be prepared to inform consumers of the essential health benefits (EHB) that qualified health plans (QHPs) must cover in the FFM(s) they service. For plan years beginning on or after January 1, 2020, states may select which benefits will be EHB in their state by:

1. Choosing from the 50 EHB-benchmark plans that other states used for the 2017 plan year;
2. Replacing one or more EHB categories of benefits under its EHB-benchmark plan used for the 2017 plan year with the same categories of benefits from another state's EHB-benchmark plan used for the 2017 plan year; or
3. Selecting a set of benefits to become its EHB-benchmark plan, provided that the new EHB-benchmark plan meets certain requirements.

When selecting an updated EHB-benchmark plan from the available options, the generosity of the state's updated EHB-benchmark plan may not exceed a 0.0 percentage point actuarial increase above the most generous among the set of comparison plans.

Remote Application Assistance

Effective June 18, 2018, Navigators in FFMs are not required to maintain a physical presence in their Marketplace service area. In some cases, Navigators may provide remote application assistance (e.g., online or by phone), provided that such assistance is permissible under their organization's contract, grant terms and conditions, or agreement with CMS and/or their organization.

Certified application counselors in FFMs may also provide remote application assistance if such assistance is permissible with their certified application counselor designated organization (CDO).

For guidance on obtaining consumers' consent remotely over the phone, visit: Marketplace.cms.gov/technical-assistance-resources/obtain-consumer-authorization.pdf.

FFM Navigator Duties

Beginning with Navigator grants awarded in 2019, FFM Navigators may but are no longer required to assist consumers with the following services referenced in this training course:

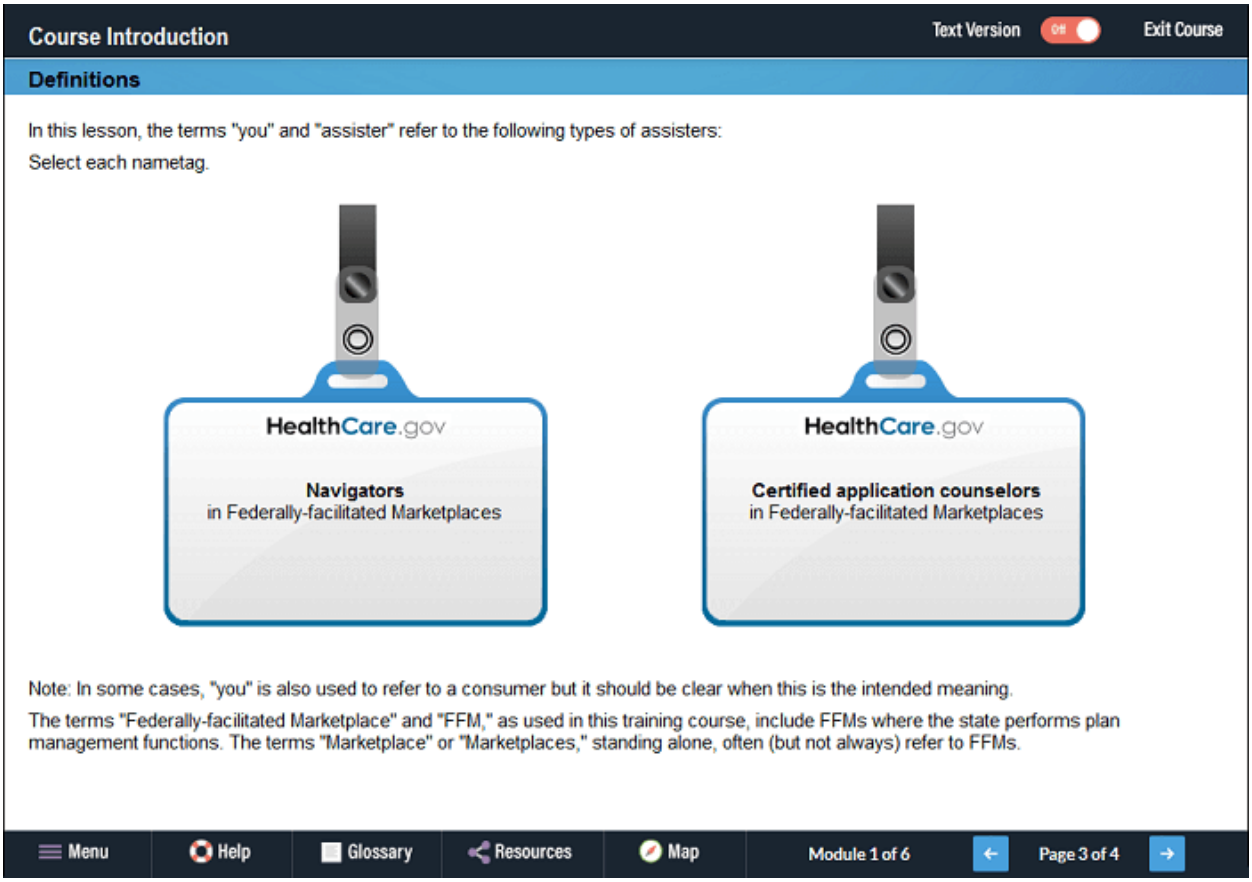
1. Understanding the process of filing Marketplace eligibility appeals;
2. Understanding and applying for exemptions from the individual shared responsibility provision granted through the Marketplace and/or claimed through the tax filing process;
3. Marketplace-related components of the premium tax credit reconciliation process;
4. Understanding basic concepts and rights related to health coverage and how to use it; and
5. Referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice related to consumer questions about the Marketplace application and enrollment process, exemptions from the requirement to maintain minimum essential coverage and from the individual shared responsibility payment, and premium tax credit reconciliations.

CMS will continue to provide all assisters with additional information related to these assistance activities through webinars, job aids, and other technical assistance resources.

Section 1557 of the Patient Protection and Affordable Care Act

This document reflects the requirements of the Section 1557 Final Rule published on June 19, 2020 (85 FR 37160). Some of these requirements may change pending the outcome of lawsuits brought against HHS seeking declaratory and injunctive relief from the Final Rule, and are also affected by previous court orders dating back to December 2016 that continue to be litigated.

Definitions



In this lesson, the terms "you" and "assister" refer to the following types of assisters:

Navigators in Federally-facilitated Marketplaces

Certified application counselors in Federally-facilitated Marketplaces

Note: In some cases, "you" is also used to refer to a consumer but it should be clear when this is the intended meaning.

The terms "Federally-facilitated Marketplace" and "FFM," as used in this training course, include FFMs where the state performs plan management functions. The terms "Marketplace" or "Marketplaces," standing alone, often (but not always) refer to FFMs.

Course Goal

This course has important information that will help you provide consumers in FFMs with eligibility and enrollment assistance or support them with exemptions and appeals.

Goal:

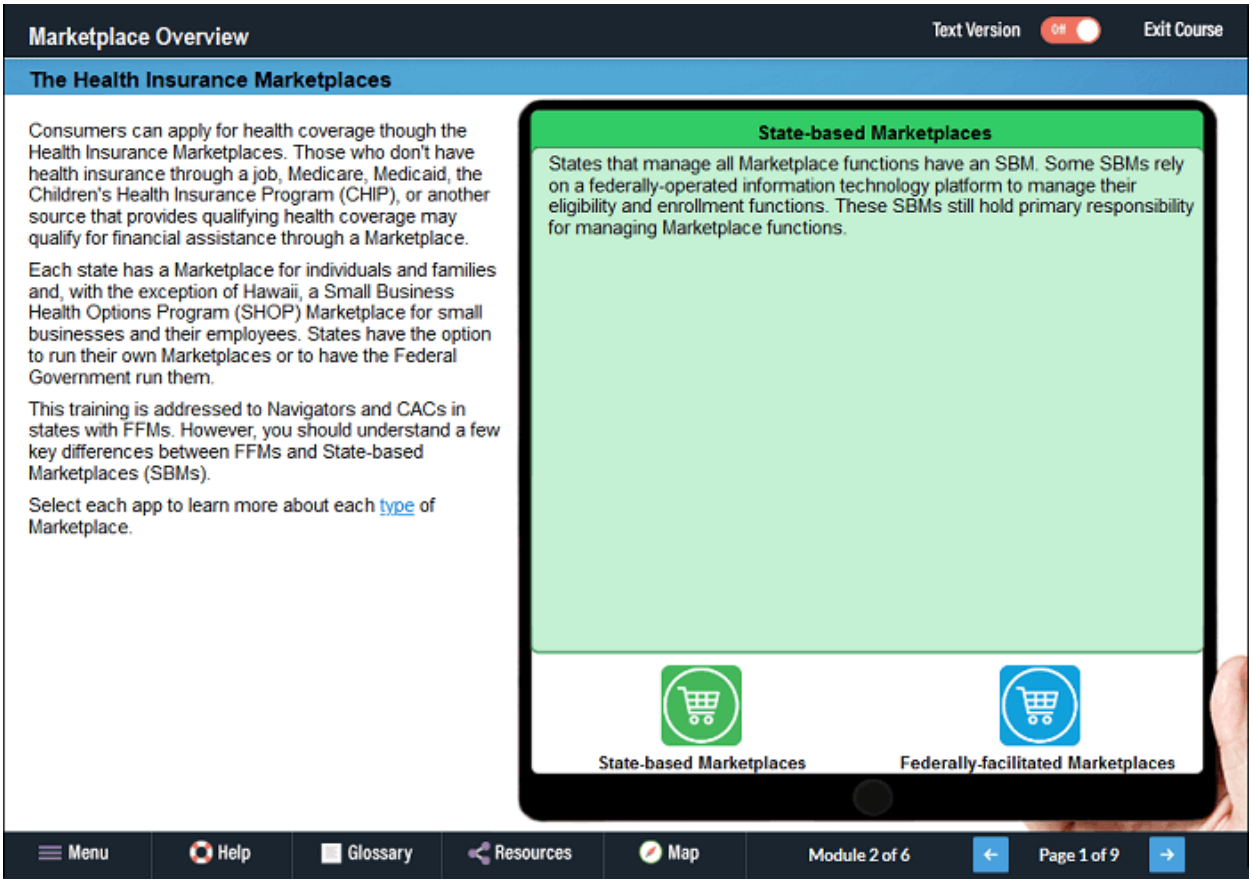
To provide the tools and information needed to help consumers apply for health coverage through the Marketplaces.

Topics:

This course includes information on:

- Consumer consent and PII
- Assessing consumers' needs
- Account creation process
- Identity verification and supporting documents
- Comparing and selecting plans
- Helping consumers enroll in and terminate coverage
- Changes in circumstances
- The individual shared responsibility requirement and exemptions
- Marketplace appeals

Marketplace Overview
The Health Insurance Marketplaces



Consumers can apply for health coverage through the Health Insurance Marketplaces. Those who don't have health insurance through a job, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or another source that provides qualifying health coverage may qualify for financial assistance through a Marketplace.

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

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

Different Types
Generally, states are the primary regulators of health insurance companies. States are generally responsible for enforcing statutory requirements for health insurance and provisions of the Patient Protection and Affordable Care Act (PPACA)—both inside and outside of the Marketplaces.

State-based Marketplaces
States that manage all Marketplace functions have an SBM. Some SBMs rely on a federally-operated information technology platform to manage their eligibility and enrollment functions. These SBMs still hold primary responsibility for managing Marketplace functions.

Federally-facilitated Marketplaces
States that choose to have the Federal Government manage all Marketplace functions have an FFM. In some FFMs, states choose to oversee or regulate plan management functions. Some states with an individual market FFM operate their own SHOP Marketplace. Others have a Federally-facilitated SHOP Marketplace (FF-SHOP).

Note:

FF-SHOP Marketplaces and FF-SHOPs using the federal platform no longer offer employee eligibility,

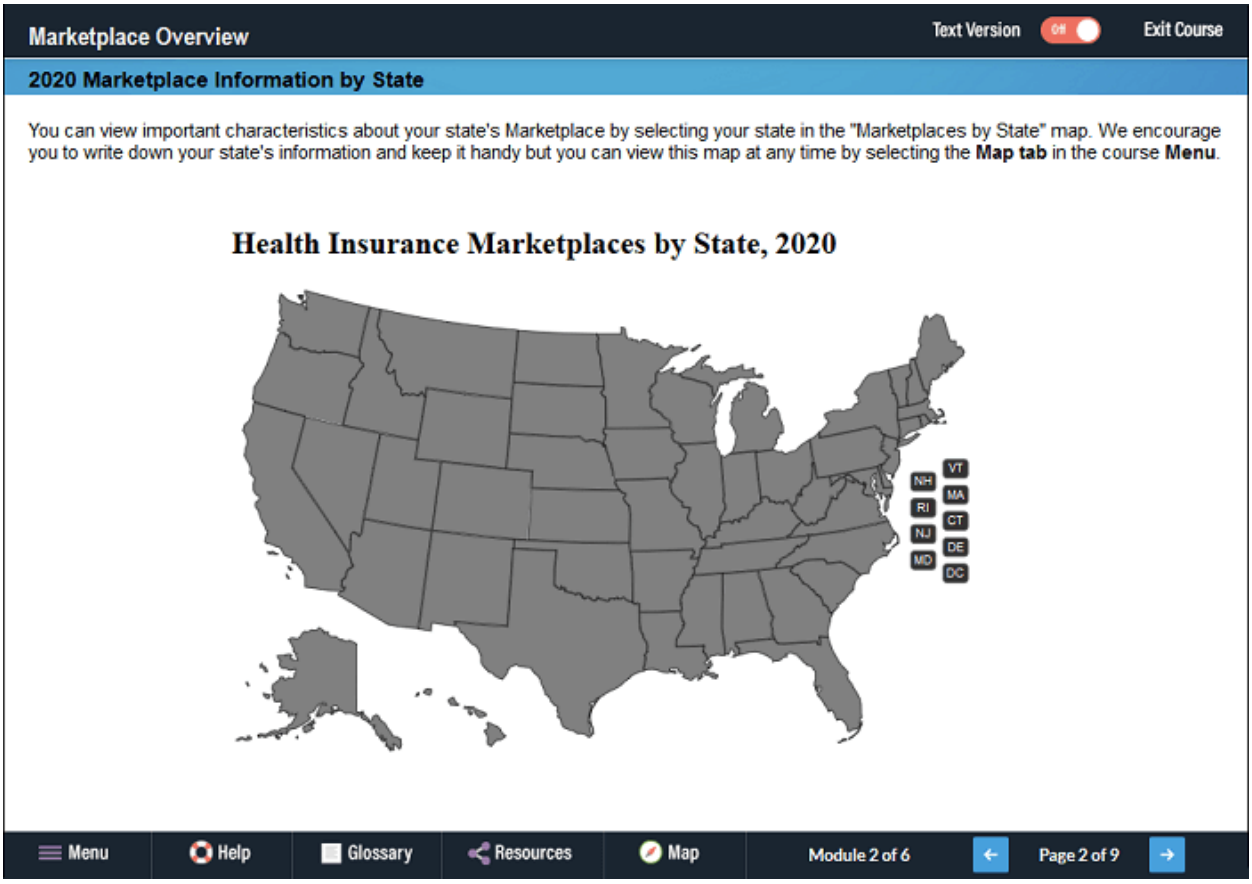
premium aggregation, and online enrollment functionality. Instead, qualified employers and employees can enroll in SHOP plans by working with a qualified health plan (QHP) issuer or SHOP-registered agent or broker.

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

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

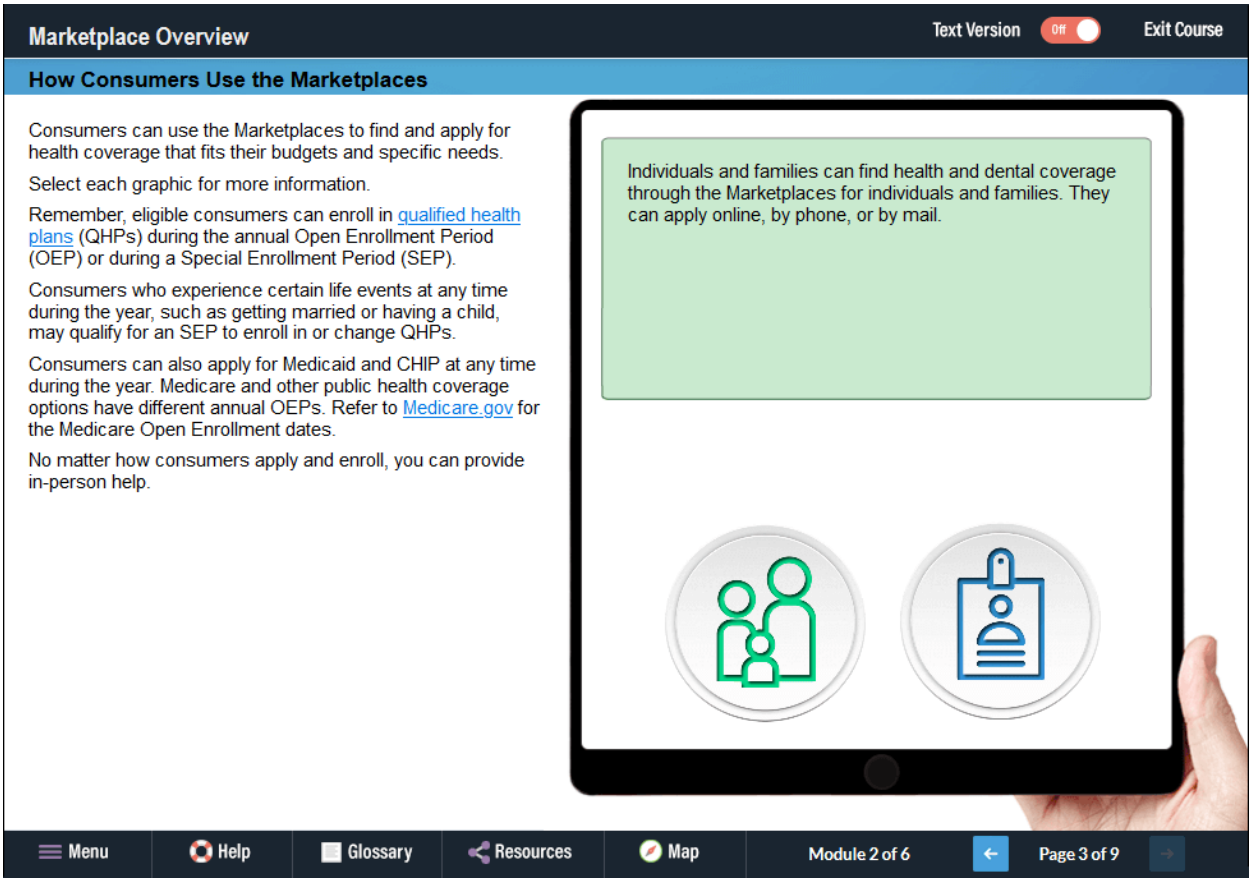
In addition, small employers can contact the SHOP Call Center for any questions or assistance related to submitting employer applications for SHOP coverage.

2020 Marketplace Information by State



You can view important characteristics about your state's Marketplace by selecting your state in the "Marketplaces by State" map. We encourage you to write down your state's information and keep it handy but you can view this map at any time by selecting the **Map tab** in the course **Menu**.

How Consumers Use the Marketplaces



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

Individuals and families can find health and dental coverage through the Marketplaces for individuals and families. They can apply online, by phone, or by mail.

Small employers can apply for eligibility determinations to purchase health and dental coverage through the SHOP Marketplaces. Eligible small employers may choose to offer coverage to eligible employees and former employees as well as their spouses and dependents. Employers can apply online or by phone, but the SHOP Marketplaces do not accept applications by mail.

Remember, eligible consumers can enroll in qualified health plans* (QHPs) during the annual Open Enrollment Period (OEP) or during a Special Enrollment Period (SEP).

Consumers who experience certain life events at any time during the year, such as getting married or having a child, may qualify for an SEP to enroll in or change QHPs.

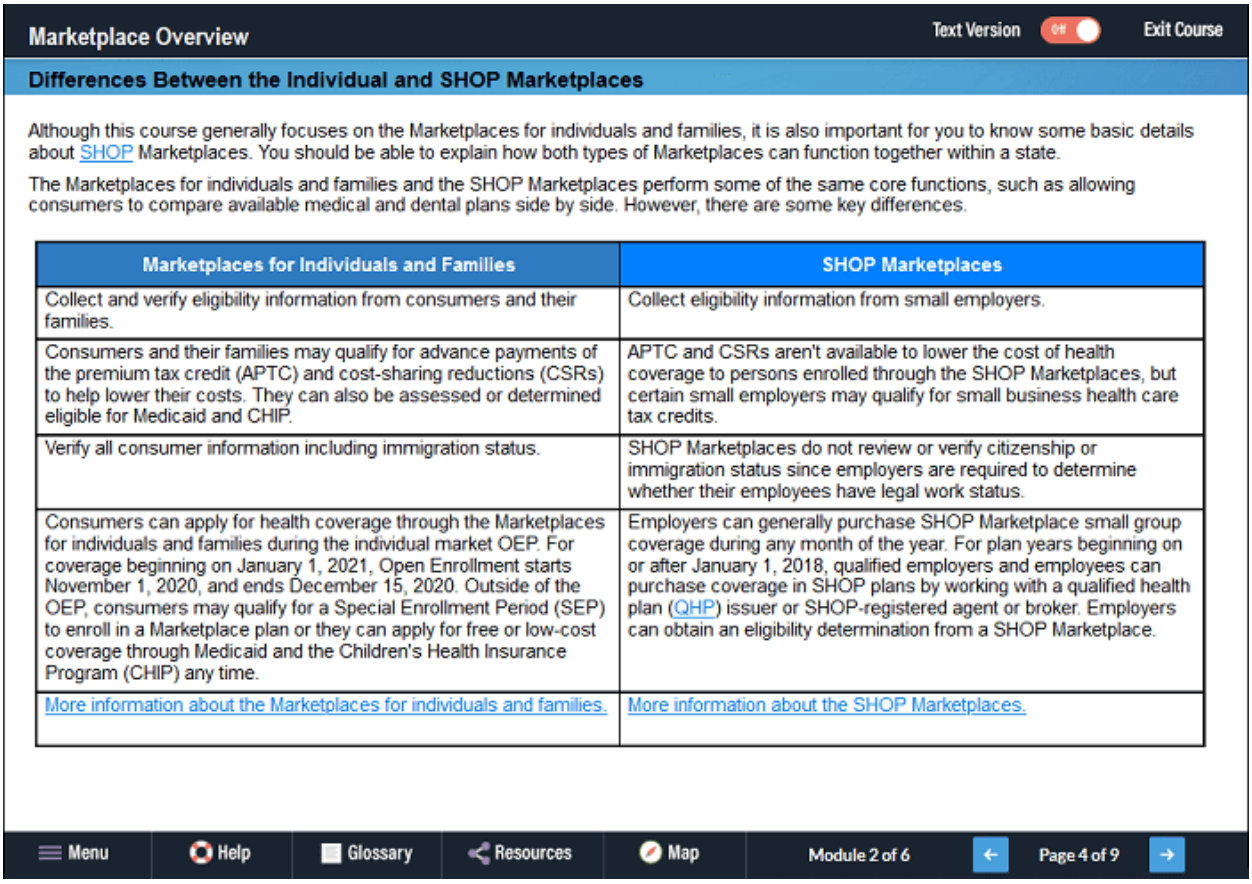
Consumers can also apply for Medicaid and CHIP at any time during the year. Medicare and other public health coverage options have different annual OEPs. Refer to Medicare.gov for the Medicare Open Enrollment dates.

No matter how consumers apply and enroll, you can provide in-person help.

***Qualified Health Plans**
Remember, all health insurance plans sold in the Marketplaces are QHPs. A QHP:

- Provides essential health benefits (EHB), including certain recommended preventive services that are covered at no additional cost to the consumer,
- Follows established limits on cost sharing (e.g., deductibles, copayments, and out-of-pocket maximum amounts),
- Is certified by an Exchange, and
- Meets other requirements.

Differences Between the Individual and SHOP Marketplaces



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

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

Marketplaces for Individuals and Families
Collect and verify eligibility information from consumers and their families.

Consumers and their families may qualify for advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs) to help lower their costs. They can also be assessed or determined eligible for Medicaid and CHIP.

Verify all consumer information including immigration status.

Consumers can apply for health coverage through the Marketplaces for individuals and families during the individual market OEP. For coverage beginning on January 1, 2021, Open Enrollment starts November 1, 2020, and ends December 15, 2020. Outside of the OEP, consumers may qualify for a Special Enrollment Period (SEP) to enroll in a Marketplace plan or they can apply for free or low-cost coverage through Medicaid and the Children's Health Insurance Program (CHIP) any time.

More information about the Marketplaces for individuals and families

SHOP Marketplaces
Collect eligibility information from small employers.

APTC and CSRs aren't available to lower the cost of health coverage to persons enrolled through the SHOP Marketplaces, but certain small employers may qualify for small business health care tax credits.

SHOP Marketplaces do not review or verify citizenship or immigration status since employers are required to determine whether their employees have legal work status.

Employers can generally purchase SHOP Marketplace small group coverage during any month of the year. For

plan years beginning on or after January 1, 2018, qualified employers and employees can purchase coverage in SHOP plans by working with a qualified health plan (QHP)** issuer or SHOP-registered agent or broker. Employers can obtain an eligibility determination from a SHOP Marketplace.

More information about the SHOP Marketplaces.

*SHOP Marketplaces

The SHOP Marketplaces are open to eligible small employers. Generally, a small employer is one that:

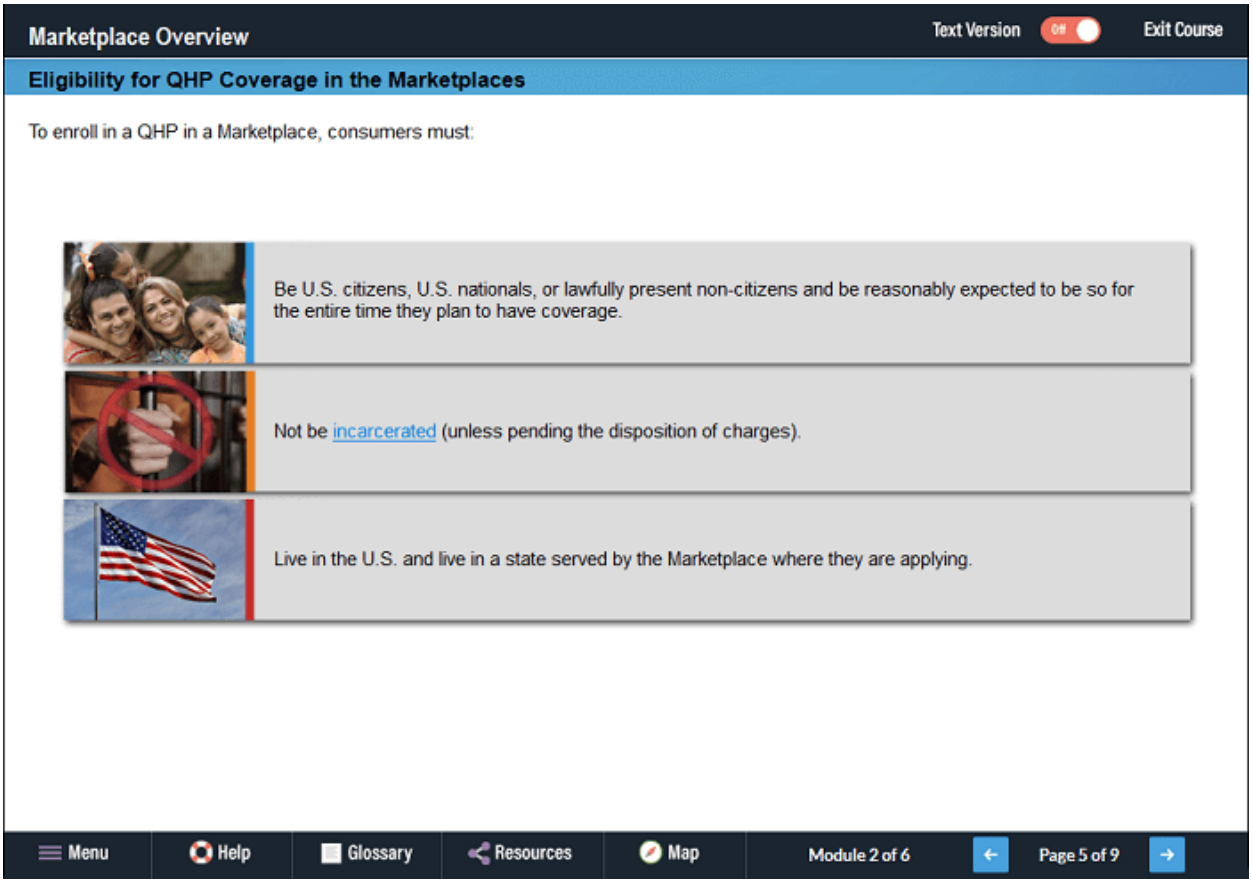
- Employed 1 to 50 (100 in some states) full-time and full-time equivalent (FTE) employees, on average, on business days during the preceding calendar year, and
- Employs at least one employee on the first day of the plan year.

**QHP

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

1. The employee has not enrolled in the SHOP coverage offered by his/her employer, AND
2. The employer's offer is not affordable for the employee, OR
3. The employer's offer does not meet minimum value.

Eligibility for QHP Coverage in the Marketplaces



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

- Be U.S. citizens, U.S. nationals, or lawfully present non-citizens and be reasonably expected to be so for the entire time they plan to have coverage.
- Not be incarcerated (unless pending the disposition of charges).
- Live in the U.S. and live in a state served by the Marketplace where they are applying.

Essential Health Benefits

Remember, the PPACA requires most types of health coverage to offer EHB, including:

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

QHPs must include

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

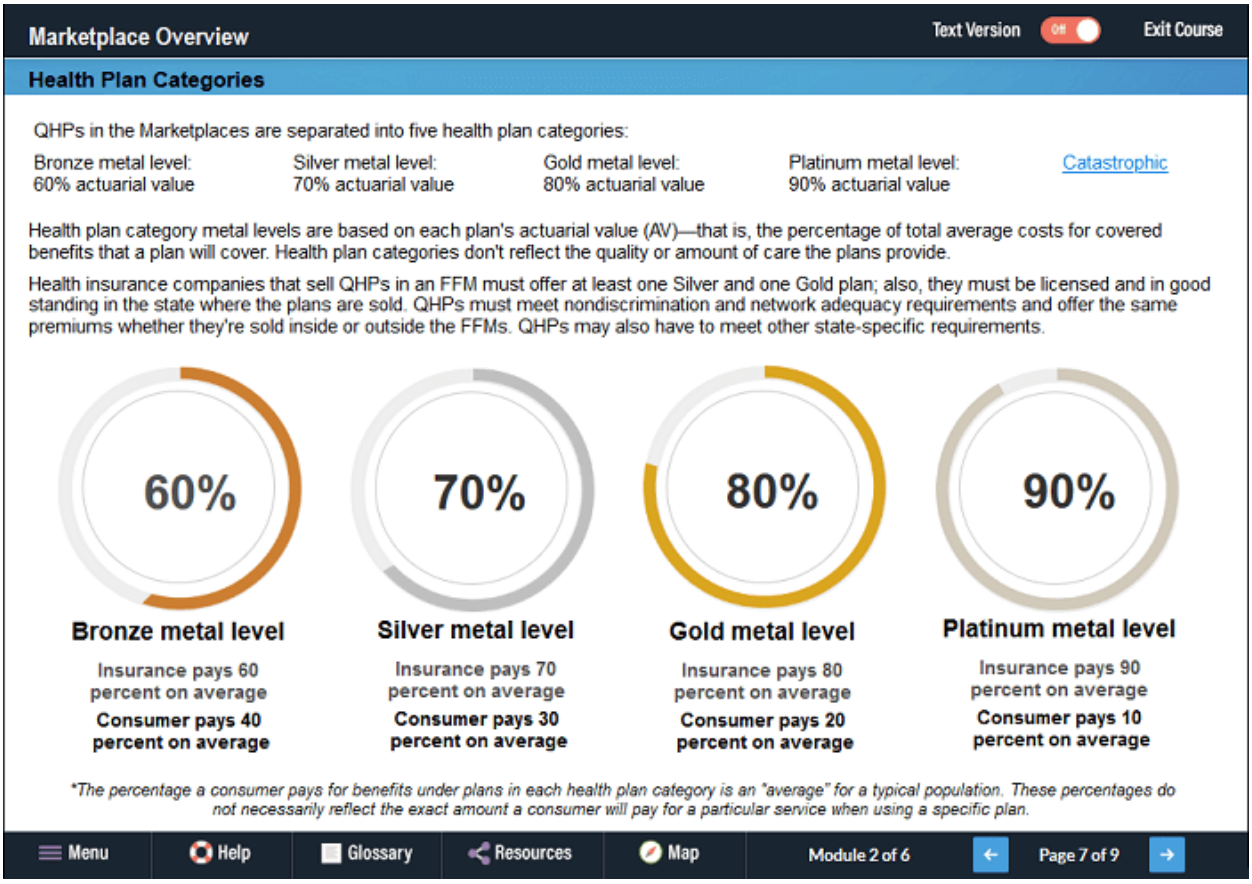
1. Ambulatory patient services (e.g., doctor and clinic visits)
2. Emergency services (e.g., ambulance, first aid, and rescue squad)
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices (e.g., therapy sessions, wheelchairs, oxygen)
8. Laboratory services
9. Preventive and wellness services and chronic disease management (e.g., blood pressure screening, immunizations)
10. Pediatric services, including dental and vision care

QHP Dental Coverage Tips

- Routine adult dental coverage isn't an EHB and most QHPs don't offer it; however, consumers may be able to purchase stand-alone dental plans in the FFMs.

- The FFMs must offer pediatric dental care either as part of QHP coverage or through stand-alone dental plans; however, parents are not required to buy dental insurance for their children.

Health Plan Categories



QHPs in the Marketplaces are separated into five health plan categories:

- Bronze metal level: 60% actuarial value
- Silver metal level: 70% actuarial value
- Gold metal level: 80% actuarial value
- Platinum metal level: 90% actuarial value
- Catastrophic

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

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

Bronze metal level: 60%
Insurance pays 60 percent on average
Consumer pays 40 percent on average

Silver metal level: 70%
Insurance pays 70 percent on average
Consumer pays 30 percent on average

Gold metal level: 80%
Insurance pays 80 percent on average
Consumer pays 20 percent on average

Platinum metal level: 90%
Insurance pays 90 percent on average

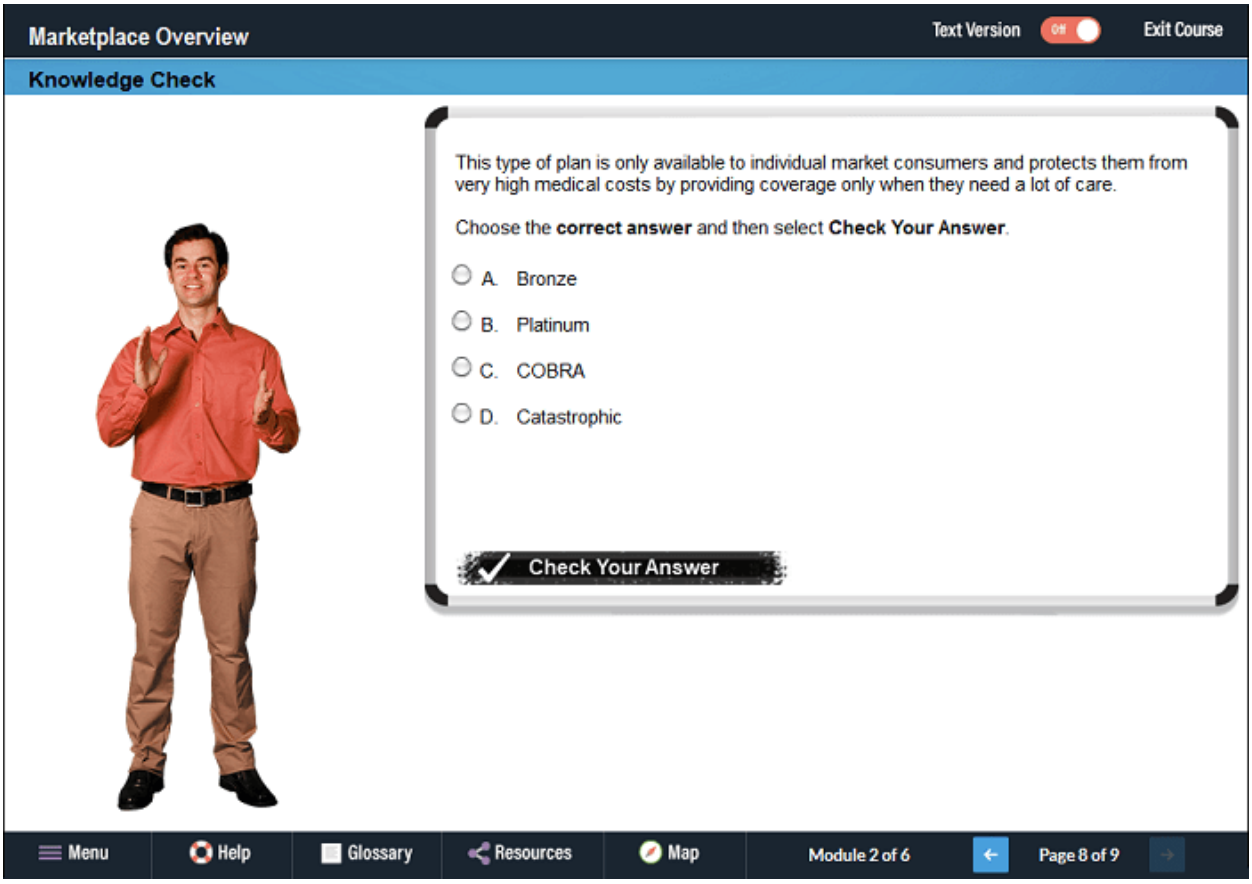
Consumer pays 10 percent on average

*The percentage a consumer pays for benefits under plans in each health plan category is an "average" for a typical population. These percentages do not necessarily reflect the exact amount a consumer will pay for a particular service when using a specific plan.

Catastrophic health insurance plans

Catastrophic plans are only available to individual market consumers under age 30 or consumers who qualify for a hardship or affordability exemption (e.g., a life situation that may prevent them from affording health insurance coverage, such as a flood or natural disaster). Catastrophic plans protect consumers from very high medical costs by only providing coverage when they need a lot of care. However, they do cover certain preventive services at no cost and also cover at least three primary care visits per year before the deductible is met. Generally, Catastrophic plans have lower premiums than the other health plan categories but consumers are responsible for higher cost-sharing amounts. Consumers cannot use APTC and CSRs to lower the costs of a Catastrophic plan like they can with other health plan categories.

Knowledge Check

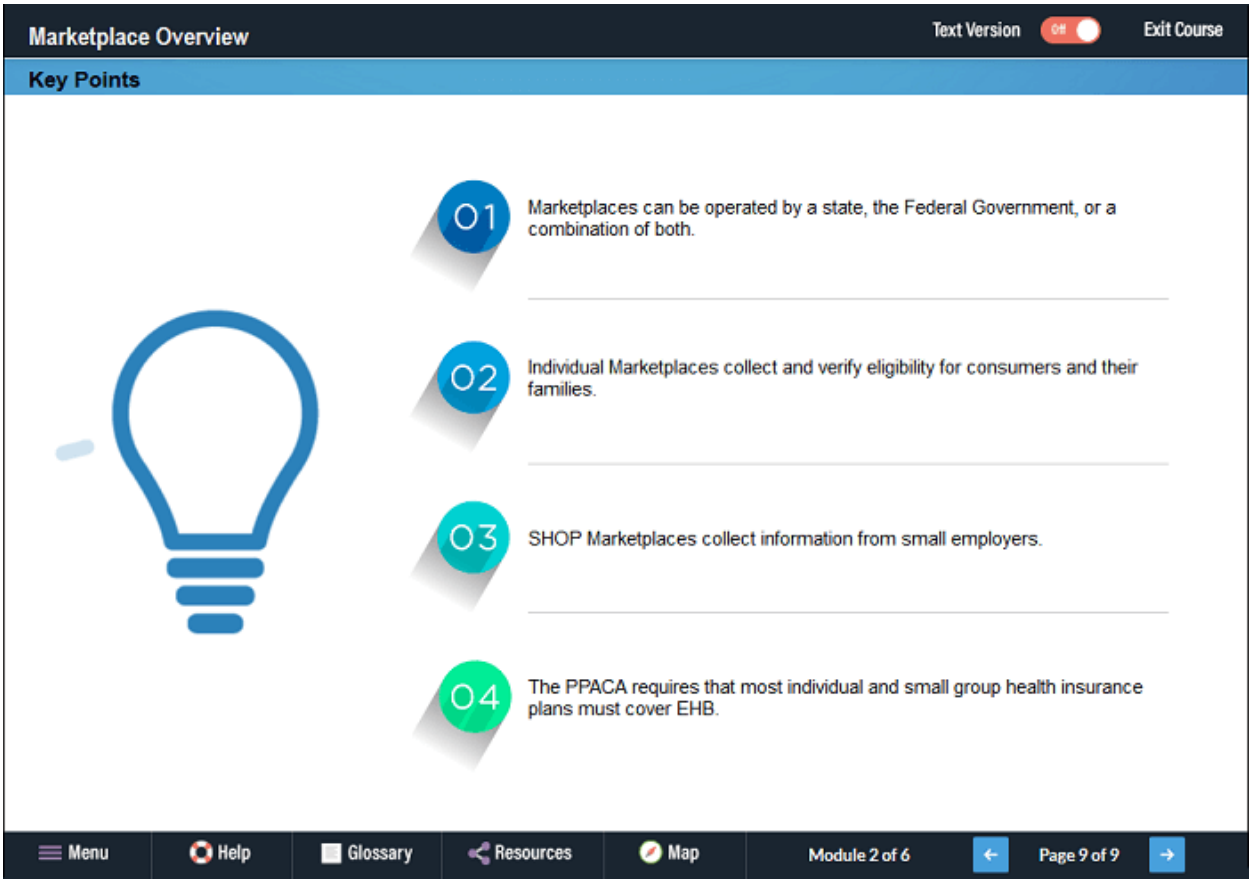


This type of plan is only available to individual market consumers and protects them from very high medical costs by providing coverage only when they need a lot of care.

A. Bronze
B. Platinum
C. COBRA
D. Catastrophic

The correct answer is D. Catastrophic plans are only available to individual market consumers and protect them from very high medical costs by providing coverage when they require a lot of care. They generally have lower premiums and higher deductibles, copayments, and coinsurance amounts than other plan categories.

Key Points



- Marketplaces can be operated by a state, the Federal Government, or a combination of both.
- Individual Marketplaces collect and verify eligibility for consumers and their families.
- SHOP Marketplaces collect information from small employers.
- The PPACA requires that most individual and small group health insurance plans must cover EHB.

Preparing to Apply
Introduction

Before we take a closer look at the application process for individuals and families in FFMs, let's review a few things you should keep in mind when you meet with consumers.

As a Navigator or CAC in an FFM, you must:

- Assist applicants and enrollees submitting Marketplace eligibility applications in an FFM's service area.
- Explain your duties and responsibilities to each consumer you assist and let them know that you cannot provide tax or legal advice in your capacity as an assister.
- Provide consumers with fair, accurate, and impartial information about the full range of health coverage options for which they're eligible.
- Clarify distinctions between health coverage options, including QHPs, Medicaid, and CHIP.
- You should also help consumers enroll in the coverage they have selected or apply for any applicable exemptions and appeals.

Culturally Appropriate Communication
It's important for you to communicate with consumers in a manner that is culturally appropriate. You should show respect for consumers' cultural diversity and provide information that is relatable and easy to understand, using translated documents when needed.

Navigators may need to provide language interpretation assistance or other accommodations for consumers with physical, developmental, and/or intellectual disabilities or for consumers with cognitive, hearing, speech, and/or vision impairments. Additionally, they must provide information and services in a manner that is accessible to persons with disabilities and persons with Limited English Proficiency (LEP).

CACs in FFMs are expected to provide referrals to Navigators or the FFM Call Center if they are not able to assist consumers with LEP.

For more information, refer to the courses on *Serving Vulnerable and Underserved Populations, Cultural Competence and Language Assistance*, and *Working with Consumers with Disabilities*.

Consumer Consent and PII

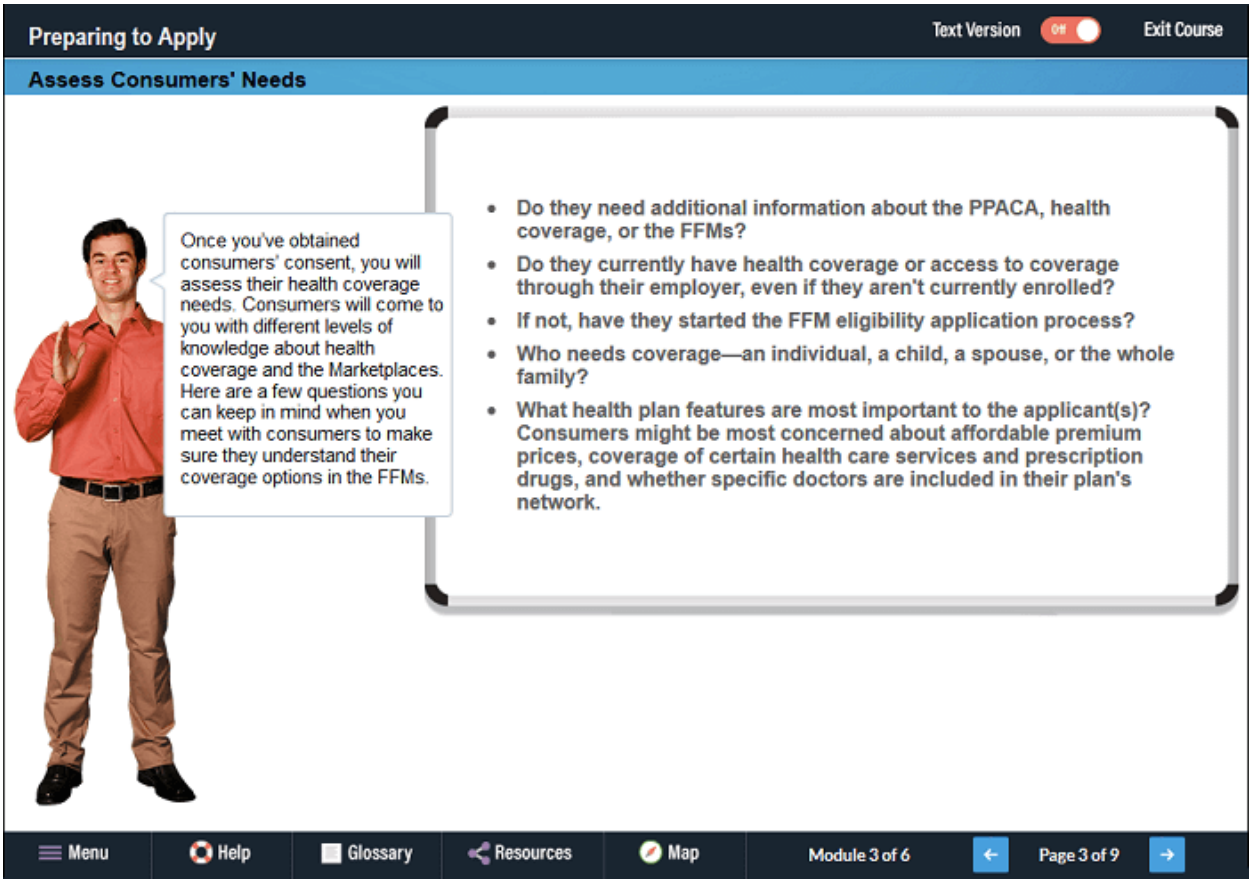
One of the first things you should do when helping consumers is obtain consent to access their personally identifiable information (PII) for purposes related to your assister functions. Remember these best practices for handling consumers' PII:

- Always return originals and copies of all documents that contain consumers' PII to them and only make copies for yourself or others if necessary to carry out your required duties. If consumers mistakenly or accidentally leave behind documents containing their PII at your organization's facility or at an enrollment event, you should store them in a safe, locked location and return them to consumers as soon as possible.
- Document consumers' preferred contact information when you obtain their consent per your organization's standard consumer consent procedures. If consumers provide consent for you to follow up with them about applying for or enrolling in coverage as well as their preferred contact information, you may keep their names and contact information to schedule appointments or follow up with them about application or enrollment issues.

PII collected from consumers, including their names, email addresses, telephone numbers, application ID numbers, home addresses, or other notes, must be stored securely.

Remember, you must successfully complete the Privacy, Security, and Fraud Prevention Standards course in addition to this course to meet certification requirements.

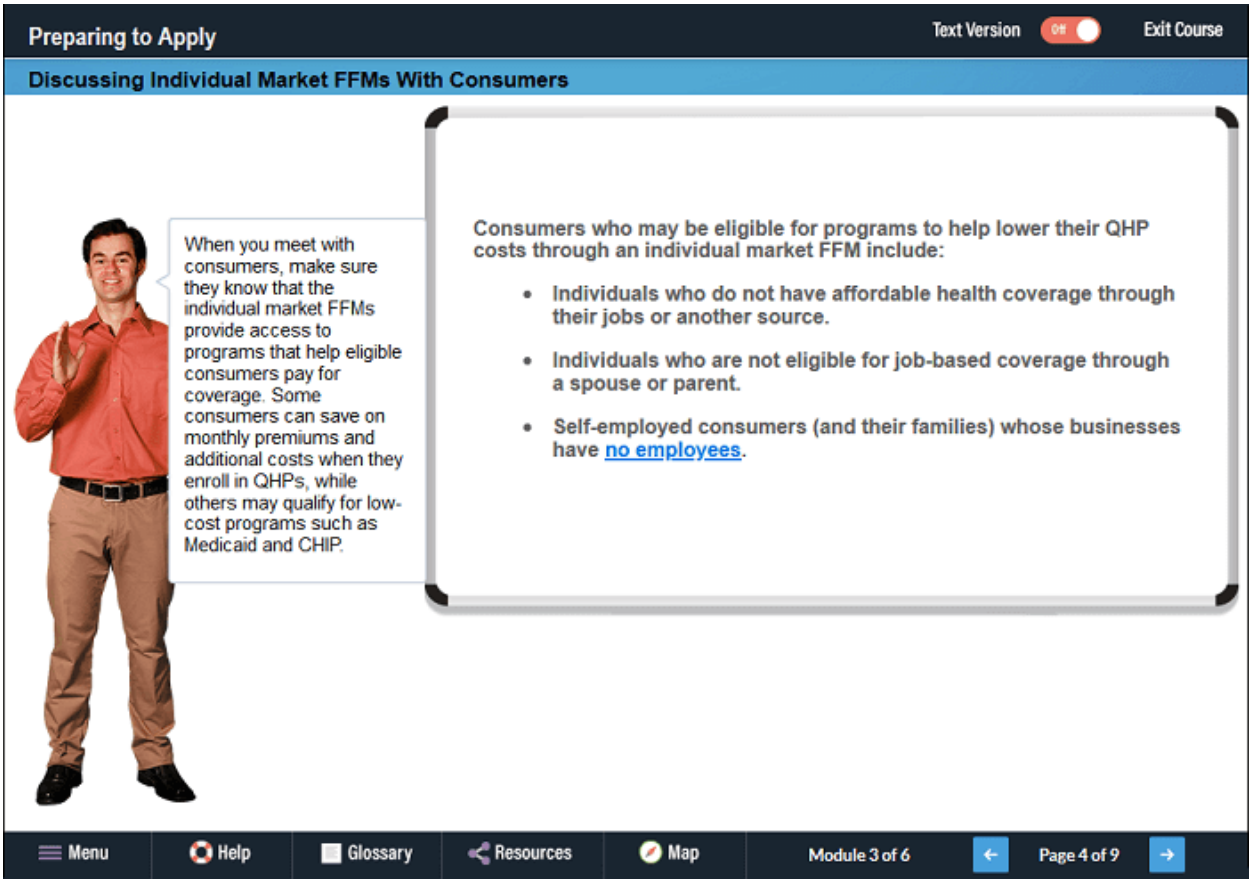
Assess Consumers' Needs



Once you've obtained consumers' consent, you will assess their health coverage needs. Consumers will come to you with different levels of knowledge about health coverage and the Marketplaces. Here are a few questions you can keep in mind when you meet with consumers to make sure they understand their coverage options in the FFMs.

- Do they need additional information about the PPACA, health coverage, or the FFMs?
- Do they currently have health coverage or access to coverage through their employer, even if they aren't currently enrolled?
- If not, have they started the FFM eligibility application process?
- Who needs coverage—an individual, a child, a spouse, or the whole family?
- What health plan features are most important to the applicant(s)? Consumers might be most concerned about affordable premium prices, coverage of certain health care services and prescription drugs, and whether specific doctors are included in their plan's network.

Discussing Individual Market FFMs With Consumers



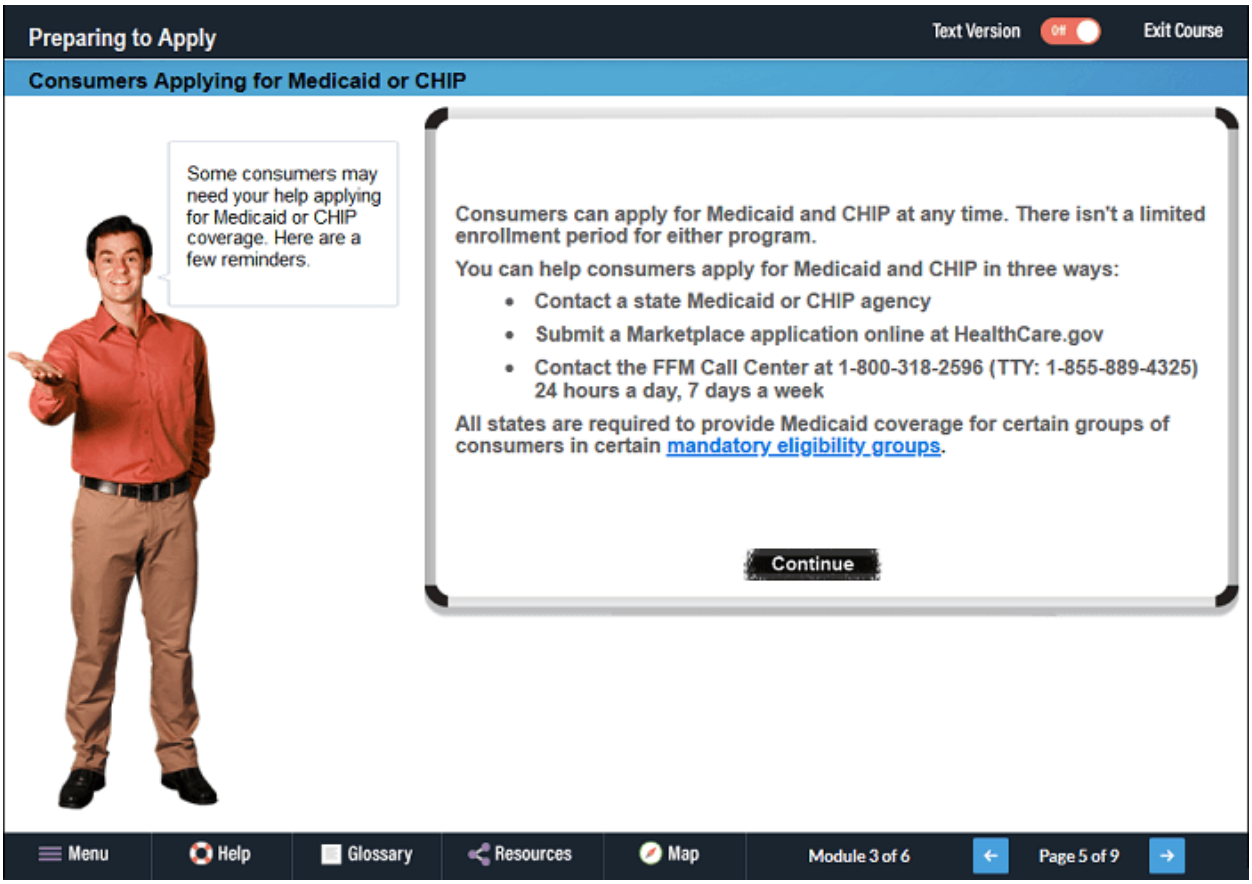
When you meet with consumers, make sure they know that the individual market FFMs provide access to programs that help eligible consumers pay for coverage. Some consumers can save on monthly premiums and additional costs when they enroll in QHPs, while others may qualify for low-cost programs such as Medicaid and CHIP.

Consumers who may be eligible for programs to help lower their QHP costs through an individual market FFM include:

- Individuals who do not have affordable health coverage through their jobs or another source.
- Individuals who are not eligible for job-based coverage through a spouse or parent.
- Self-employed consumers (and their families) whose businesses have no employees.

Businesses with No Employees
Generally, self-employed consumers whose businesses have no employees may not purchase group coverage through a SHOP Marketplace.

Consumers Applying for Medicaid or CHIP



Some consumers may need your help applying for Medicaid or CHIP coverage. Here are a few reminders.

Consumers can apply for Medicaid and CHIP at any time. There isn't a limited enrollment period for either program.

You can help consumers apply for Medicaid and CHIP in three ways:

- Contact a state Medicaid or CHIP agency
- Submit a Marketplace application online at HealthCare.gov
- Contact the FFM Call Center at 1-800-318-2596 (TTY: 1-855-889-4325) 24 hours a day, 7 days a week

All states are required to provide Medicaid coverage for certain groups of consumers in certain mandatory eligibility groups*.

If you help consumers in a state that has not expanded Medicaid and they are not otherwise eligible for Medicaid or other coverage, they may qualify for APTC and CSRs if they enroll in a QHP offered through a Marketplace. Otherwise, they may be eligible to purchase Catastrophic health coverage.

Sometimes, it's faster and more straightforward for consumers to apply for Medicaid and CHIP coverage directly through their state Medicaid or CHIP agency rather than through the individual market FFMs. This is true for individuals who have disabilities and those who are enrolled in other public benefits programs like the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF).

Refer to the *Patient Protection and Affordable Care Act Basics* course for detailed information about Medicaid and CHIP coverage, including eligibility requirements.

* Mandatory Eligibility Groups

Under federal law, all states are required to cover certain groups of consumers referred to as mandatory eligibility groups. These groups include:

- Pregnant women at or below a certain household income level

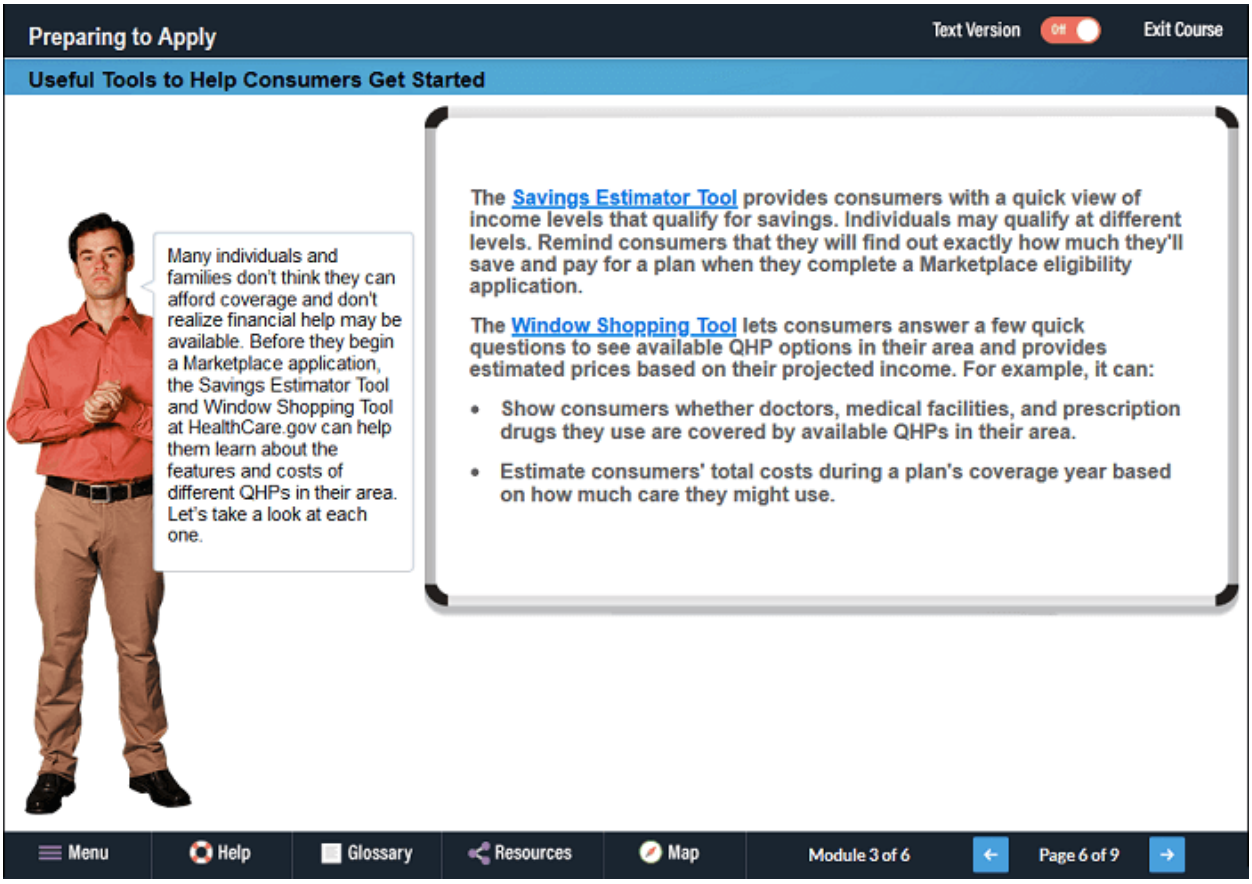
- Children in households with certain income levels
- Parents/caretaker relatives at or below a certain household income level
- Consumers with disabilities
- Some low-income older adults

Some states choose to cover other groups of consumers referred to as **optional eligibility groups**, whom federal law doesn't require states to cover under Medicaid. Examples of optional groups include:

- Adults without dependent children
- Medically-needy consumers

Medicaid coverage for optional groups varies from state to state. It's important that you know which groups are covered by Medicaid and the household income requirements for each group in your state.

Useful Tools to Help Consumers Get Started



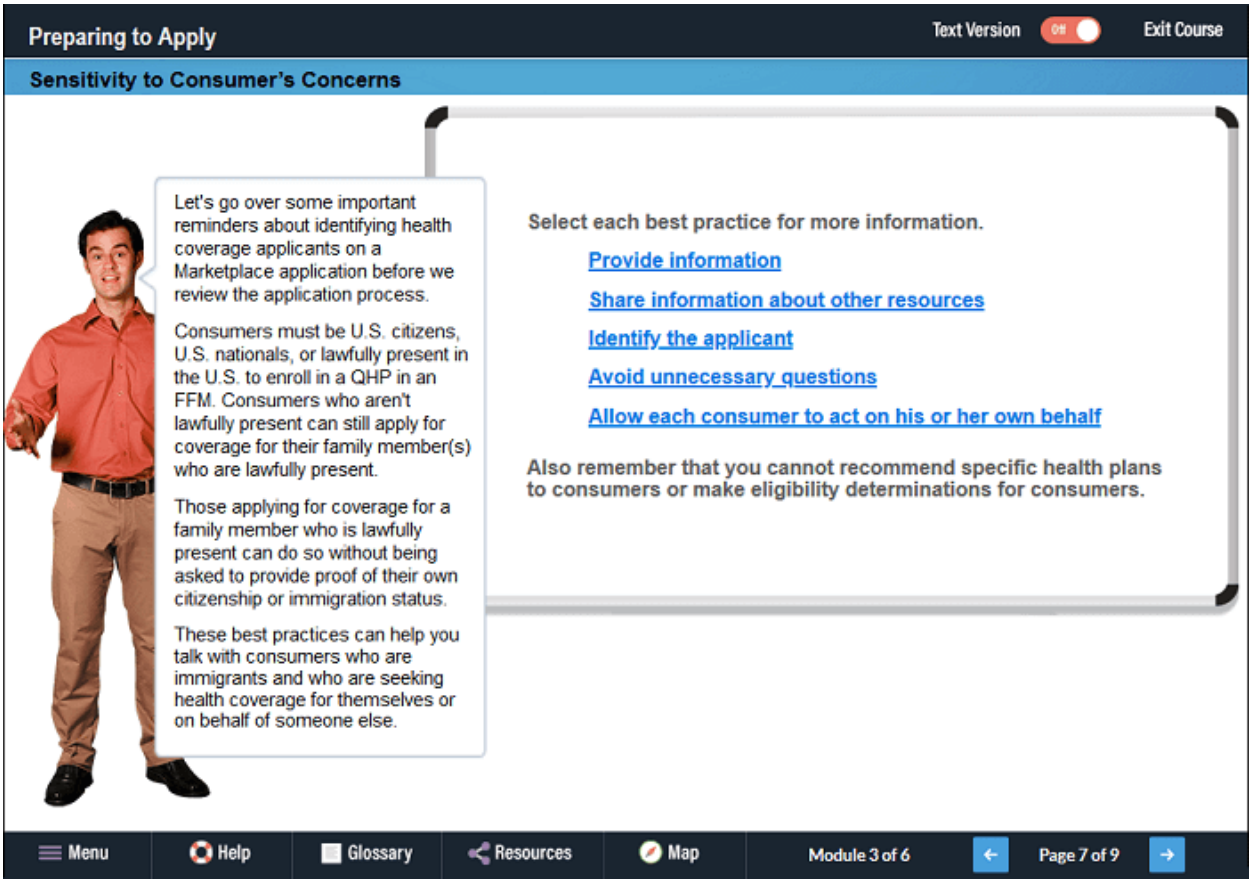
Many individuals and families don't think they can afford coverage and don't realize financial help may be available. Before they begin a Marketplace application, the Savings Estimator Tool and Window Shopping Tool at HealthCare.gov can help them learn about the features and costs of different QHPs in their area. Let's take a look at each one.

The Savings Estimator Tool provides consumers with a quick view of income levels that qualify for savings. Individuals may qualify at different levels. Remind consumers that they will find out exactly how much they'll save and pay for a plan when they complete a Marketplace eligibility application.

The Window Shopping Tool lets consumers answer a few quick questions to see available QHP options in their area and provides estimated prices based on their projected income. For example, it can:

- Show consumers whether doctors, medical facilities, and prescription drugs they use are covered by available QHPs in their area.
- Estimate consumers' total costs during a plan's coverage year based on how much care they might use.

Sensitivity to Consumer's Concerns



Let's go over some important reminders about identifying health coverage applicants on a Marketplace application before we review the application process.

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

Those applying for coverage for a family member who is lawfully present can do so without being asked to provide proof of their own citizenship or immigration status.

These best practices can help you talk with consumers who are immigrants and who are seeking health coverage for themselves or on behalf of someone else.

Review each best practice for more information.

- Provide information
- Share information about other resources
- Identify the applicant
- Avoid unnecessary questions
- Allow each consumer to act on his or her own behalf

Also remember that you cannot recommend specific health plans to consumers or make eligibility determinations for consumers.

Provide information
Provide information about eligible immigration statuses and acceptable immigration documents. Consumers then have the information they need to decide who in their family may have an eligible immigration status to apply for health coverage.

Share information about other resources
Share information with consumers about other resources in the community that might be able to help them:

- Determine whether they have an eligible immigration status, or
- Obtain immigration documents if they don't have them readily available.

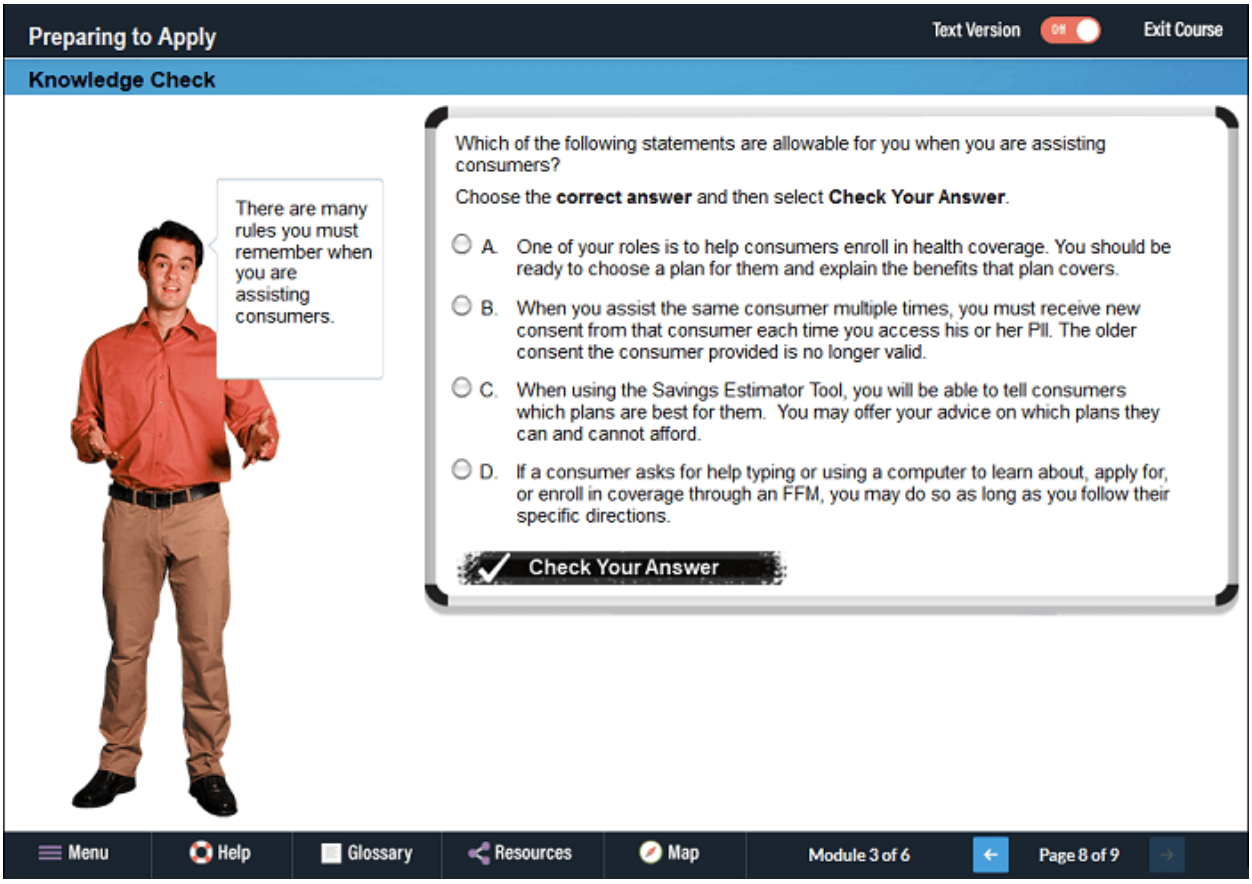
Identify the applicant
Be sure to correctly identify the consumer(s) who are applying for health coverage by asking them if they're seeking coverage for themselves or on behalf of someone else.

Avoid unnecessary questions
Avoid unnecessary questions, especially questions about the immigration status of consumers who aren't applying for health coverage and live in mixed immigration status households.

Avoid words such as "undocumented," "unauthorized," or "illegal." Instead, use words such as "eligible immigrant" and "eligible status."

Allow the Consumer to Act on His or Her own Behalf
Consumers should always input their own information in an online or paper application. If a consumer asks for help typing or using a computer to learn about, apply for, or enroll in coverage in an FFM, an assister may only use the keyboard or mouse to follow the consumer's specific directions.

Knowledge Check



There are many rules you must remember when you are assisting consumers.

Which of the following statements are allowable for you when you are assisting consumers?

A. One of your roles is to help consumers enroll in health coverage. You should be ready to choose a plan for them and explain the benefits that plan covers.

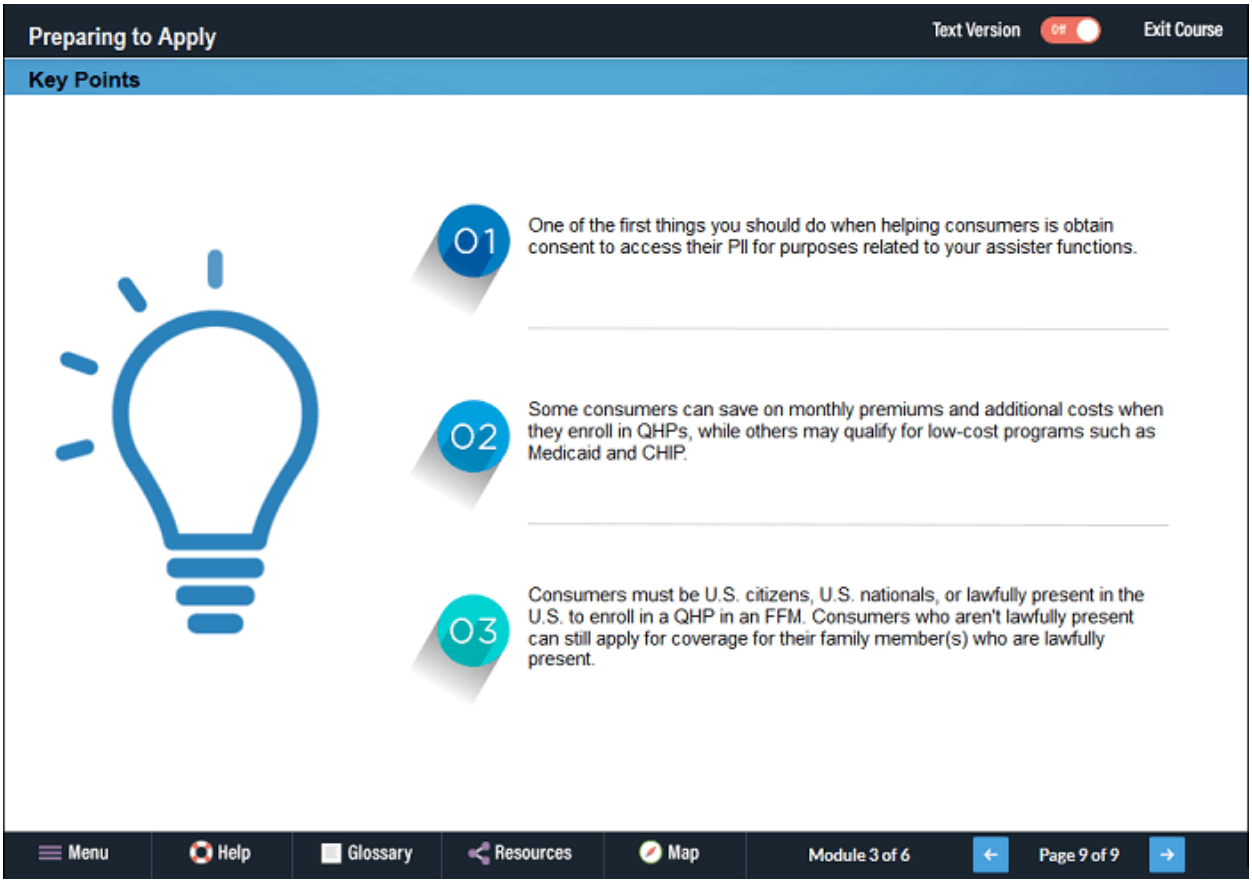
B. When you assist the same consumer multiple times, you must receive new consent from that consumer each time you access his or her PII. The older consent the consumer provided is no longer valid.

C. When using the Savings Estimator Tool, you will be able to tell consumers which plans are best for them. You may offer your advice on which plans they can and cannot afford.

D. If a consumer asks for help typing or using a computer to learn about, apply for, or enroll in coverage through an FFM, you may do so as long as you follow their specific directions.

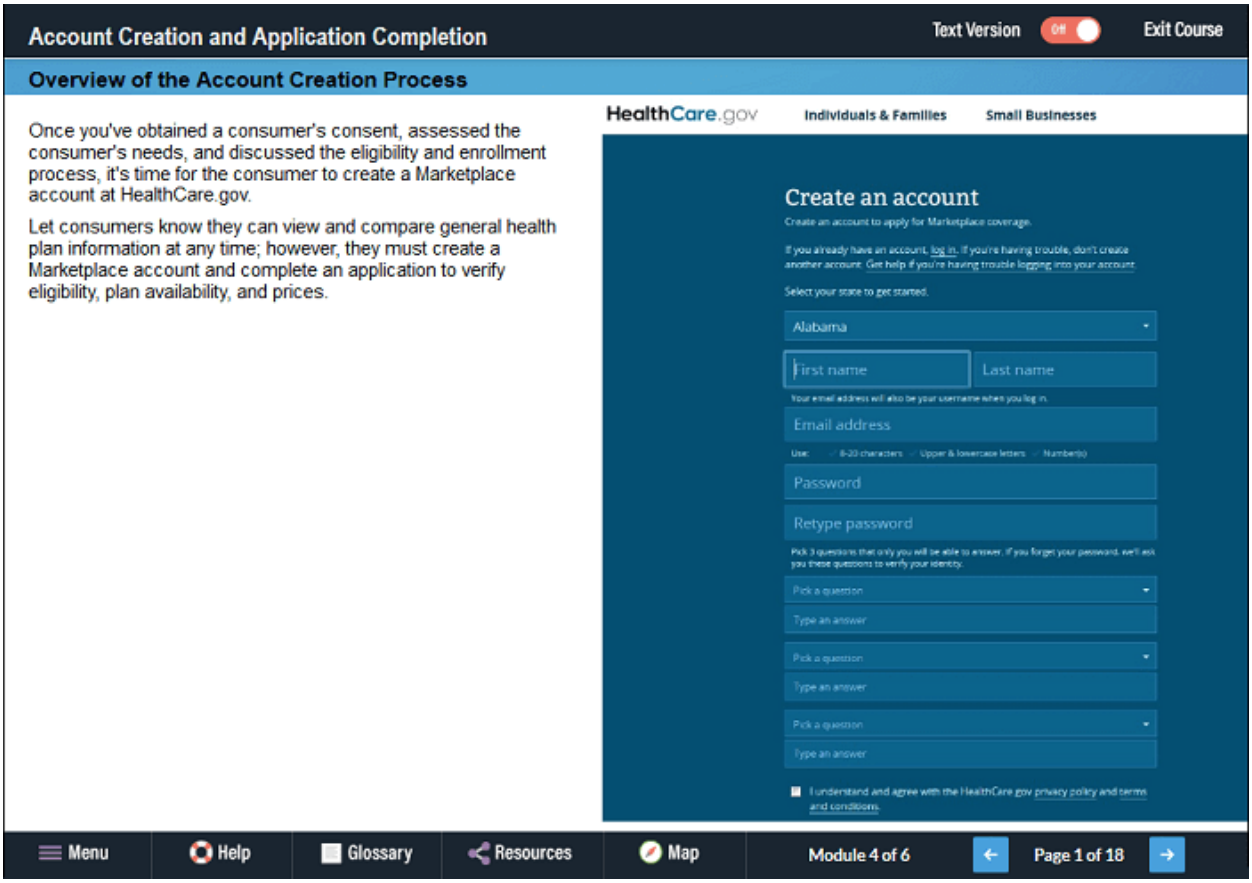
The correct answer choice is D. When consumers ask you for help inputting information on a paper application or on a computer, you may do so as long as you follow their specific directions.

Key Points



- One of the first things you should do when helping consumers is obtain consent to access their PII for purposes related to your assister functions.
- Some consumers can save on monthly premiums and additional costs when they enroll in QHPs, while others may qualify for low-cost programs such as Medicaid and CHIP.
- Consumers must be U.S. citizens, U.S. nationals, or lawfully present in the U.S. to enroll in a QHP in an FFM. Consumers who aren't lawfully present can still apply for coverage for their family member(s) who are lawfully present.

Account Creation and Application Completion
Overview of the Account Creation Process



Once you've obtained a consumer's consent, assessed the consumer's needs, and discussed the eligibility and enrollment process, it's time for the consumer to create a Marketplace account at HealthCare.gov.

Let consumers know they can view and compare general health plan information at any time; however, they must create a Marketplace account and complete an application to verify eligibility, plan availability, and prices.

Assist Consumers with Creating a Marketplace Account

Here's a quick overview of how the process works.

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

Step 1: Enter Information
Visit HealthCare.gov, select Individuals and Families, and enter basic information (i.e., name and state).

Step 2: Password Creation
Enter a valid email address, which is also used as a consumer's Marketplace account username. Then choose a password. Passwords must contain 8-20 characters, at least one number, and a mix of uppercase and lowercase letters. How to reset a password*.

Step 3: Security Questions
Choose security questions and provide responses. These questions are used for verification purposes if necessary. You should advise consumers to write these down and keep them in a secure place.

Step 4: Create Account
Select the Create Account option.

Step 5: Verify Account
In the last step, consumers verify their identity by answering questions based on information the FFMs gather from trusted data sources (e.g., a consumer's credit report). This prevents other people from creating an account using their name. If a consumer's identity is not verified, he or she may receive a prompt with instructions and next steps. Additional information about Marketplace identity verification is available at Marketplace.cms.gov/outreach-and-education/your-marketplace-application.pdf.

*How to reset a password

There are three steps consumers should follow to reset a password:

1. Select **Forgot your password?** from the login page and enter the email address associated with the Marketplace account.
2. The FFM sends a password reset email to this address. Select the link in the password reset email to verify that the email address is correct. If selecting doesn't work, the consumer should copy and paste

the link into an Internet browser.

3. Follow the directions to choose a new password.

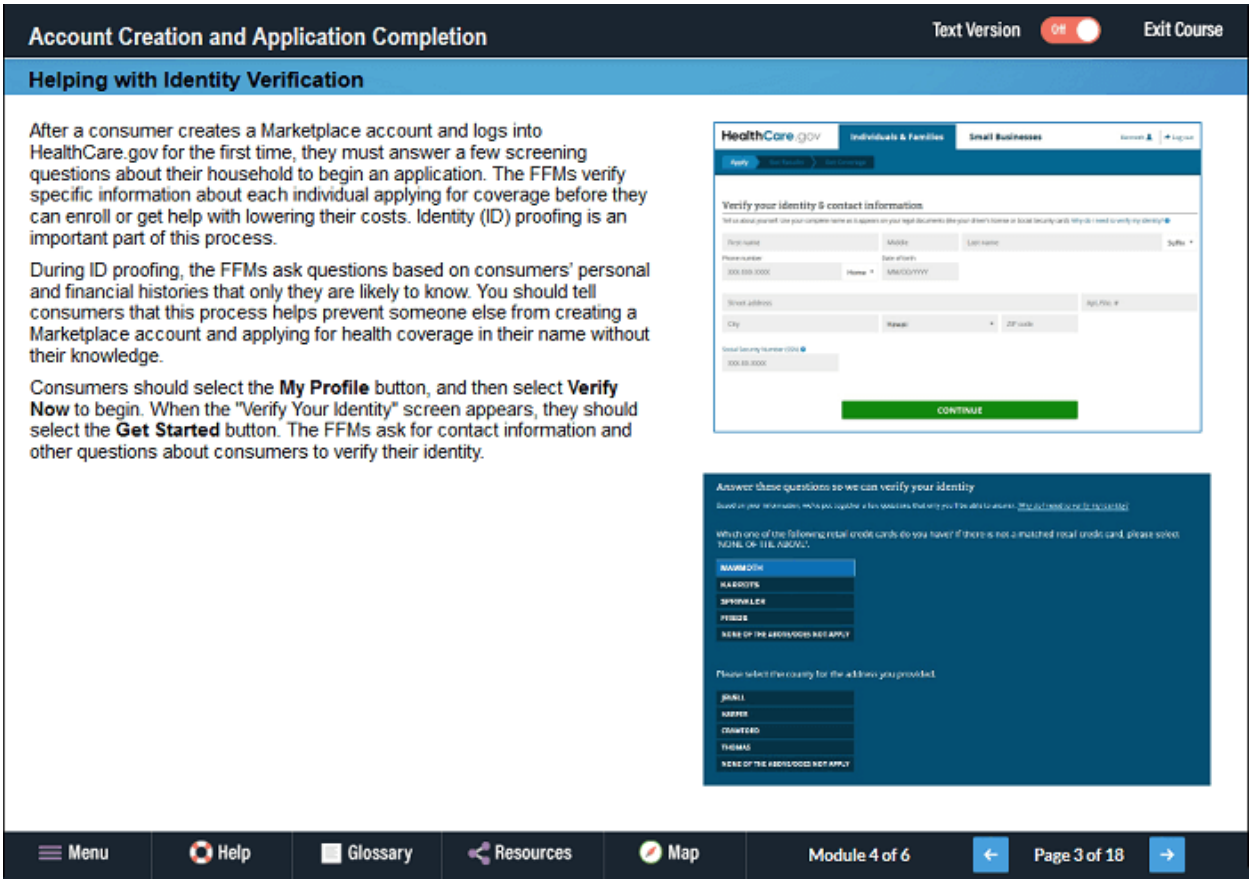
Sometimes the FFMs reset consumers' passwords due to security measures. If this happens, consumers will not be able to log in successfully until they reset their password.

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

The FFM Call Center is open 24 hours a day, 7 days a week (except federal holidays).

IMPORTANT: Don't create a second account!
Consumers should never try to create a new account if they already have one. Instead, they should call the FFM Call Center or follow the steps at HealthCare.gov/tips-and-troubleshooting/logging-in/.

Helping with Identity Verification

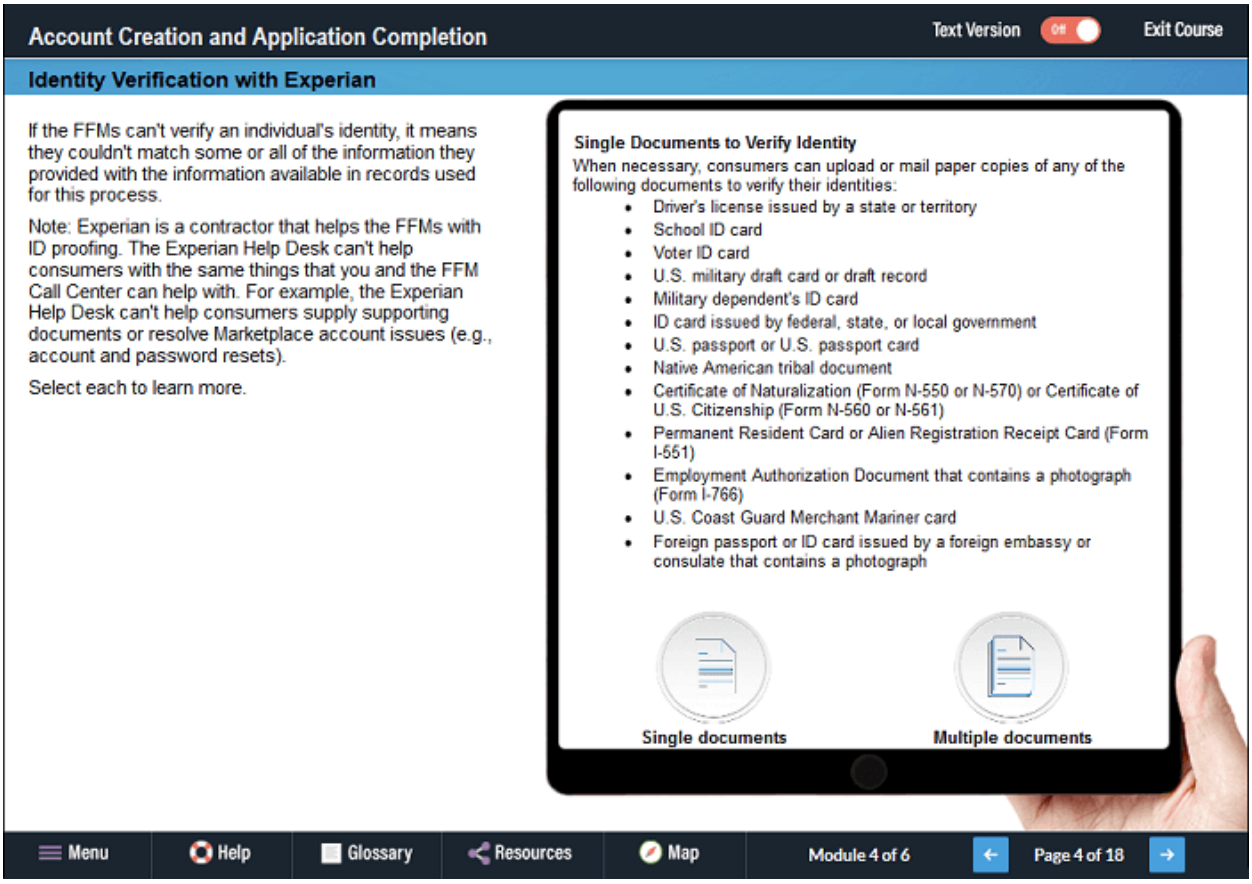


After a consumer creates a Marketplace account and logs into HealthCare.gov for the first time, they must answer a few screening questions about their household to begin an application. The FFMs verify specific information about each individual applying for coverage before they can enroll or get help with lowering their costs. Identity (ID) proofing is an important part of this process.

During ID proofing, the FFMs ask questions based on consumers' personal and financial histories that only they are likely to know. You should tell consumers that this process helps prevent someone else from creating a Marketplace account and applying for health coverage in their name without their knowledge.

Consumers should select the **My Profile** button, and then select **Verify Now** to begin. When the "Verify Your Identity" screen appears, they should select the **Get Started** button. The FFMs ask for contact information and other questions about consumers to verify their identity.

Identity Verification with Experian



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

Note: Experian is a contractor that helps the FFMs with ID proofing. The Experian Help Desk can't help consumers with the same things that you and the FFM Call Center can help with. For example, the Experian Help Desk can't help consumers supply supporting documents or resolve Marketplace account issues (e.g., account and password resets).

Single Documents to Verify Identity
When necessary, consumers can upload or mail paper copies of any of the following documents to verify their identities:

- Driver's license issued by a state or territory
- School ID card
- Voter ID card
- U.S. military draft card or draft record
- Military dependent's ID card
- ID card issued by federal, state, or local government
- U.S. passport or U.S. passport card
- Native American tribal document
- Certificate of Naturalization (Form N-550 or N-570) or Certificate of U.S. Citizenship (Form N-560 or N-561)
- Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
- Employment Authorization Document that contains a photograph (Form I-766)
- U.S. Coast Guard Merchant Mariner card

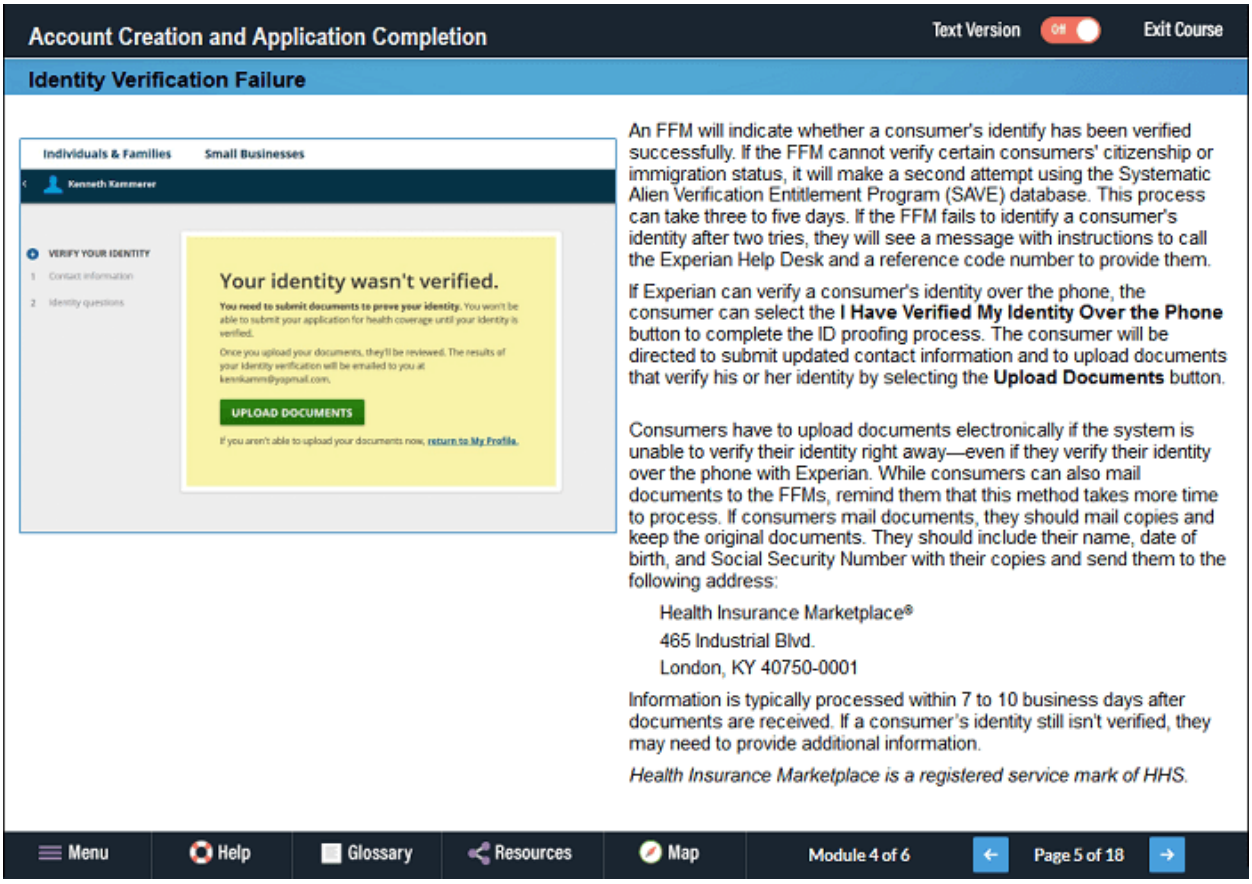
- Foreign passport or ID card issued by a foreign embassy or consulate that contains a photograph

Multiple Documents to Verify Identity

If consumers can't provide a copy of one of the documents above, they can submit copies of two of these documents:

- Birth certificate
- Social Security card
- Marriage certificate
- Divorce decree
- Employer ID card
- High school or college diploma, including high school equivalency diploma
- Property deed or title

Identity Verification Failure



An FFM will indicate whether a consumer's identify has been verified successfully. If the FFM cannot verify certain consumers' citizenship or immigration status, it will make a second attempt using the Systematic Alien Verification Entitlement Program (SAVE) database. This process can take three to five days. If the FFM fails to identify a consumer's identity after two tries, they will see a message with instructions to call the Experian Help Desk and a reference code number to provide them.

If Experian can verify a consumer's identity over the phone, the consumer can select the **I Have Verified My Identity Over the Phone** button to complete the ID proofing process. The consumer will be directed to submit updated contact information and to upload documents that verify his or her identity by selecting the **Upload Documents** button.

Consumers have to upload documents electronically if the system is unable to verify their identity right away—even if they verify their identity over the phone with Experian. While consumers can also mail documents to the FFMs, remind them that this method takes more time to process. If consumers mail documents, they should mail copies and keep the original documents. They should include their name, date of birth, and Social Security Number with their copies and send them to the following address:

Health Insurance Marketplace®

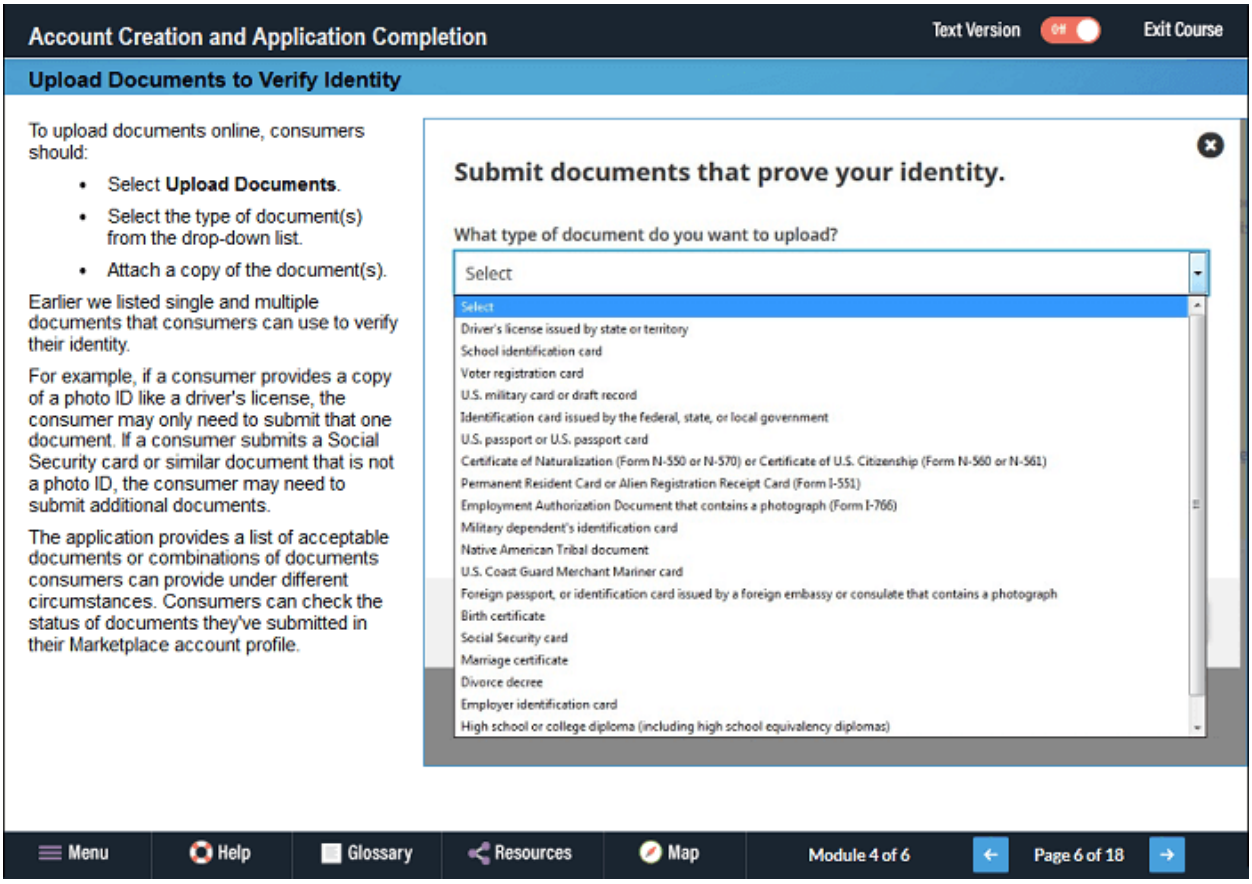
465 Industrial Blvd.

London, KY 40750-0001

Information is typically processed within 7 to 10 business days after documents are received. If a consumer's identity still isn't verified, they may need to provide additional information.

Health Insurance Marketplace is a registered service mark of HHS.

Upload Documents to Verify Identity



To upload documents online, consumers should:

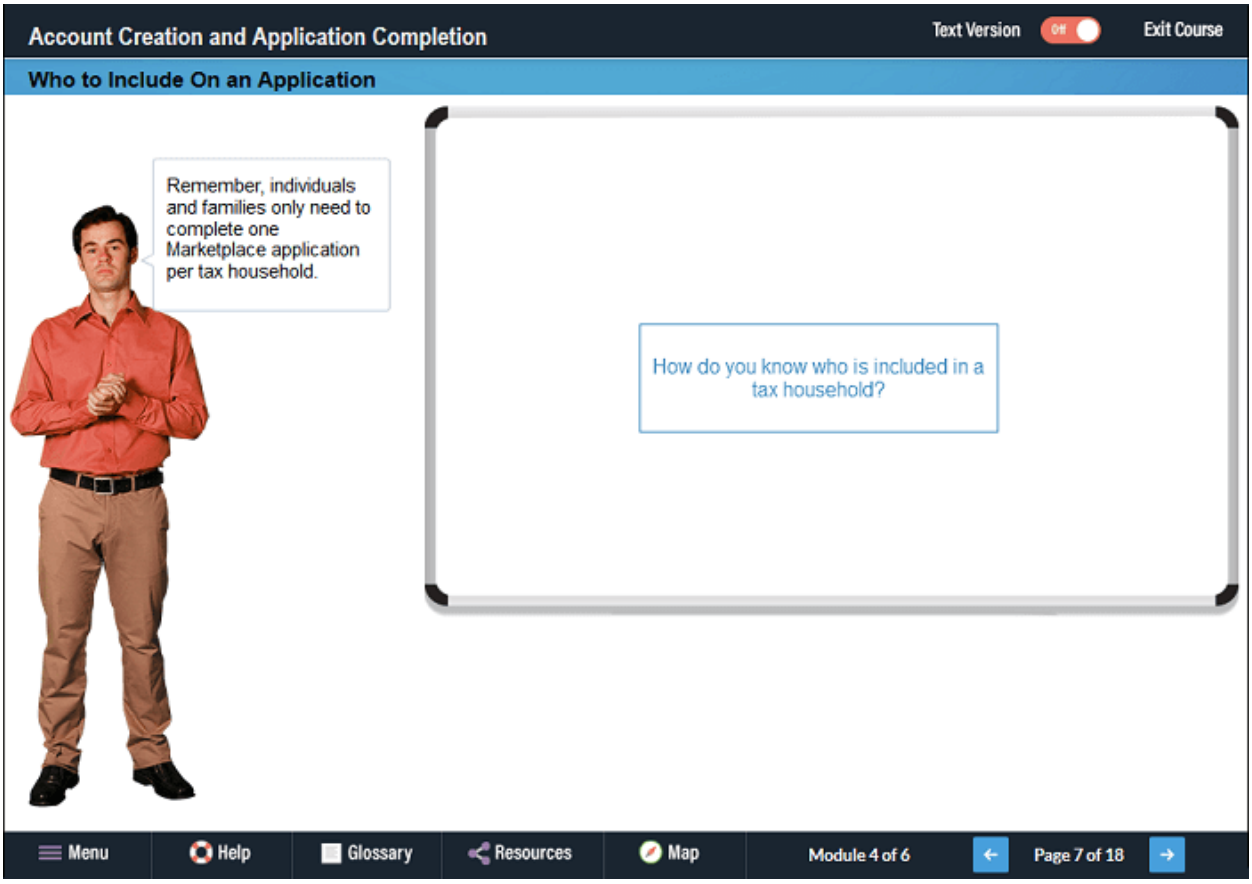
- Select Upload Documents.
- Select the type of document(s) from the drop-down list.
- Attach a copy of the document(s).

Earlier we listed single and multiple documents that consumers can use to verify their identity.

For example, if a consumer provides a copy of a photo ID like a driver's license, the consumer may only need to submit that one document. If a consumer submits a Social Security card or similar document that is not a photo ID, the consumer may need to submit additional documents.

The application provides a list of acceptable documents or combinations of documents consumers can provide under different circumstances. Consumers can check the status of documents they've submitted in their Marketplace account profile.

Who to Include On an Application



Remember, individuals and families only need to complete one Marketplace application per tax household.

How do you know who is included in a tax household?

If two consumers file federal income taxes together using the same federal income tax return, they're considered part of the same tax household and they generally should submit one Marketplace application with both applicants listed together. If two or more consumers are part of separate tax households—that is, they file their taxes separately—they must complete separate Marketplace applications.

Which household members should consumers include on a Marketplace application?

If consumers are only applying for QHP coverage in an FFM (without any help paying for it), they should only include those household members who want coverage on their applications.

Individuals Included on Applications for Coverage
The consumer applying for coverage and, as applicable, the following individuals should be included on applications for coverage where the applicant is applying for help paying for coverage:

- Their spouse
- Anyone they include on their tax return as a tax dependent (such as a child), even if the tax dependents don't live with the consumer or they have their own tax filing requirement
- Their children who live with them, even if they make enough money to file a tax return themselves
    - Members of the same household may need to complete separate applications if they are in a multi-tax household and apply for help paying for coverage. Currently, each tax household must create a Marketplace account to apply for programs to help lower their health coverage costs. For more information, refer to the course on *Advanced Marketplace Issues and Technical Support*.
- Anyone else under 21 years of age whom they take care of and who lives with them

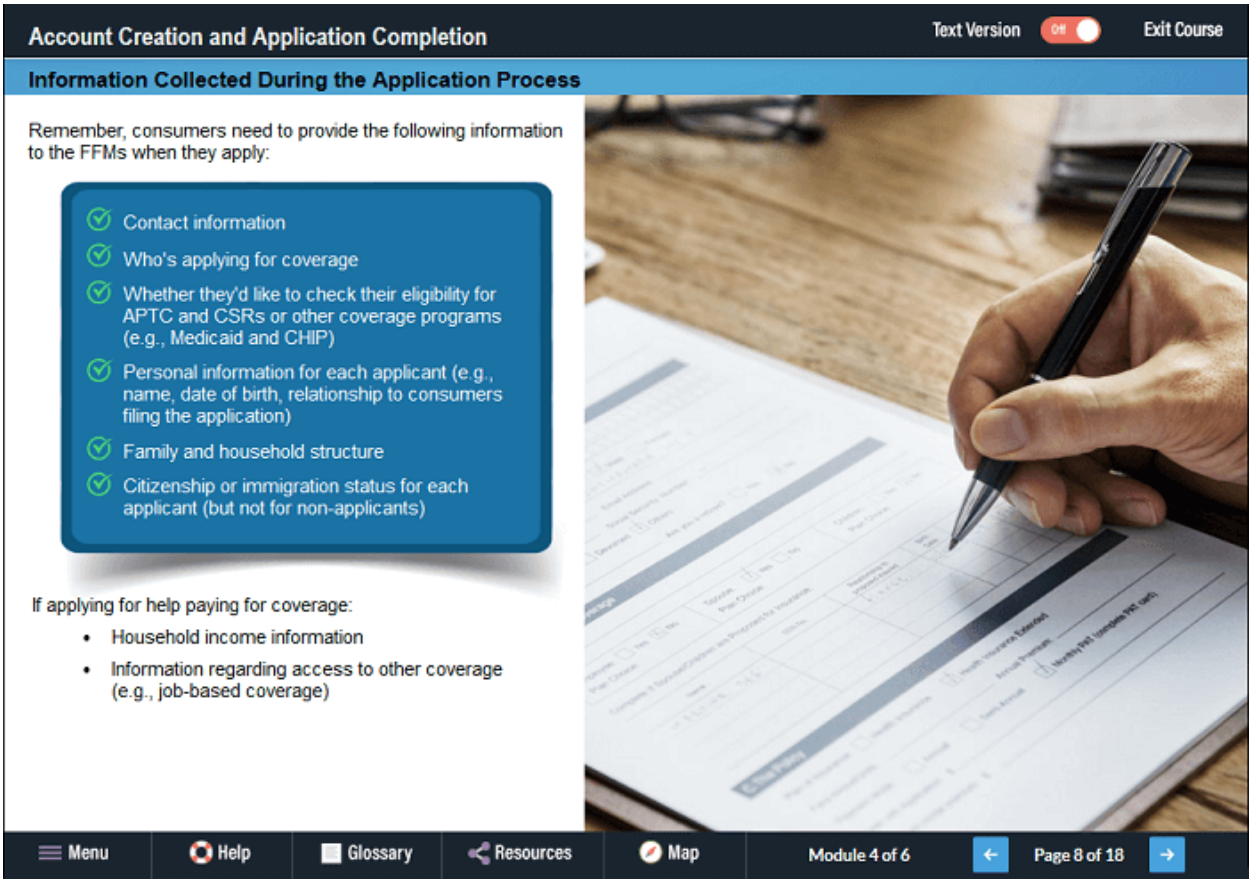
Individuals NOT Included on Applications for Coverage
The following individuals should not be included on their applications:

- Their unmarried partner
    - Domestic partners are one example of a multi-tax household that may have to file separate applications. Consumers should include an unmarried domestic partner **only** if they have a child together or they'll claim their partner as a tax dependent. For more information, refer to the course on *Advanced Marketplace Issues and Technical Support*.
- Their unmarried partner's children, if the children are not the applying consumer's children or tax dependents
- Their parents who live with them but file their own tax returns and aren't tax dependents of the consumer (and spouses of parents, as applicable)
- Other relatives who file their own tax returns and aren't tax dependents of the consumer (and spouse, if they have one).

Note: The Marketplace application asks applicants whether they are married. Consumers should select No if they are:

- Unmarried for tax-filing purposes
- Filing federal income taxes separately due to domestic violence or spousal abandonment

Information Collected During the Application Process



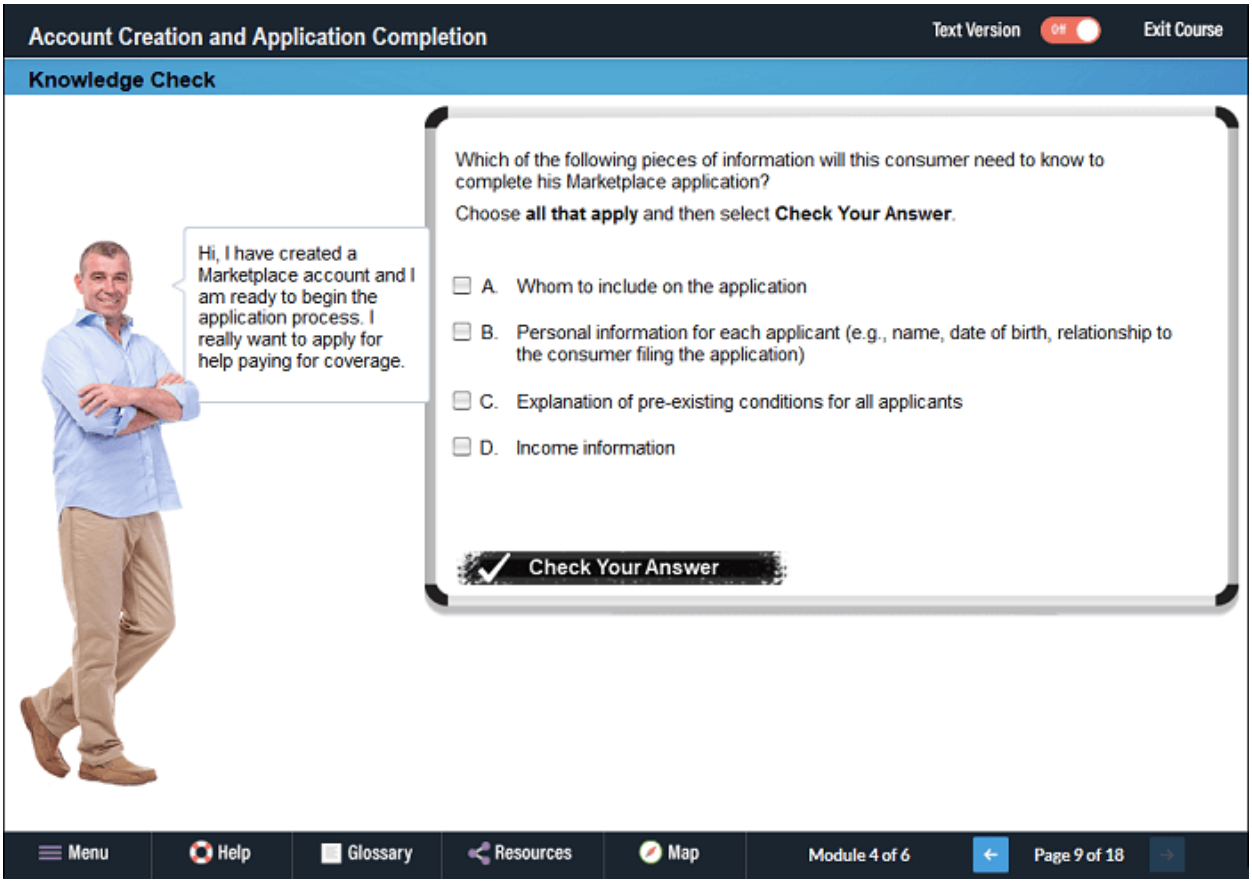
Remember, consumers need to provide the following information to the FFMs when they apply:

- Contact information
- Who's applying for coverage
- Whether they'd like to check their eligibility for APTC and CSRs or other coverage programs (e.g., Medicaid and CHIP)
- Personal information for each applicant (e.g., name, date of birth, relationship to consumers filing the application)
- Family and household structure
- Citizenship or immigration status for each applicant (but not for non-applicants)

If applying for help paying for coverage:

- Household income information
- Information regarding access to other coverage (e.g., job-based coverage)

Knowledge Check



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

Which of the following pieces of information will this consumer need to know to complete his Marketplace application?

A. Whom to include on the application

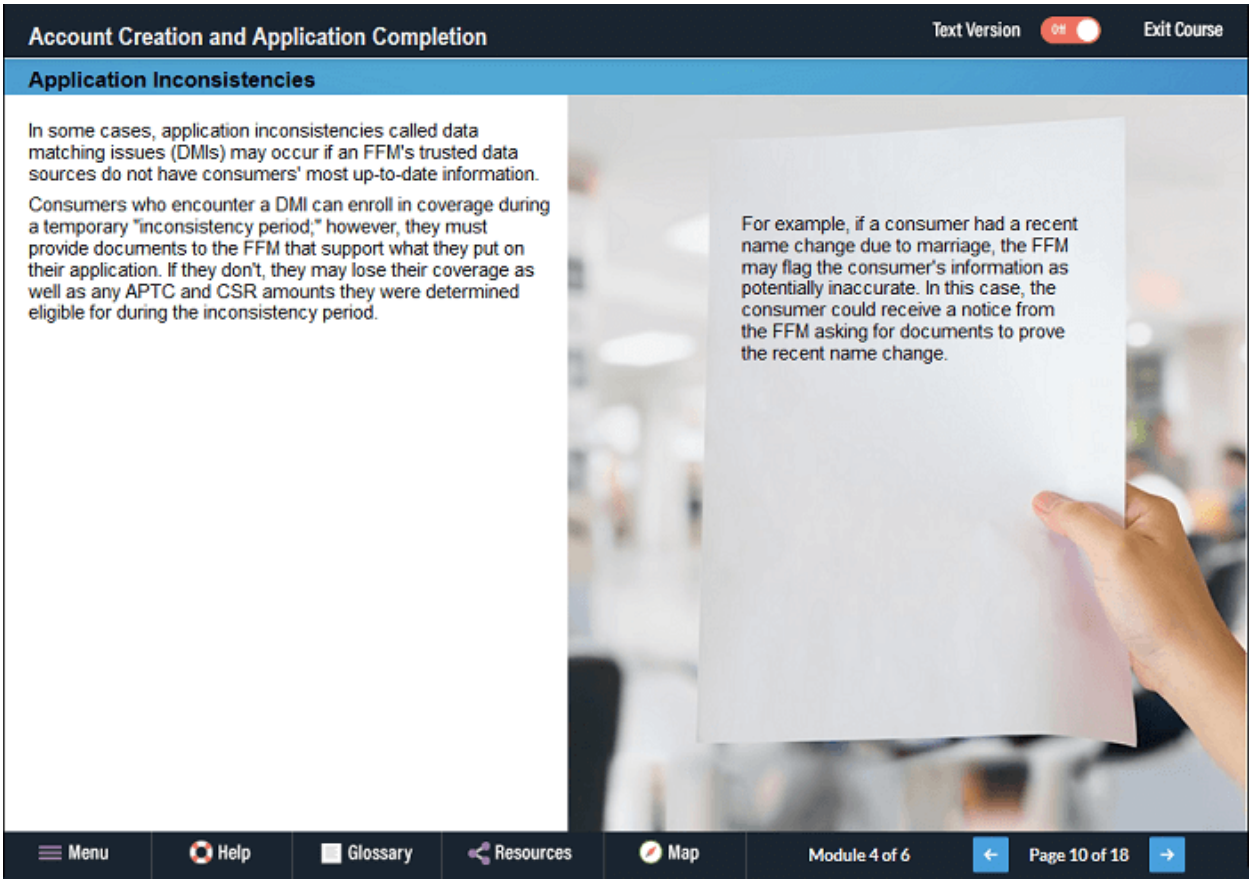
B. Personal information for each applicant (e.g., name, date of birth, relationship to the consumer filing the application)

C. Explanation of pre-existing conditions for all applicants

D. Income information

The correct answers are A, B, and D. This consumer should complete the application and the FFM will help determine whether he or members of his family are eligible for other programs to help lower their costs. However, he needs to know which household members he'll include on his application, personal information for each applicant, and whether each applicant can get coverage through an employer. You do not need to explain pre-existing conditions to all applicants. All Marketplace insurance plans must cover treatment for pre-existing medical conditions.

Application Inconsistencies

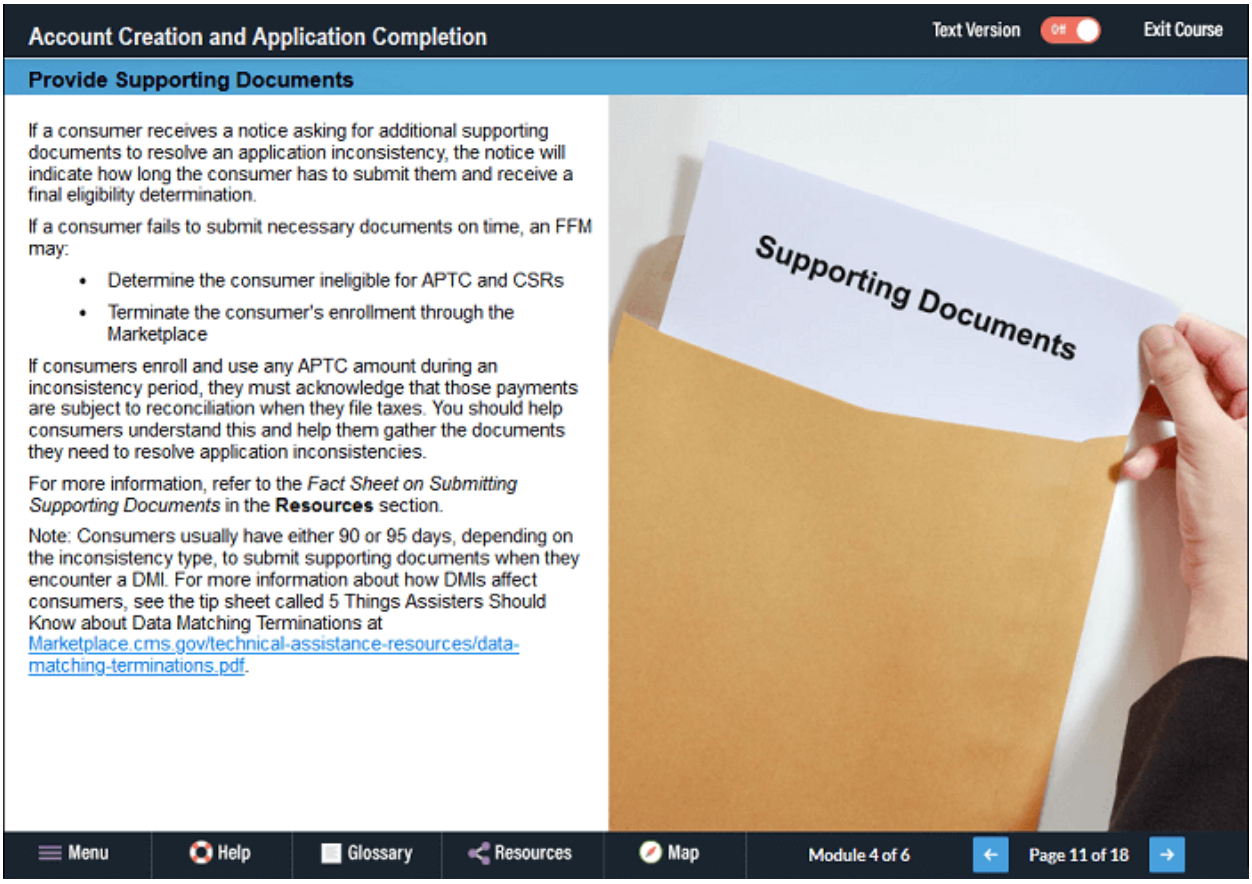


In some cases, application inconsistencies called data matching issues (DMIs) may occur if an FFM's trusted data sources do not have consumers' most up-to-date information.

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

For example, if a consumer had a recent name change due to marriage, the FFM may flag the consumer's information as potentially inaccurate. In this case, the consumer could receive a notice from the FFM asking for documents to prove the recent name change.

Provide Supporting Documents



If a consumer receives a notice asking for additional supporting documents to resolve an application inconsistency, the notice will indicate how long the consumer has to submit them and receive a final eligibility determination.

If a consumer fails to submit necessary documents on time, an FFM may:

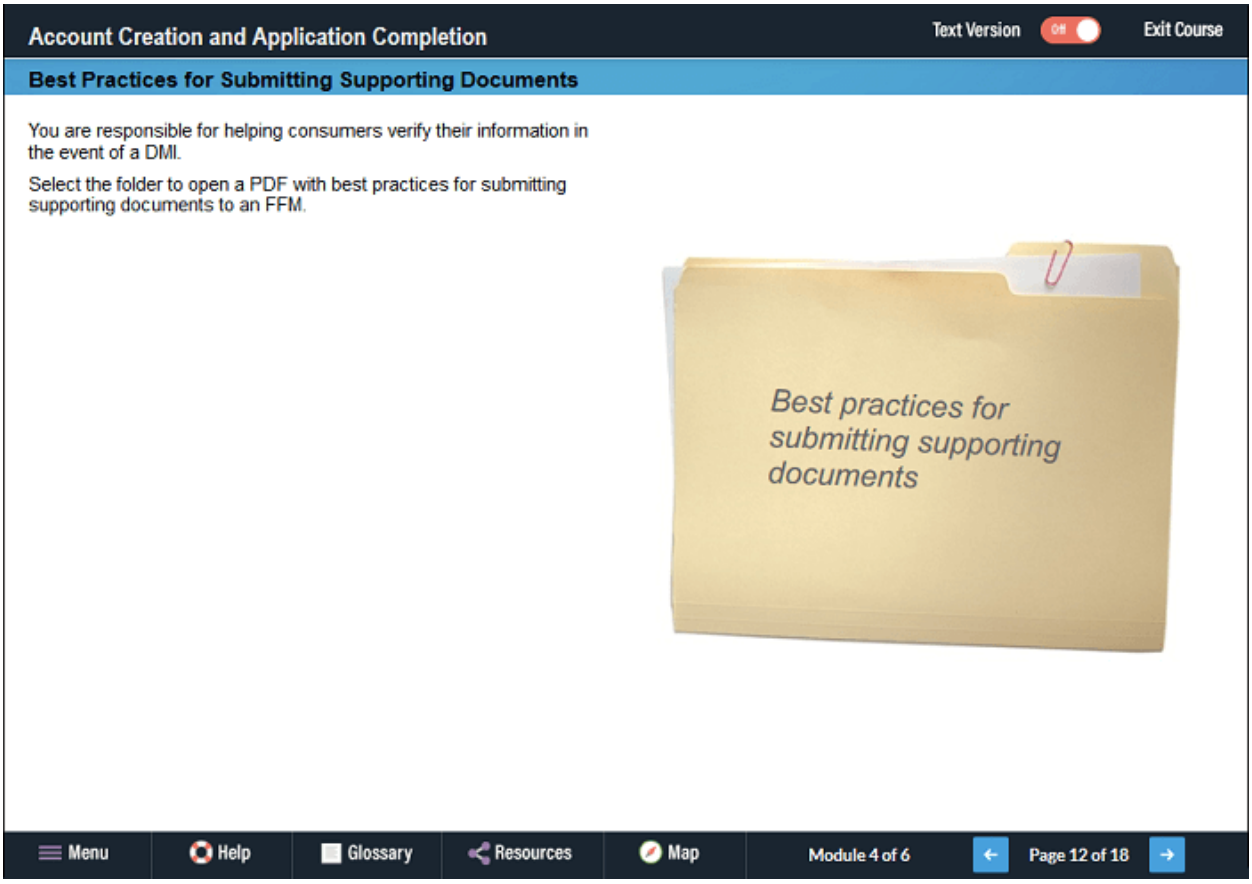
- Determine the consumer ineligible for APTC and CSRs
- Terminate the consumer's enrollment through the Marketplace

If consumers enroll and use any APTC amount during an inconsistency period, they must acknowledge that those payments are subject to reconciliation when they file taxes. You should help consumers understand this and help them gather the documents they need to resolve application inconsistencies.

For more information, refer to the Fact Sheet on Submitting Supporting Documents in the **Resources** section.

Note: Consumers usually have either 90 or 95 days, depending on the inconsistency type, to submit supporting documents when they encounter a DMI. For more information about how DMIs affect consumers, see the tip sheet called 5 Things Assisters Should Know about Data Matching Terminations at Marketplace.cms.gov/technical-assistance-resources/data-matching-terminations.pdf.

Best Practices for Submitting Supporting Documents



Uploading documents at HealthCare.gov is the fastest way to resolve a DMI. When consumers are ready, you should remind them to:

- Include the application ID number associated with the DMI on each page they submit.
- Choose the "Other" option from the drop-down list if they need to upload documents that do not fall into a specific document type category.
- Upload a .pdf, .jpeg, .jpg, .gif, .xml, .png, .tiff, or .bmp file.
- Upload a file no larger than 10 MB.

Do not include any of the following characters in the file name:

- Forward slash
- Back slash
- Colon
- Asterisk
- Quotation marks
- Angle brackets
- Vertical bar
- Question mark

If consumers have trouble uploading documents or don't have the option to upload, they can also mail paper copies; however, they cannot fax documents to an FFM. Here are some helpful tips:

- Keep the original versions of any documents and only send copies. Consumers can send documents that say "do not copy" on them. These shouldn't be treated as original documents—the FFMs just need copies to verify consumers' information.

- Include the bar code page from the initial eligibility notice the FFM mailed to them.
- Write their legal names and application ID numbers on each page that they submit if they don't have a bar code page. This makes it easier for the FFMs to match the documents to consumers' application records. Consumers can find their application ID numbers on the letters they received about their DMIs. You can also help them look up their application ID numbers for them online.

Send all documents to:

Health Insurance Marketplace

Attn: Coverage Processing

465 Industrial Blvd.

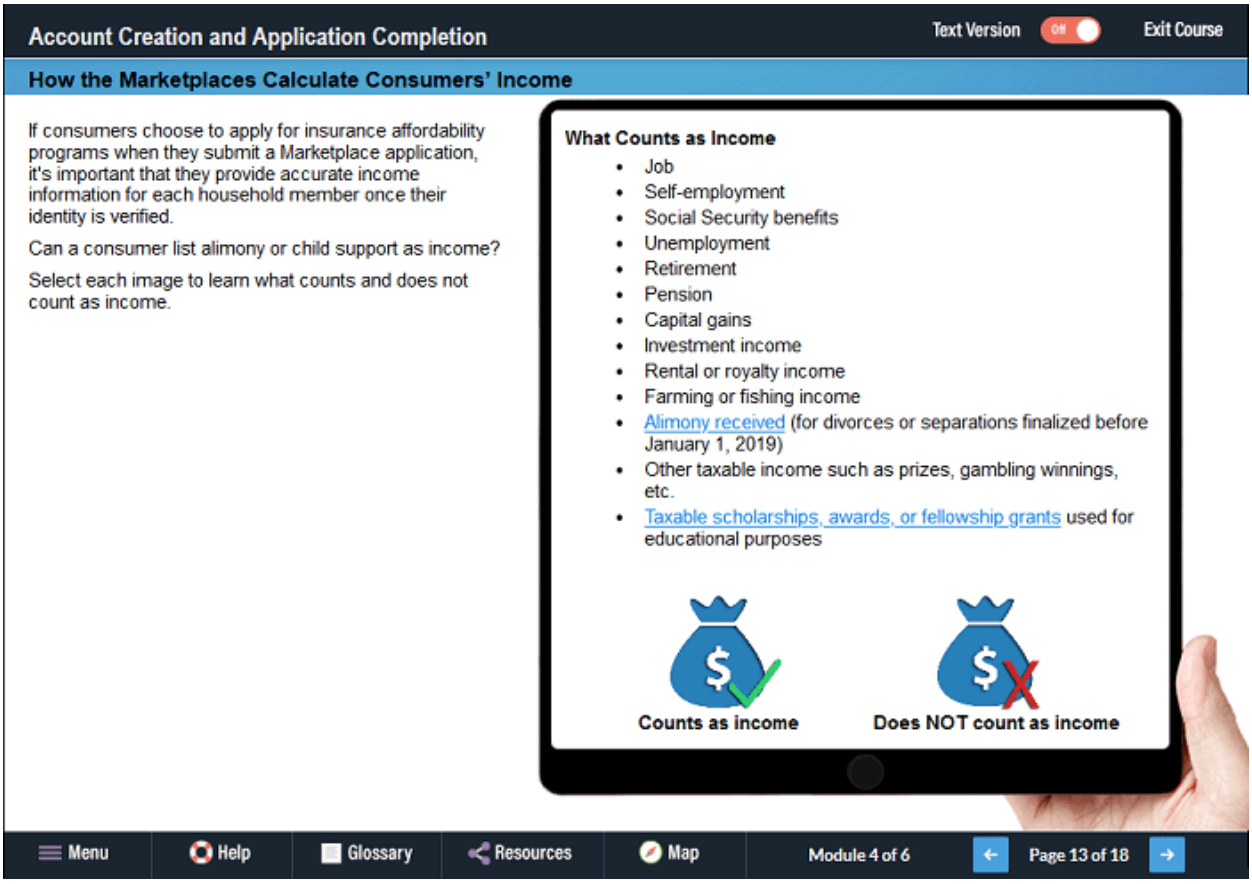
London, KY 40750-0001

Key Tip: Once consumers' documents are reviewed and processed, they are securely shredded and destroyed.

Remember

There is no need to send documents through FedEx, UPS, or United States Postal Service certified mail or to send documents with a confirmation. If consumers do use these services, the documents will still reach the processing center and will fall within the federal requirements for document retention.

How the Marketplaces Calculate Consumers' Income



If consumers choose to apply for insurance affordability programs when they submit a Marketplace application, it's important that they provide accurate income information for each household member once their identity is verified.

Can a consumer list alimony or child support as income?

What Counts as Income

- Job
- Self-employment
- Social Security benefits
- Unemployment
- Retirement
- Pension
- Capital gains
- Investment income
- Rental or royalty income
- Farming or fishing income
- Alimony received (for divorces or separations finalized before January 1, 2019)
- Other taxable income such as prizes, gambling winnings, etc.
- Taxable scholarships, awards, or fellowship grants used for education purposes*

* Key Tip: Taxable scholarships, awards, or fellowship grants used for education purposes count as income in the FFMs and consumers should enter them on a Marketplace application. However, they do not count as income when determining consumers' eligibility for Medicaid and CHIP.

What Does NOT Count as Income

- Alimony received (for divorces or separations finalized on or after January 1, 2019)
- Child support
- Gifts
- Supplemental Security Income (SSI)
- Veterans' disability payments
- Workers' compensation
- Proceeds from loans like student, home equity, or bank loan

Alimony received

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

For divorces and separations finalized on or after January 1, 2019, alimony should not be reported on the Marketplace application as income or as a deduction.

For divorces and separations finalized before January 1, 2019, alimony should be reported on the Marketplace application as income or as a deduction.

- This means that alimony payments to a former spouse will continue to be tax deductible and alimony payments received from a former spouse will continue to be reported as income.
- If a divorce or separation is modified on or after January 1, 2019, and the modification expressly provides that the alimony rule in the Tax Cuts and Jobs Act's amendment applies to this modification, then alimony should not be reported on the Marketplace application as income or a deduction.

Modified Adjusted Gross Income and Insurance Affordability Programs

The FFMs use consumers' modified adjusted gross income (MAGI) to determine whether they meet income requirements. MAGI is adjusted gross income (AGI) as reported on a consumer's federal income return plus these, if any: untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest. MAGI is generally very close to consumers' AGI. However, it does not appear as a line on federal income tax returns and does not include Supplemental Security Income (SSI).

Tax Returns
It's a good idea to advise consumers who file taxes to have their tax returns from the previous year available when they complete a Marketplace application. That's because:

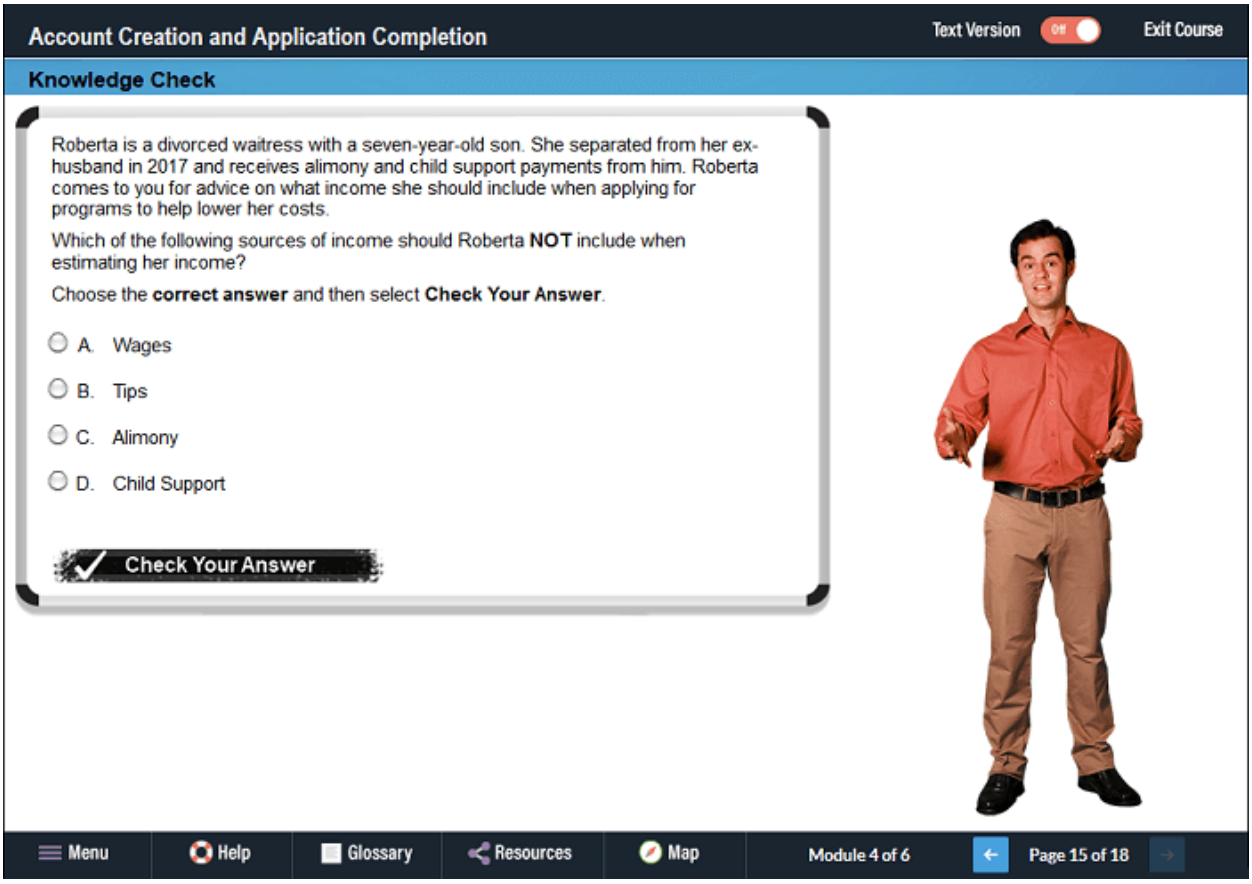
- Income claimed on a federal income tax return from a previous year can help a consumer estimate his or her household's MAGI.
- Both Marketplace applications and tax returns should have similar information about a consumer's household size.

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

Remember, the Marketplaces calculate MAGI differently from state Medicaid and CHIP agencies. Refer to the *Patient Protection and Affordable Care Act Basics* course for more information.

Notice
CMS is offering this link for informational purposes only and this fact should not be construed as an endorsement of the host organization’s programs or activities.

Knowledge Check



Roberta is a divorced waitress with a seven-year-old son. She separated from her ex-husband in 2017 and receives alimony and child support payments from him. Roberta comes to you for advice on what income she should include when applying for programs to help lower her costs.

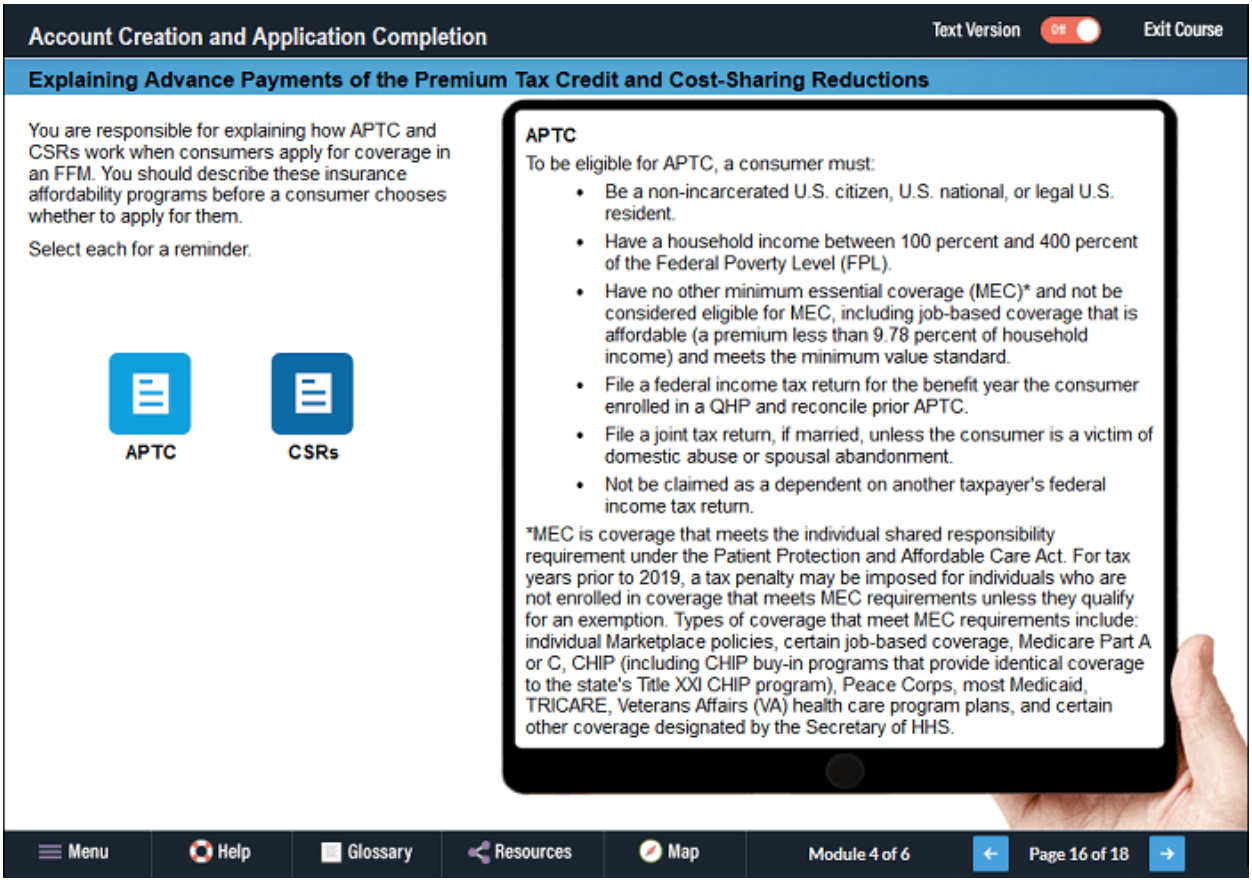
Which of the following sources of income should Roberta NOT include when estimating her income?

A. Wages
B. Tips
C. Alimony
D. Child Support

The correct answer is D. Roberta should not include child support when estimating her household income. However, she should include wages, tips, and alimony.

Note: If Roberta's separation from her ex-husband was finalized on or after January 1, 2019, then she **should not include child support and alimony** when estimating her household income.

Explaining Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions



You are responsible for explaining how APTC and CSRs work when consumers apply for coverage in an FFM. You should describe these insurance affordability programs before a consumer chooses whether to apply for them.

APTC

To be eligible for APTC, a consumer must:

- Be a non-incarcerated U.S. citizen, U.S. national, or legal U.S. resident.
- Have a household income between 100 percent and 400 percent of the Federal Poverty Level (FPL).
- Have no other minimum essential coverage (MEC)* and not be considered eligible for MEC, including job-based coverage that is affordable (a premium less than 9.78 percent of household income) and meets the minimum value standard.
- File a federal income tax return for the benefit year the consumer enrolled in a QHP and reconcile prior APTC.
- File a joint tax return, if married, unless the consumer is a victim of domestic abuse or spousal abandonment.
- Not be claimed as a dependent on another taxpayer's federal income tax return.

*MEC is coverage that meets the individual shared responsibility requirement under the Patient Protection and Affordable Care Act. For tax years prior to 2019, a tax penalty may be imposed for individuals who are not enrolled in coverage that meets MEC requirements unless they qualify for an exemption. Types of coverage that meet MEC requirements include: individual Marketplace policies, certain job-based coverage, Medicare Part A or C, CHIP (including CHIP buy-in programs that provide identical coverage to the state's Title XXI CHIP program), Peace Corps, most Medicaid, TRICARE, Veterans Affairs (VA) health care program plans, and certain other coverage designated by the Secretary of HHS.

CSRs

Consumers who qualify for APTC may also qualify for CSRs. CSR payments are advanced directly to insurance companies for eligible consumers. To qualify for CSRs, consumers* must:

- Meet the eligibility criteria for APTC.
- Enroll in a Silver plan in a Marketplace.
- Have a household income between 100 percent and 250 percent of the FPL.

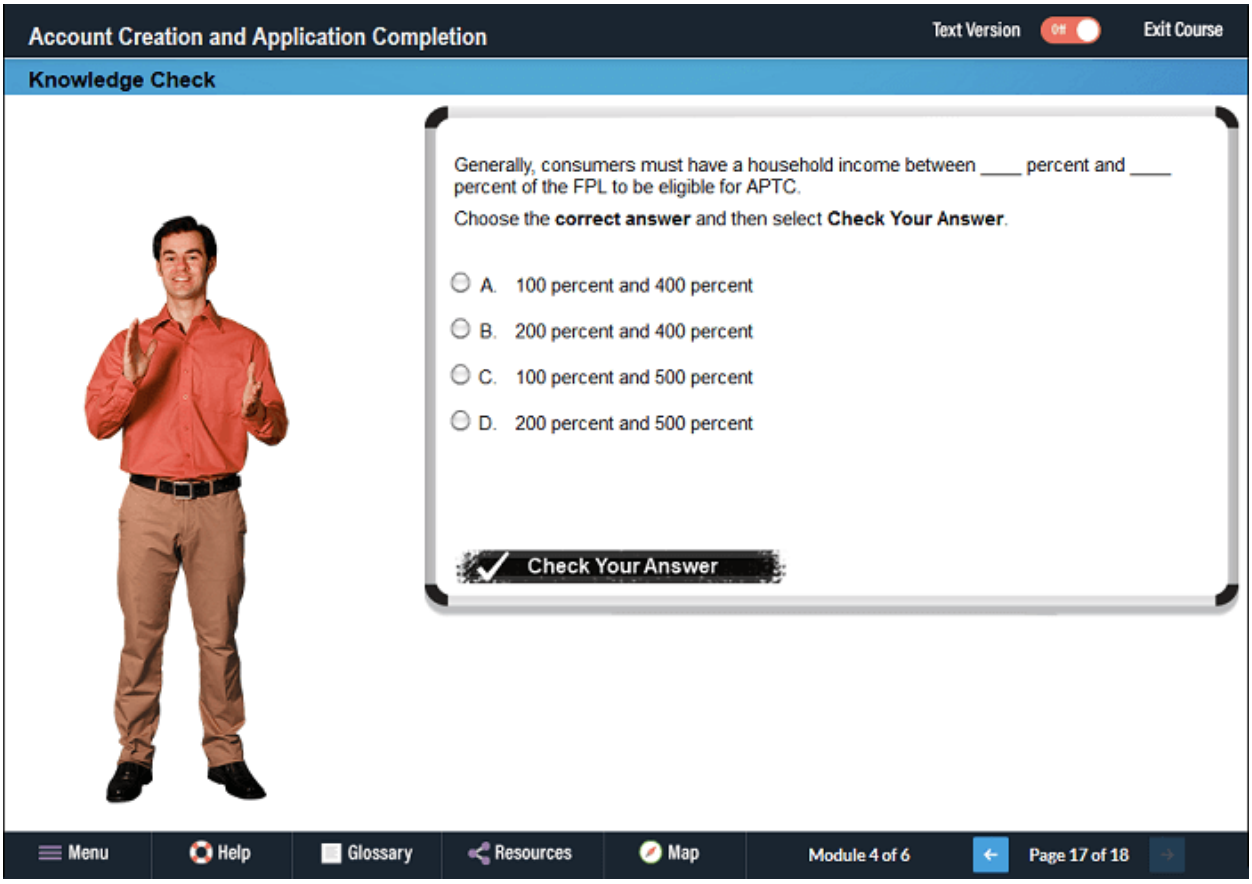
Key Tip: Use the tool available at HealthCare.gov/see-plans to search for Silver plans available in a consumer's area.

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

*American Indians and Alaska Natives (AI/ANs) or members of federally recognized tribes with household incomes up to 300 percent of the FPL qualify for CSRs regardless of which metal level health plan category they choose. They can also continue to receive health services from the following:

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

Knowledge Check

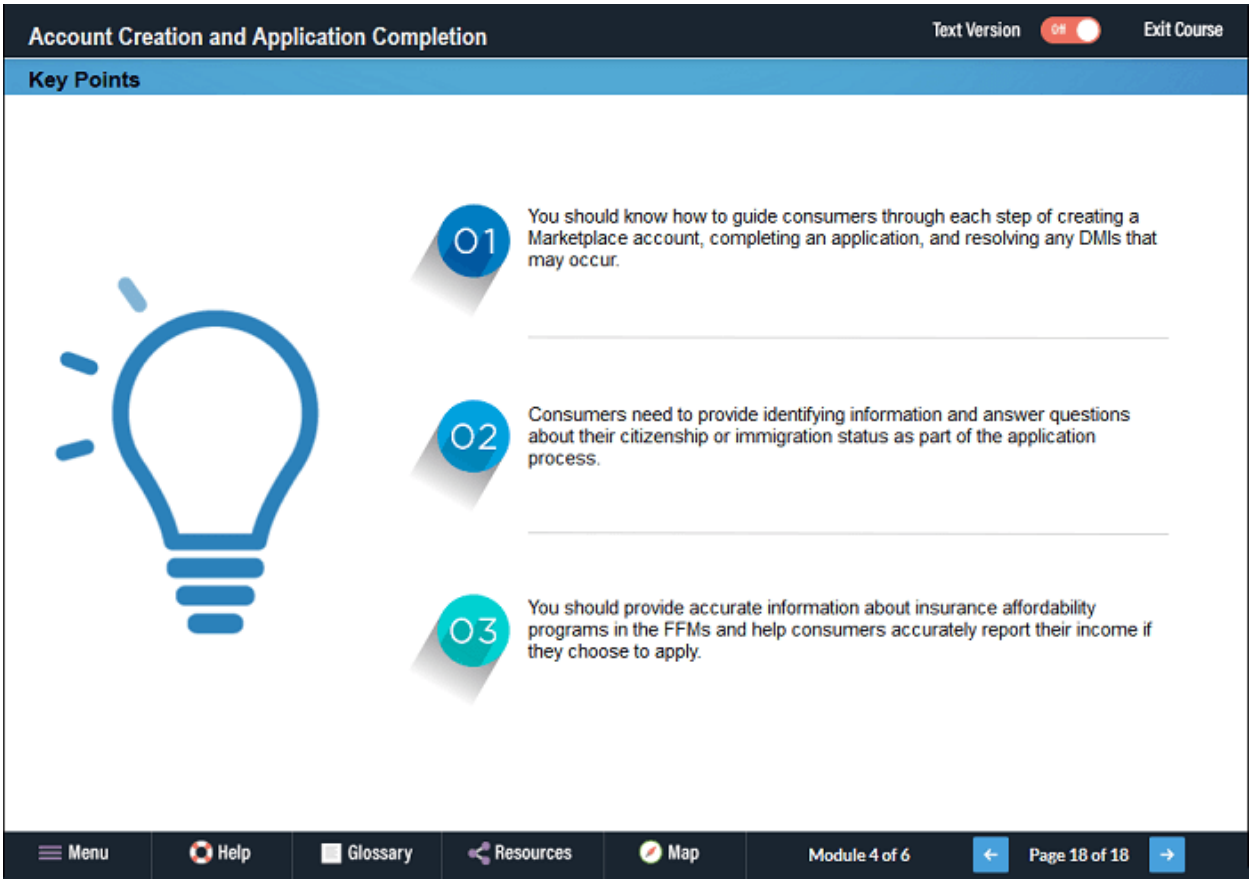


Generally, consumers must have a household income between ____ percent and ____ percent of the FPL to be eligible for APTC.

A. 100 percent and 400 percent
B. 200 percent and 400 percent
C. 100 percent and 500 percent
D. 200 percent and 500 percent

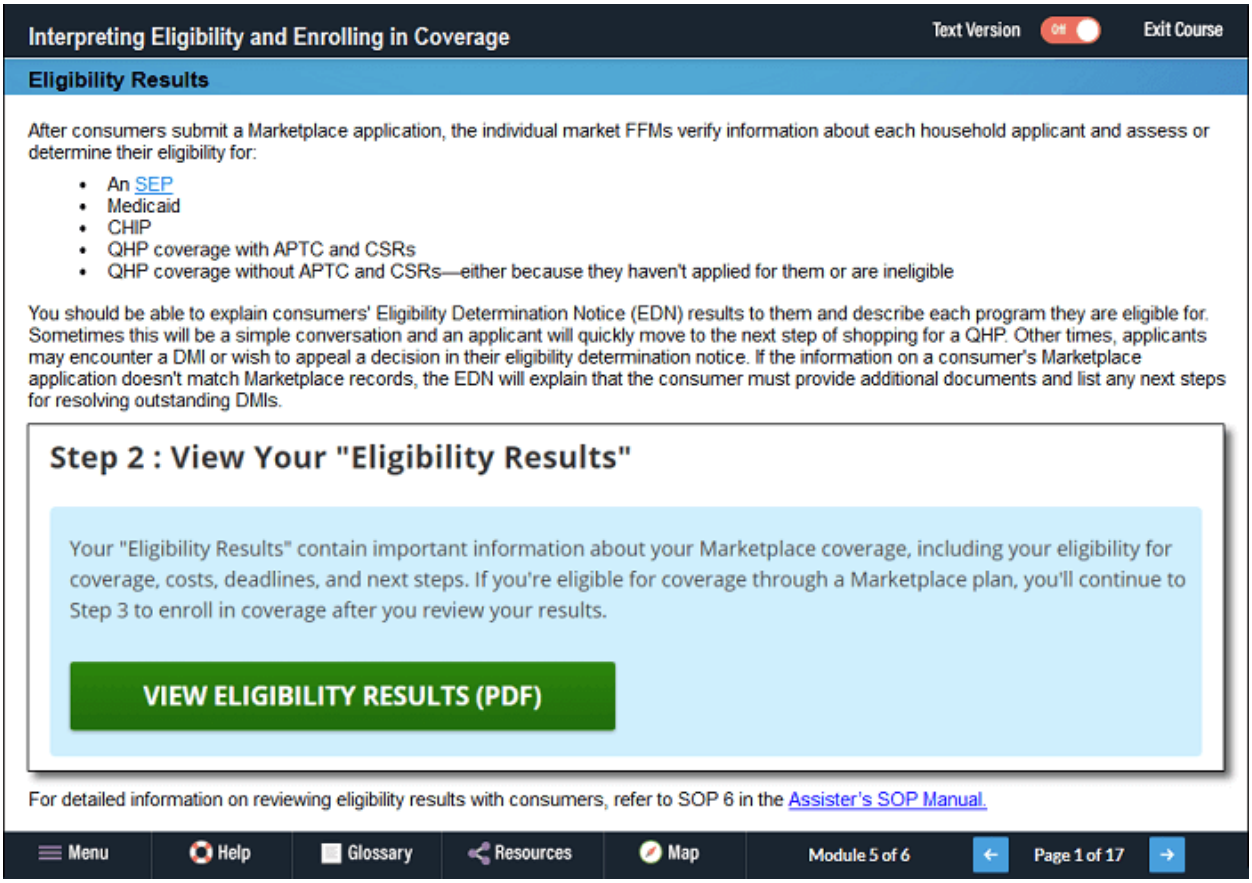
The correct answer is A. Consumers must generally have a household income between 100 percent and 400 percent of the FPL to be eligible for APTC.

Key Points



- You should know how to guide consumers through each step of creating a Marketplace account, completing an application, and resolving any DMIs that may occur.
- Consumers need to provide identifying information and answer questions about their citizenship or immigration status as part of the application process.
- You should provide accurate information about insurance affordability programs in the FFMs and help consumers accurately report their income if they choose to apply.

Interpreting Eligibility and Enrolling in Coverage
Eligibility Results



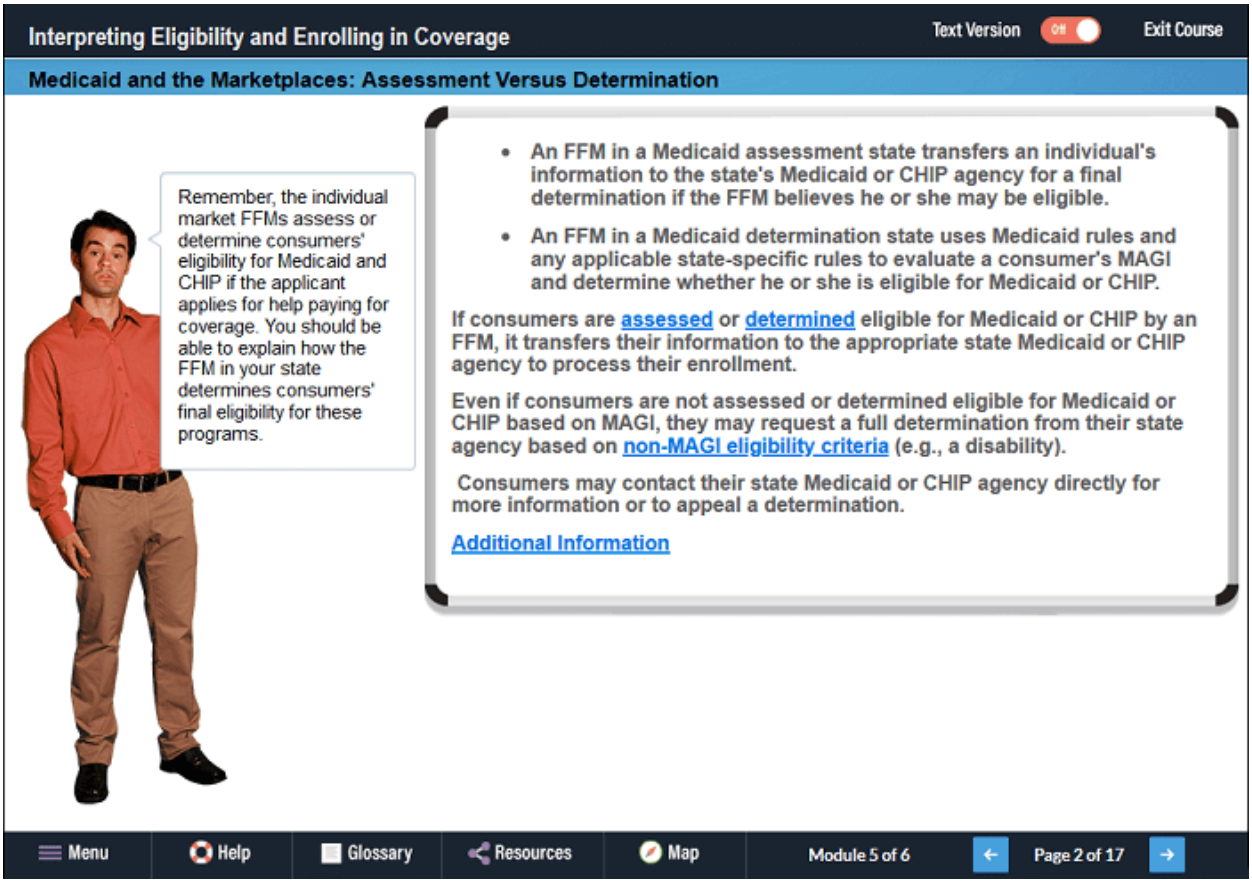
After consumers submit a Marketplace application, the individual market FFMs verify information about each household applicant and assess or determine their eligibility for:

- An SEP (Consumers applying for an SEP generally must submit supporting documents to an FFM to prove their eligibility before the FFM sends their information to a QHP issuer for processing.)
- Medicaid
- CHIP
- QHP coverage with APTC and CSRs
- QHP coverage without APTC and CSRs—either because they haven't applied for them or are ineligible

You should be able to explain consumers' Eligibility Determination Notice (EDN) results to them and describe each program they are eligible for. Sometimes this will be a simple conversation and an applicant will quickly move to the next step of shopping for a QHP. Other times, applicants may encounter a DMI or wish to appeal a decision in their eligibility determination notice. If the information on a consumer's Marketplace application doesn't match Marketplace records, the EDN will explain that the consumer must provide additional documents and list any next steps for resolving outstanding DMIs.

For detailed information on reviewing eligibility results with consumers, refer to SOP 6 in the Assister's SOP Manual.

Medicaid and the Marketplaces: Assessment Versus Determination



Remember, the individual market FFMs assess or determine consumers' eligibility for Medicaid and CHIP if the applicant applies for help paying for coverage. You should be able to explain how the FFM in your state determines consumers' final eligibility for these programs.

- An FFM in a Medicaid assessment state transfers an individual's information to the state's Medicaid or CHIP agency for a final determination if the FFM believes he or she may be eligible.
- An FFM in a Medicaid determination state uses Medicaid rules and any applicable state-specific rules to evaluate a consumer's MAGI and determine whether he or she is eligible for Medicaid or CHIP.

If consumers are assessed* or determined** eligible for Medicaid or CHIP by an FFM, it transfers their information to the appropriate state Medicaid or CHIP agency to process their enrollment.

Even if consumers are not assessed or determined eligible for Medicaid or CHIP based on MAGI, they may request a full determination from their state agency based on non-MAGI eligibility criteria (e.g., a disability).

Consumers may contact their state Medicaid or CHIP agency directly for more information or to appeal a determination.

***Medicaid Assessment**
In a Medicaid assessment state, the FFM makes an initial decision that a consumer is potentially eligible for Medicaid or CHIP based on their household's MAGI and other eligibility criteria. When this happens, the FFM transfers the consumer's application to the state Medicaid or CHIP agency for a final eligibility determination. The agency then sends a notice to the consumer with a final eligibility determination or requests additional information if necessary.

****Medicaid Determination**
In a Medicaid determination state, the FFM makes a final determination about a consumer's eligibility for Medicaid or CHIP based on their household's MAGI only and sends the consumer's information to the state Medicaid or CHIP agency for processing.

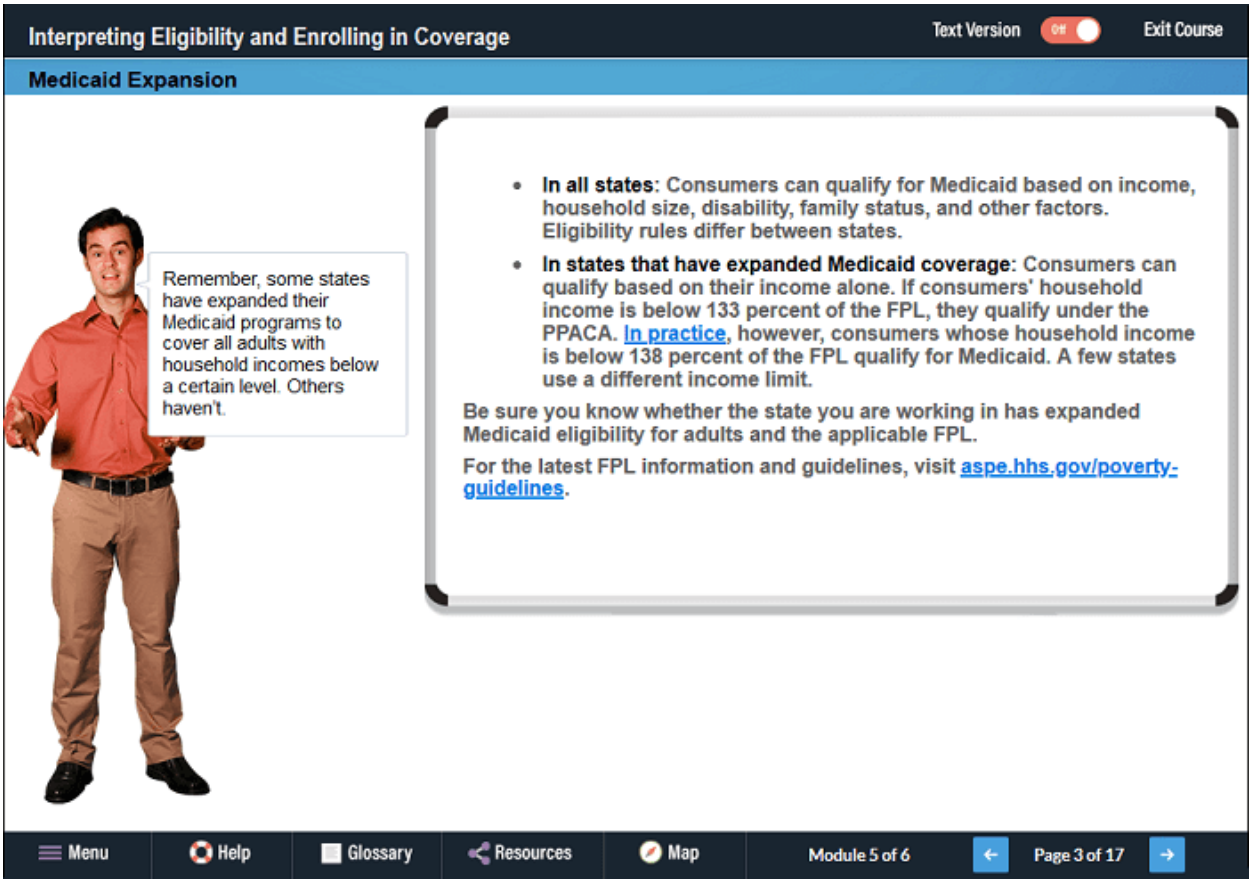
Additional Information
Remember, you can use the **Map tab** in the course **Menu** to determine whether your state or other states

make an assessment or determination for Medicaid and CHIP eligibility.

Key Tip: If an individual is assessed or determined **ineligible** for Medicaid and CHIP, an eligibility determination notice will state whether that individual can enroll in a QHP and receive APTC and CSRs.

You can find more detailed information about assisting consumers with Medicaid and CHIP eligibility in the Medicaid and CHIP: Fast Facts for Assisters tip sheet at Marketplace.cms.gov/technical-assistance-resources/fast-facts-medicaid-chip.pdf.

Medicaid Expansion



Remember, some states have expanded their Medicaid programs to cover all adults with household incomes below a certain level. Others haven't.

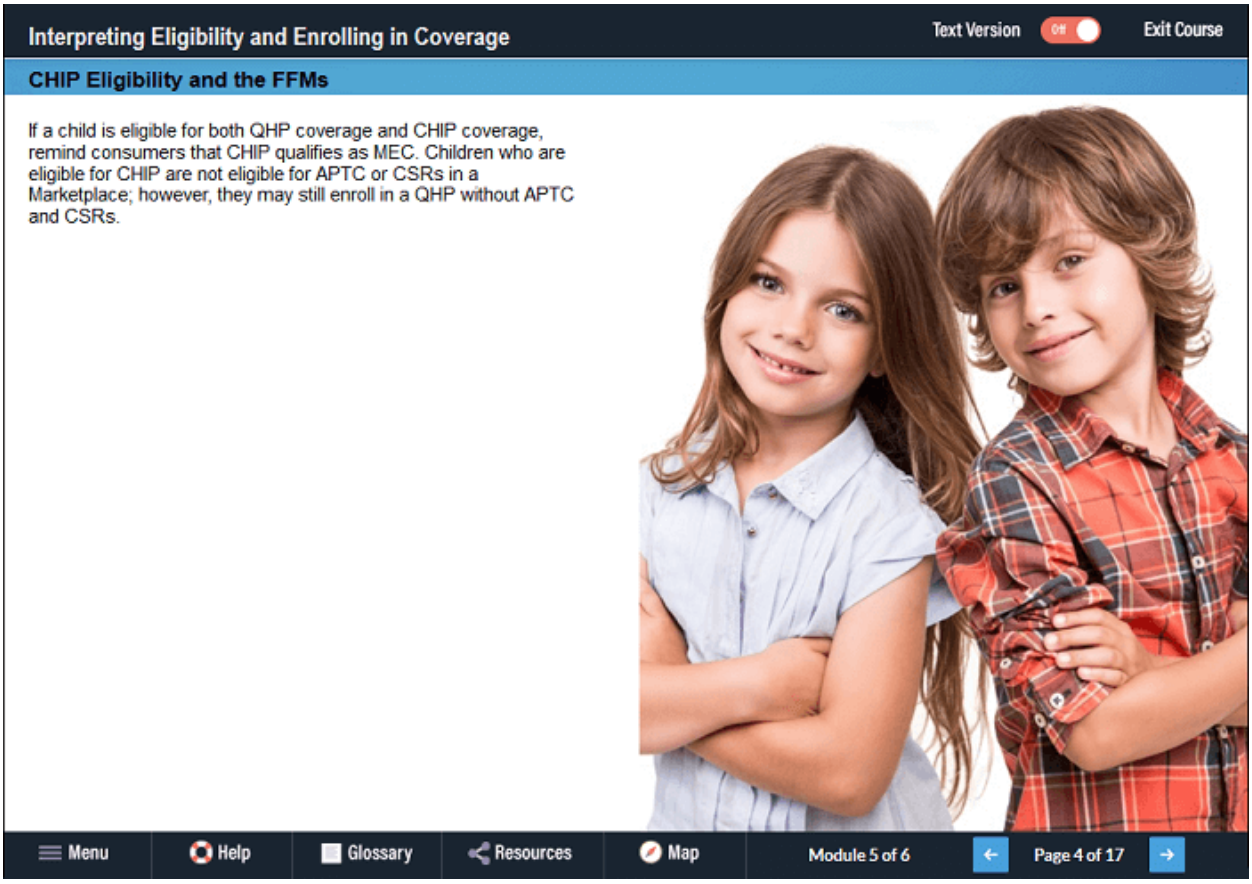
- **In all states**: Consumers can qualify for Medicaid based on income, household size, disability, family status, and other factors. Eligibility rules differ between states.
- **In states that have expanded Medicaid coverage**: Consumers can qualify based on their income alone. If consumers' household income is below 133 percent of the FPL, they qualify under the PPACA. **In practice***, however, consumers whose household income is below 138 percent of the FPL qualify for Medicaid. A few states use a different income limit.

Be sure you know whether the state you are working in has expanded Medicaid eligibility for adults and the applicable FPL.

For the latest FPL information and guidelines, visit aspe.hhs.gov/poverty-guidelines.

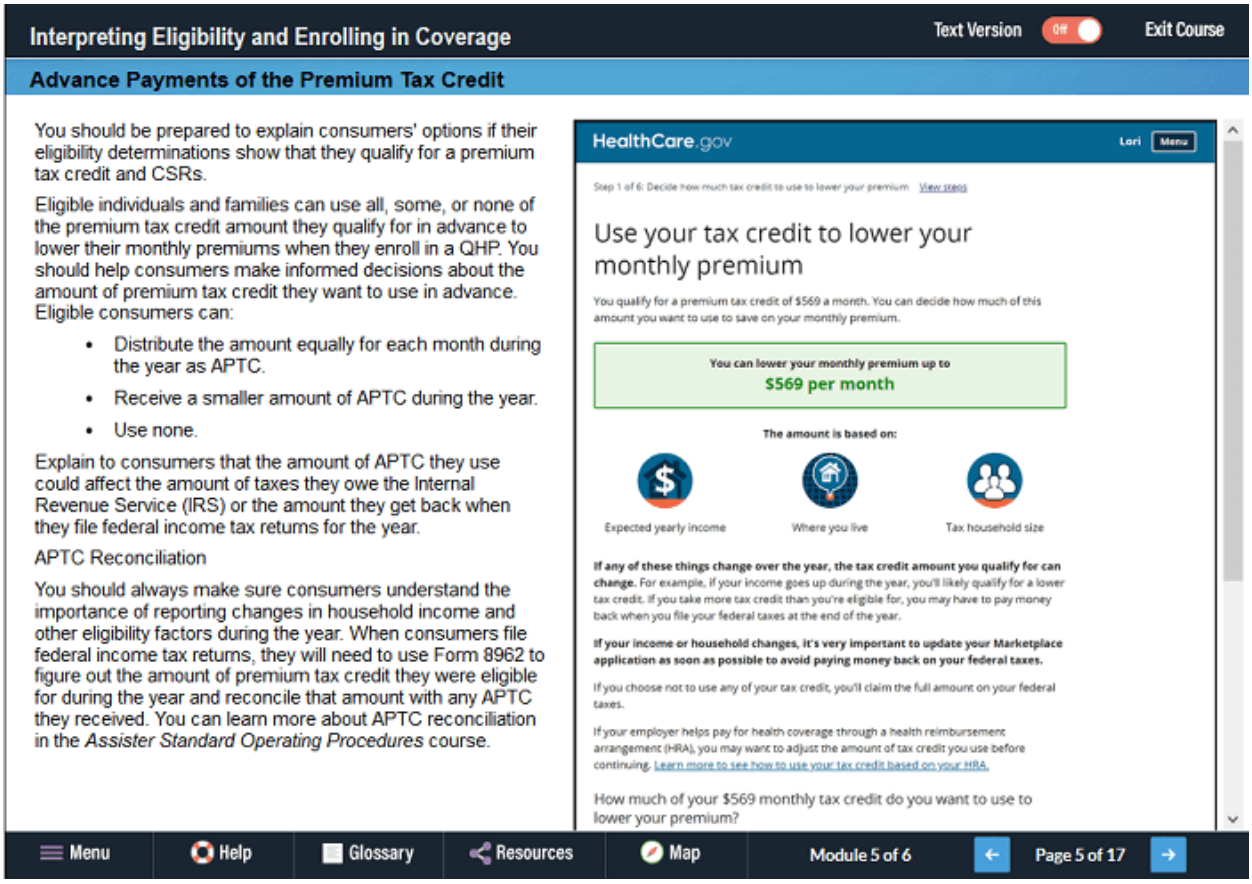
***In practice**
The PPACA's MAGI calculation is based on AGI as defined in the Internal Revenue Code. However, the PPACA's regulations add a five percent point deduction from the FPL—one of several ways in which the AGI is "modified." With this five percent disregard, the Medicaid eligibility threshold is effectively 138 percent of the FPL.

CHIP Eligibility and the FFMs



If a child is eligible for both QHP coverage and CHIP coverage, remind consumers that CHIP qualifies as MEC. Children who are eligible for CHIP are not eligible for APTC or CSRs in a Marketplace; however, they may still enroll in a QHP without APTC and CSRs.

Advance Payments of the Premium Tax Credit



You should be prepared to explain consumers' options if their eligibility determinations show that they qualify for a premium tax credit and CSRs.

Eligible individuals and families can use all, some, or none of the premium tax credit amount they qualify for in advance to lower their monthly premiums when they enroll in a QHP. You should help consumers make informed decisions about the amount of premium tax credit they want to use in advance. Eligible consumers can:

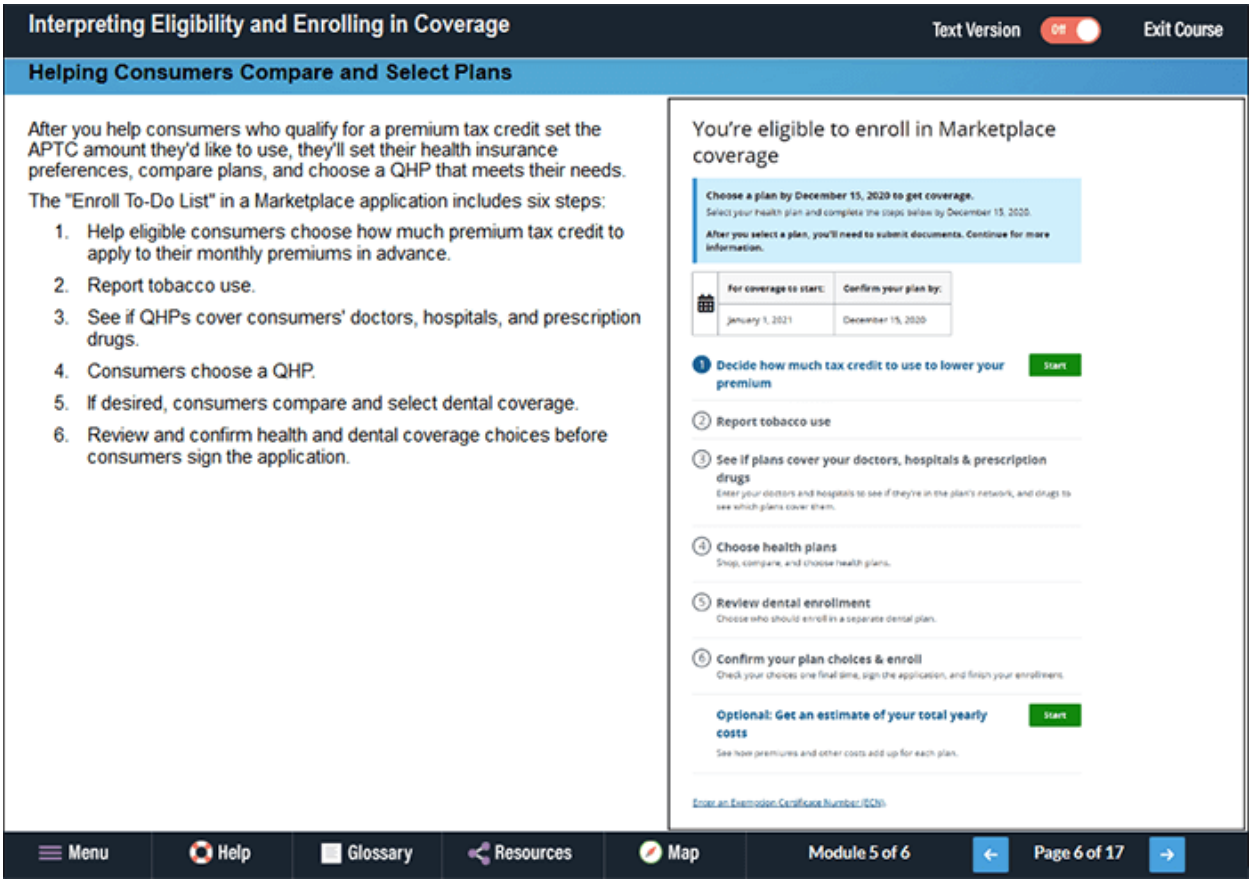
- Distribute the amount equally for each month during the year as APTC.
- Receive a smaller amount of APTC during the year.
- Use none.

Explain to consumers that the amount of APTC they use could affect the amount of taxes they owe the Internal Revenue Service (IRS) or the amount they get back when they file federal income tax returns for the year.

APTC Reconciliation

You should always make sure consumers understand the importance of reporting changes in household income and other eligibility factors during the year. When consumers file federal income tax returns, they will need to use Form 8962 to figure out the amount of premium tax credit they were eligible for during the year and reconcile that amount with any APTC they received. You can learn more about APTC reconciliation in the *Assister Standard Operating Procedures* course.

Helping Consumers Compare and Select Plans

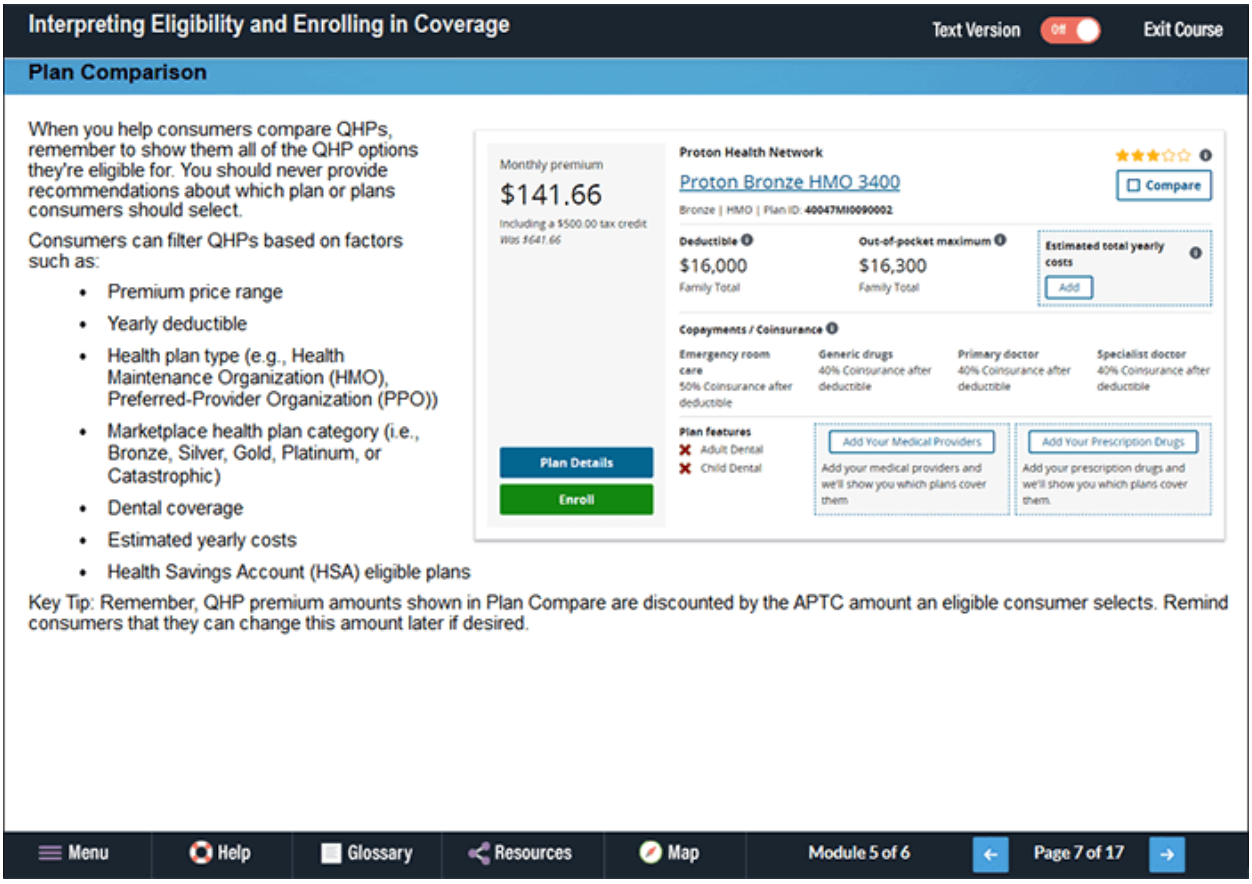


After you help consumers who qualify for a premium tax credit set the APTC amount they'd like to use, they'll set their health insurance preferences, compare plans, and choose a QHP that meets their needs.

The "Enroll To-Do List" in a Marketplace application includes six steps:

1. Help eligible consumers choose how much premium tax credit to apply to their monthly premiums in advance.
2. Report tobacco use.
3. See if QHPs cover consumers' doctors, hospitals, and prescription drugs.
4. Consumers choose a QHP.
5. If desired, consumers compare and select dental coverage.
6. Review and confirm health and dental coverage choices before consumers sign the application.

Plan Comparison



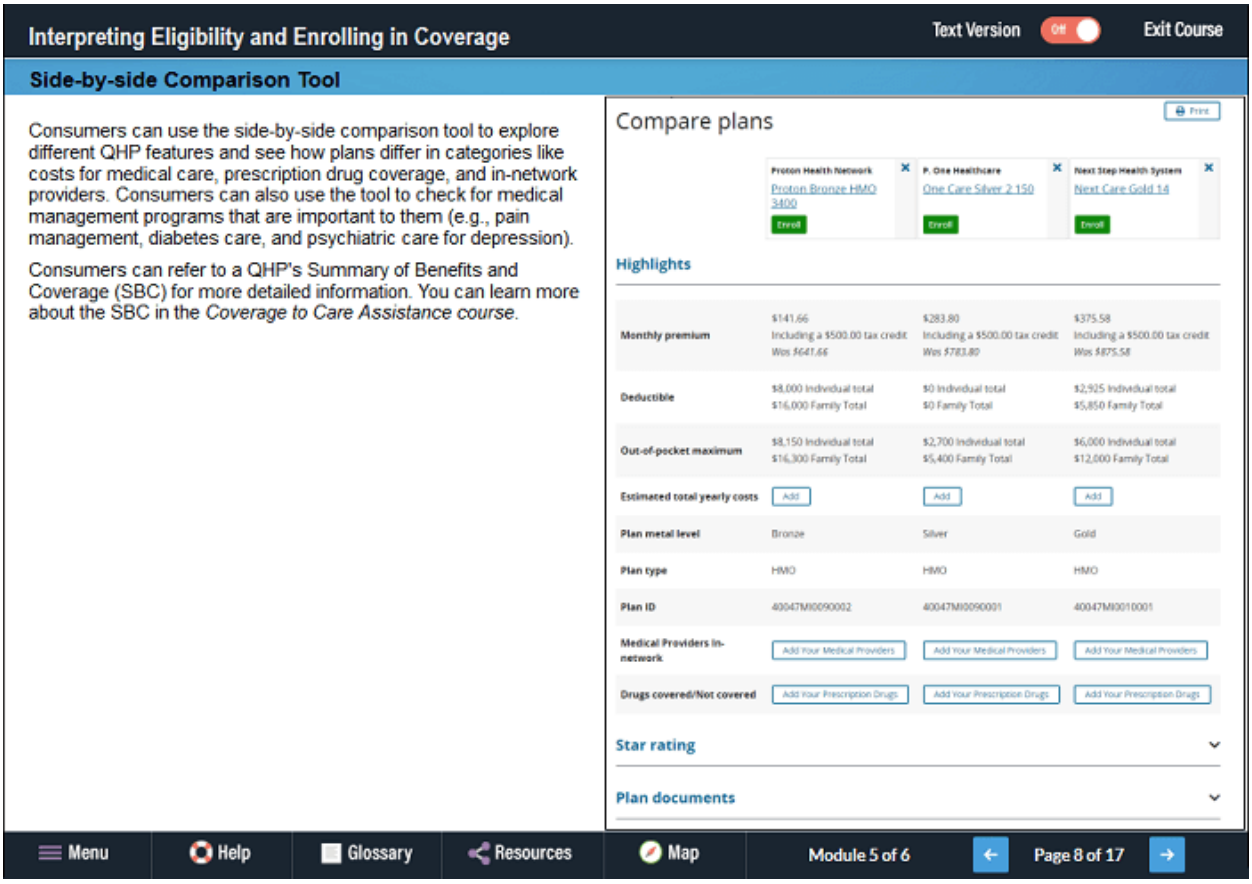
When you help consumers compare QHPs, remember to show them all of the QHP options they're eligible for. You should never provide recommendations about which plan or plans consumers should select.

Consumers can filter QHPs based on factors such as:

- Premium price range
- Yearly deductible
- Health plan type (e.g., Health Maintenance Organization (HMO), Preferred-Provider Organization (PPO))
- Marketplace health plan category (i.e., Bronze, Silver, Gold, Platinum, or Catastrophic)
- Dental coverage
- Estimated yearly costs
- Health Savings Account (HSA) eligible plans

Key Tip: Remember, QHP premium amounts shown in Plan Compare are discounted by the APTC amount an eligible consumer selects. Remind consumers that they can change this amount later if desired.

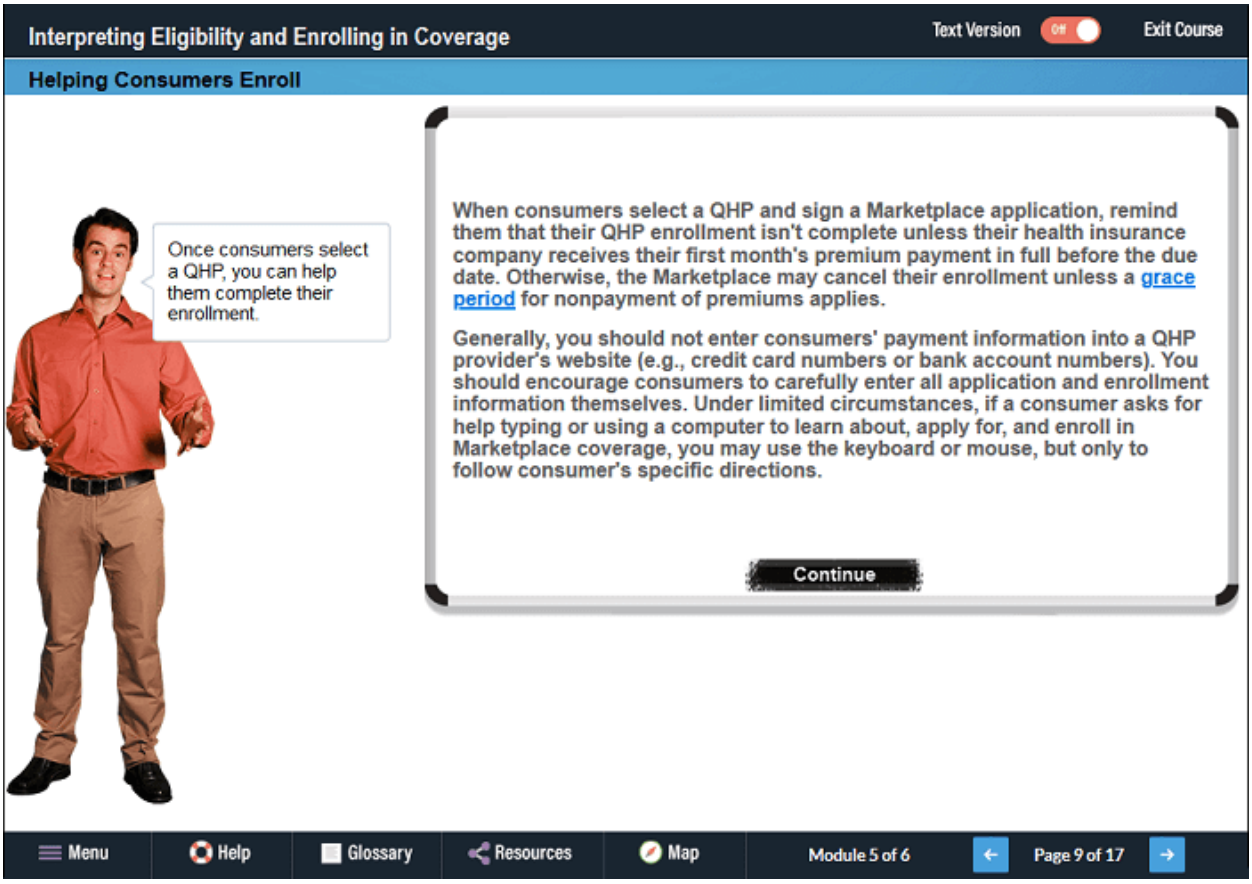
Side-by-side Comparison Tool



Consumers can use the side-by-side comparison tool to explore different QHP features and see how plans differ in categories like costs for medical care, prescription drug coverage, and in-network providers. Consumers can also use the tool to check for medical management programs that are important to them (e.g., pain management, diabetes care, and psychiatric care for depression).

Consumers can refer to a QHP's Summary of Benefits and Coverage (SBC) for more detailed information. You can learn more about the SBC in the *Coverage to Care Assistance* course.

Helping Consumers Enroll



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

When consumers select a QHP and sign a Marketplace application, remind them that their QHP enrollment isn't complete unless their health insurance company receives their first month's premium payment in full before the due date. Otherwise, the Marketplace may cancel their enrollment unless a grace period for nonpayment of premiums applies.

Generally, you should not enter consumers' payment information into a QHP provider's website (e.g., credit card numbers or bank account numbers). You should encourage consumers to carefully enter all application and enrollment information themselves. Under limited circumstances, if a consumer asks for help typing or using a computer to learn about, apply for, and enroll in Marketplace coverage, you may use the keyboard or mouse, but only to follow consumer's specific directions.

Effective Date of Coverage

In most cases, the earliest date consumers' coverage can start – that is, their "effective date of coverage"—is:

- January 1st for consumers who enroll during Open Enrollment, or
- For Special Enrollment Periods:
  - The first day of the month following plan selection for consumers who select a plan between the first and the fifteenth day of the month.
  - The first day of the second month following plan selection for consumers who select a plan between the sixteenth and the last day of any month.
  - Unless a special effective date applies.

Remember to tell consumers that their effective date of coverage is based on when they choose a plan and the type of SEP they qualify for, not the first date on which they actually use the coverage to get care.

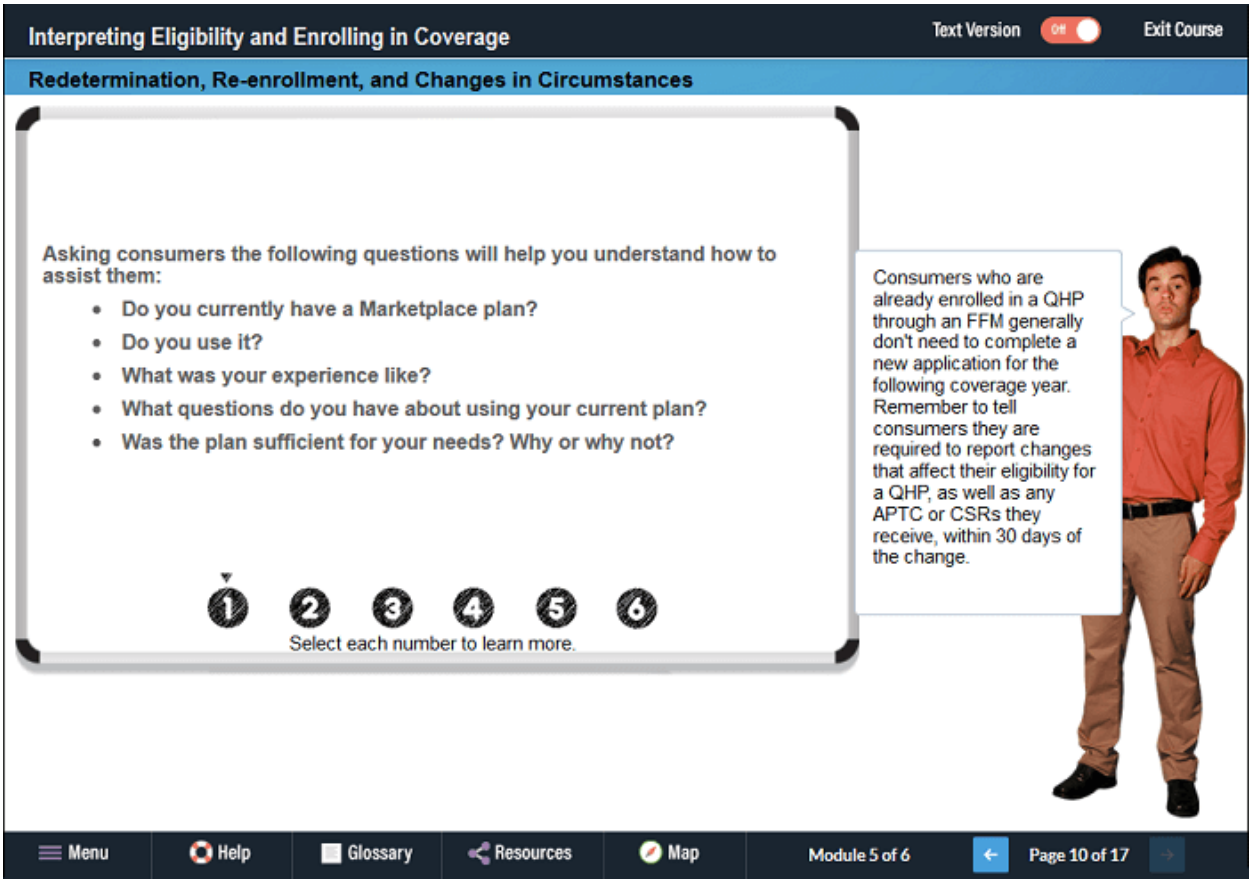
Key Tip: The individual market OEP for 2021 coverage begins on November 1, 2020 and ends December 15, 2020. Consumers must enroll and, for new coverage, generally must pay their first month's premium by the deadline noted by the health insurance issuer in the enrollment materials. If there are questions about the

deadline for payment, the consumer should call his or her issuer directly.

Grace Period

There's a three-month grace period for consumers who are receiving APTC when they fail to pay their premiums by the due date noted in the issuer's enrollment materials. A QHP must continue to pay claims during the first month of the grace period; however, it may delay payments for any claims made in the second and third months until consumers pay any overdue premiums. If consumers still haven't paid their premiums in full after the third month, their QHP is terminated retroactively to the end of the first month of the grace period. This means the consumer may have to pay any claims made on his or her behalf during the second and third months of the grace period. have to pay any claims made on his or her behalf during the second and third months of the grace period.

Redetermination, Re-enrollment, and Changes in Circumstances



Consumers who are already enrolled in a QHP through an FFM generally don't need to complete a new application for the following coverage year. Remember to tell consumers they are required to report changes that affect their eligibility for a QHP, as well as any APTC or CSRs they receive, within 30 days of the change. Even if consumers believe they have no changes to report, it's strongly recommended that they contact the FFM to make sure their eligibility information is up to date.

Asking consumers the following questions will help you understand how to assist them:

- Do you currently have a Marketplace plan?
- Do you use it?
- What was your experience like?
- What questions do you have about using your current plan?
- Was the plan sufficient for your needs? Why or why not?

Before each OEP, the FFMs send a notice to all current enrollees that summarizes their eligibility for the coming year (unless they have terminated their coverage and the FFM has a cancellation request on file).

There are four variations of this eligibility notice:

- Standard eligibility notice
- Income-based outreach notice
- Did-not-reconcile notice
- Special notice

The eligibility notice will also state:

- Whether the consumer's plan will be available for the next plan year.
- Any changes to the plan.
- If the plan won't be available, what plan the consumer will be enrolled in for the next plan year.

You should advise consumers to review the notice and contact the FFM if anything is incorrect. If the FFM found that a consumer's household income has changed, the notice will advise the consumer to report the change and obtain updated eligibility results. This is very important for consumers who receive financial assistance. If consumers' household income exceeds 500 percent of the FPL when the FFMs recheck their data, the FFM will discontinue their eligibility for APTC and CSRs at the end of the coverage year and re-enroll them in a QHP without financial assistance.

Consumers who meet any of the following criteria must also contact the FFM to obtain updated eligibility results:

- No updated tax return information is provided by the IRS in response to the Marketplace's request;
- The most recent Marketplace eligibility results for the current plan year reflect household income in excess of 350 percent of the FPL; or
- The IRS provides updated household income information from tax data that, when evaluated together with the family size used for the enrollee's most recent eligibility results for the current plan year, reflects:
    - Household income in excess of 350 percent of the FPL
    - An increase or decrease in household income of greater than 50 percent when compared to the household income from the most recent FFM eligibility results
    - Household income under 100 percent of the FPL; or
    - Household income that meets other criteria established by the FFM.

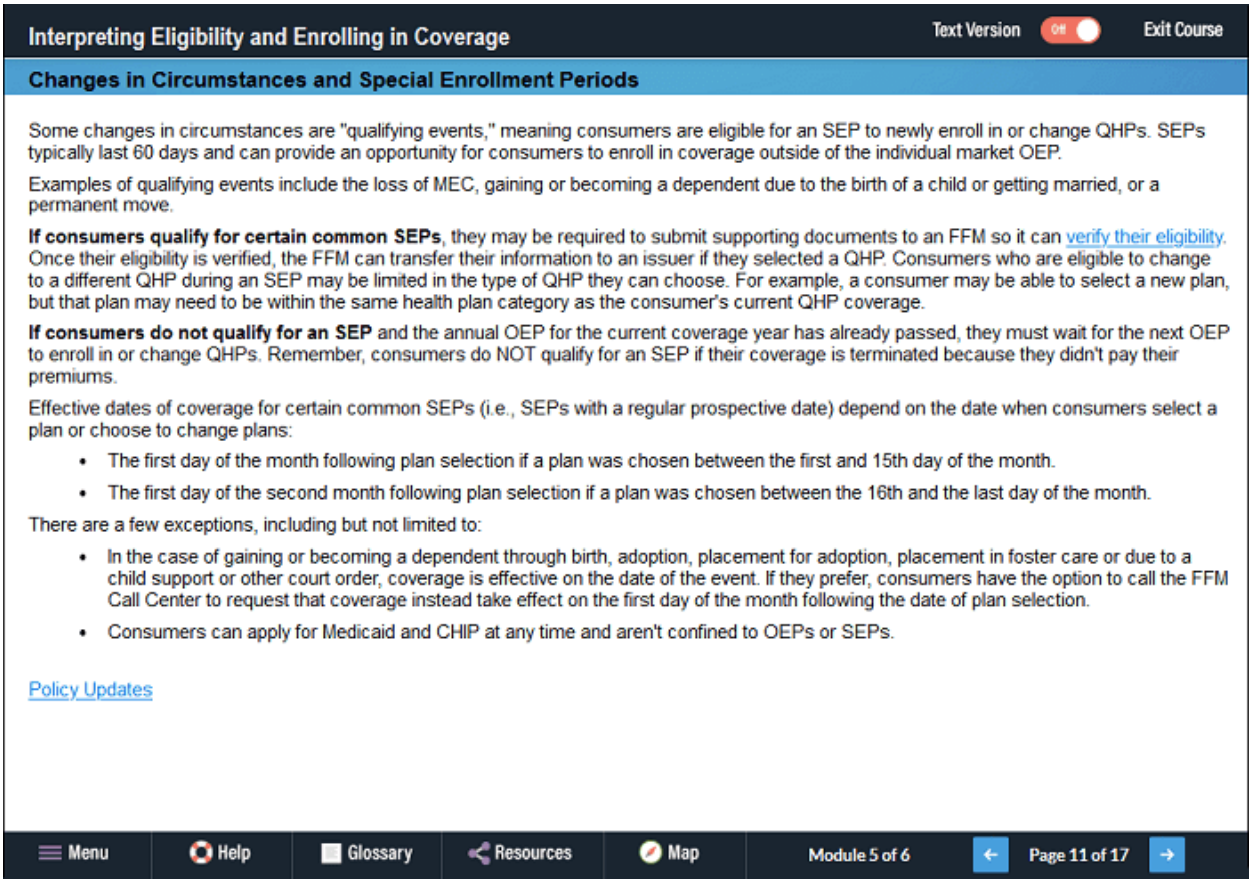
Existing QHP enrollees will also get a notice from their health insurance company indicating whether their current plan has changed or can be renewed for the following coverage year.

Changes in circumstance may also affect consumers' eligibility and enrollment (e.g., a move or a new job). Consumers should report changes to the FFMs within 30 days of the change occurring.

Before Open Enrollment, the FFMs request updated tax return information from the IRS for all consumers who have agreed to allow the Marketplaces to recheck their information. If these consumers are currently enrolled in QHPs, the FFMs will determine whether they are eligible to receive APTC and CSRs. Any changes in coverage or eligibility as a result of the redetermination process are effective on January 1 of the following coverage year.

If consumers requested help paying for health coverage on their Marketplace application but didn't agree to allow the FFM to recheck their federal tax data on an annual basis, they will receive a notice asking them to contact the FFM to get updated eligibility results. If they don't do this by December 15 of the current coverage year, the enrollees' APTC and CSRs will end on December 31. The FFM will still renew consumers' QHP coverage without APTC and CSRs for the following year if the coverage is available unless the FFM determines they are no longer eligible to purchase a QHP.

Changes in Circumstances and Special Enrollment Periods



Some changes in circumstances are "qualifying events," meaning consumers are eligible for an SEP to newly enroll in or change QHPs. SEPs typically last 60 days and can provide an opportunity for consumers to enroll in coverage outside of the individual market OEP.

Examples of qualifying events include the loss of MEC, gaining or becoming a dependent due to the birth of a child or getting married, or a permanent move.

If consumers qualify for certain common SEPs, they may be required to submit supporting documents to an FFM so it can verify their eligibility*. Once their eligibility is verified, the FFM can transfer their information to an issuer if they selected a QHP. Consumers who are eligible to change to a different QHP during an SEP may be limited in the type of QHP they can choose. For example, a consumer may be able to select a new plan, but that plan may need to be within the same health plan category as the consumer's current QHP coverage.

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

Effective dates of coverage for certain common SEPs (i.e., SEPs with a regular prospective date) depend on the date when consumers select a plan or choose to change plans:

- The first day of the month following plan selection if a plan was chosen between the first and 15th day of the month.
- The first day of the second month following plan selection if a plan was chosen between the 16th and the last day of the month.

There are a few exceptions, including but not limited to:

- In the case of gaining or becoming a dependent through birth, adoption, placement for adoption, placement in foster care or due to a child support or other court order, coverage is effective on the date of the event. If they prefer, consumers have the option to call the FFM Call Center to request that coverage instead take effect on the first day of the month following the date of plan selection.
- Consumers can apply for Medicaid and CHIP at any time and aren't confined to OEPs or SEPs.

***Verify their eligibility**
The following types of SEPs require consumers newly enrolling in Marketplace coverage to verify their eligibility by submitting supporting documents:

- Adoption, placement for adoption, placement for foster care, or child support or other court order
- Change in primary place of living (permanent move)
- Loss of qualifying health coverage
- Marriage
- Medicaid or CHIP denial
- New, mid-year eligibility for APTC after experiencing a decrease in household income (for individuals with existing MEC purchased outside the FFMs)

Consumers generally have 60 days from the date of their qualifying life event to enroll, change plans, or add new dependents to their current plan. The submission of required documents to verify their SEP eligibility also takes place during the 60-day window.

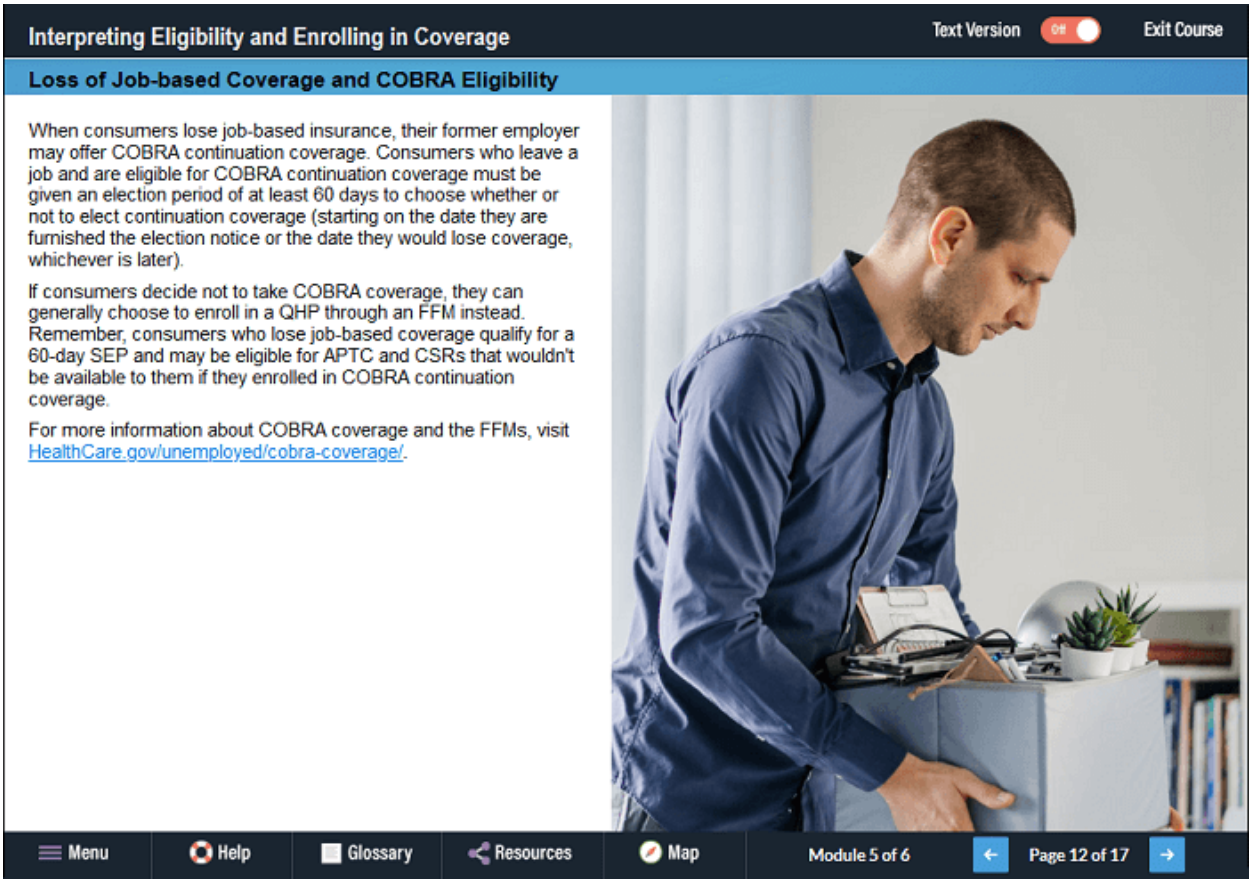
For all other SEP types, including birth, consumers do not need to submit documents before they can start using their new coverage.

Policy Updates

Effective January 1, 2020, consumers may be eligible for an SEP if they or their dependent newly gain access to an Individual Coverage Health Reimbursement Arrangement (ICHRA) or are newly provided a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA).

- Eligible individuals qualify for an SEP to enroll in individual coverage through or outside of the Marketplace.
- The qualifying event is the first day on which coverage for the qualified individual, enrollee, or dependent under the ICHRA can take effect, or the first day on which coverage under the QSEHRA takes effect.

Loss of Job-based Coverage and COBRA Eligibility

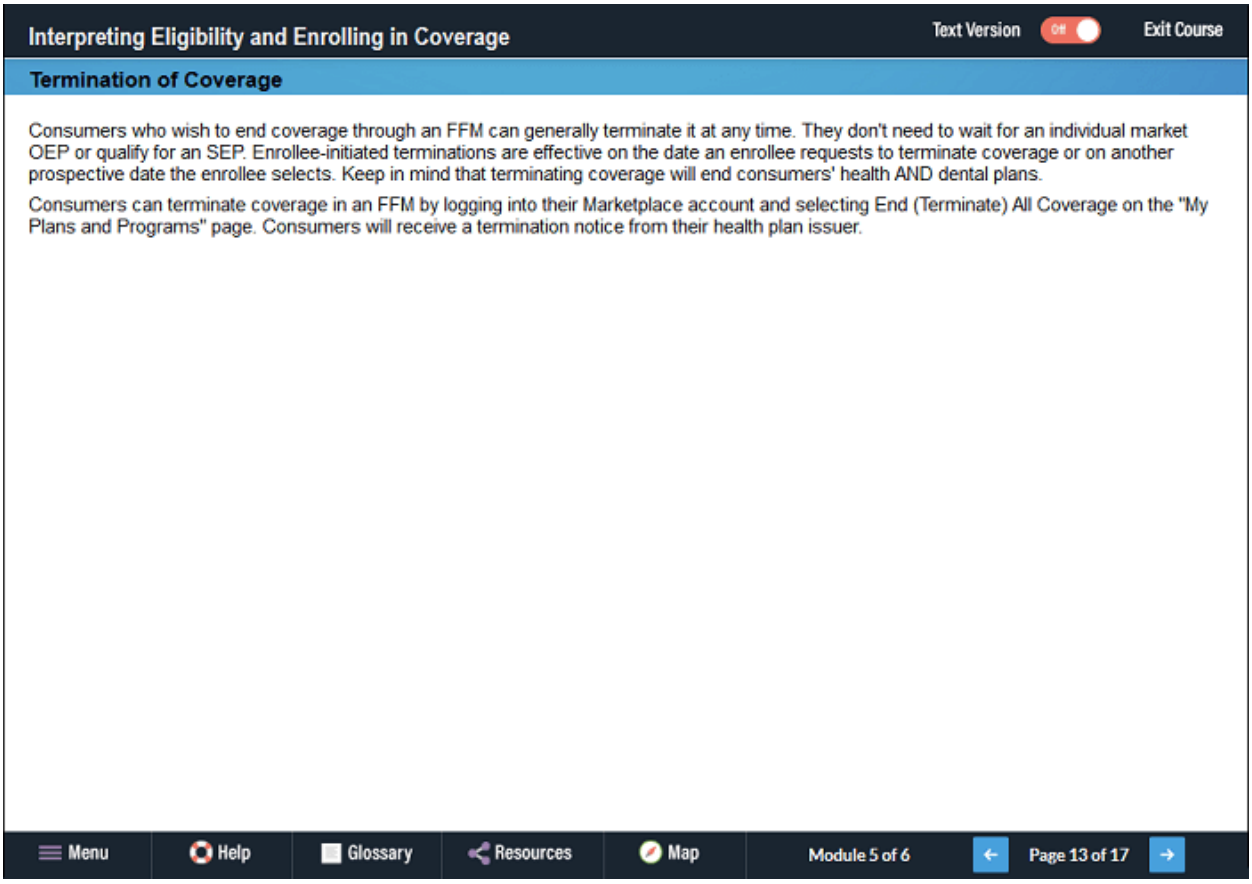


When consumers lose job-based insurance, their former employer may offer COBRA continuation coverage. Consumers who leave a job and are eligible for COBRA continuation coverage must be given an election period of at least 60 days to choose whether or not to elect continuation coverage (starting on the date they are furnished the election notice or the date they would lose coverage, whichever is later).

If consumers decide not to take COBRA coverage, they can generally choose to enroll in a QHP through an FFM instead. Remember, consumers who lose job-based coverage qualify for a 60-day SEP and may be eligible for APTC and CSRs that wouldn't be available to them if they enrolled in COBRA continuation coverage.

For more information about COBRA coverage and the FFMs, visit HealthCare.gov/unemployed/cobra-coverage/.

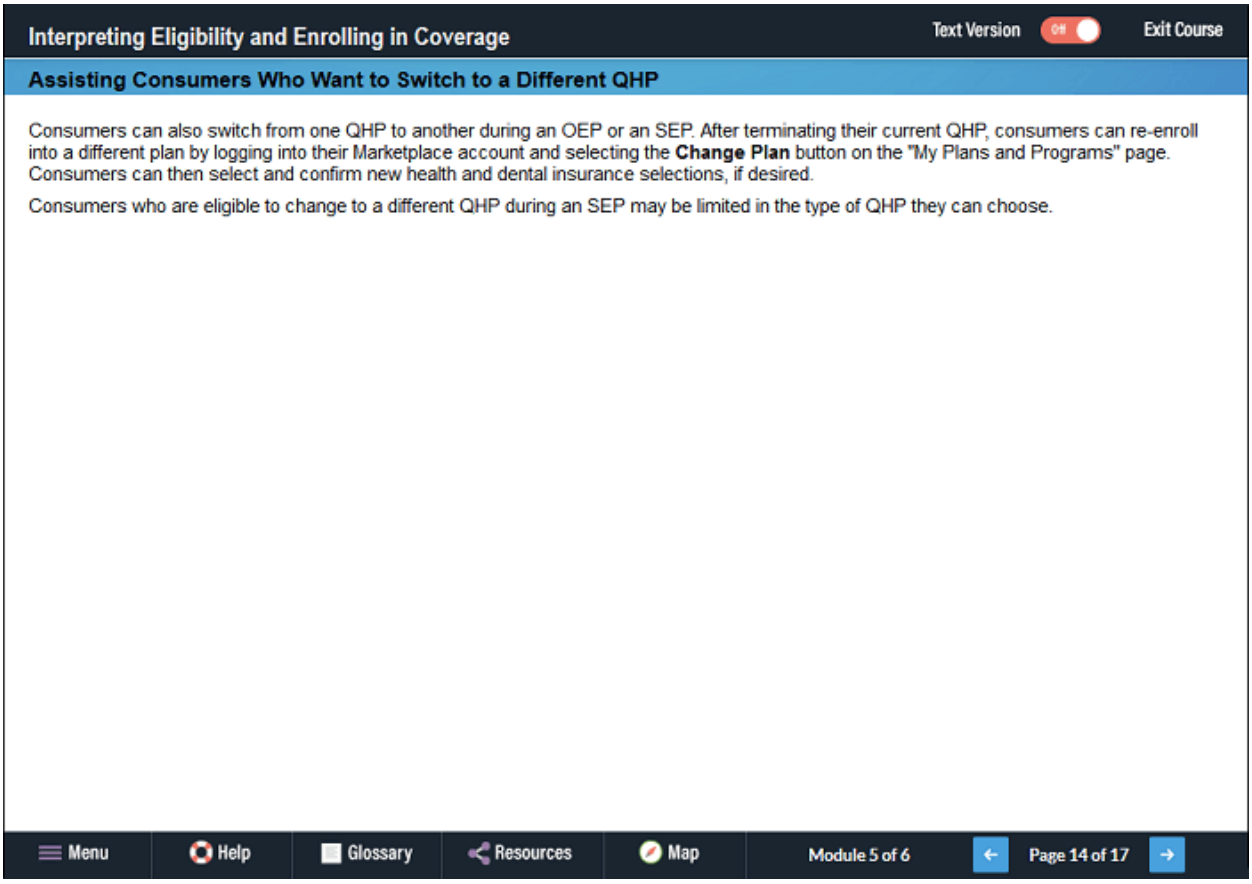
Termination of Coverage



Consumers who wish to end coverage through an FFM can generally terminate it at any time. They don't need to wait for an individual market OEP or qualify for an SEP. Enrollee-initiated terminations are effective on the date an enrollee requests to terminate coverage or on another prospective date the enrollee selects. Keep in mind that terminating coverage will end consumers' health AND dental plans.

Consumers can terminate coverage in an FFM by logging into their Marketplace account and selecting End (Terminate) All Coverage on the "My Plans and Programs" page. Consumers will receive a termination notice from their health plan issuer.

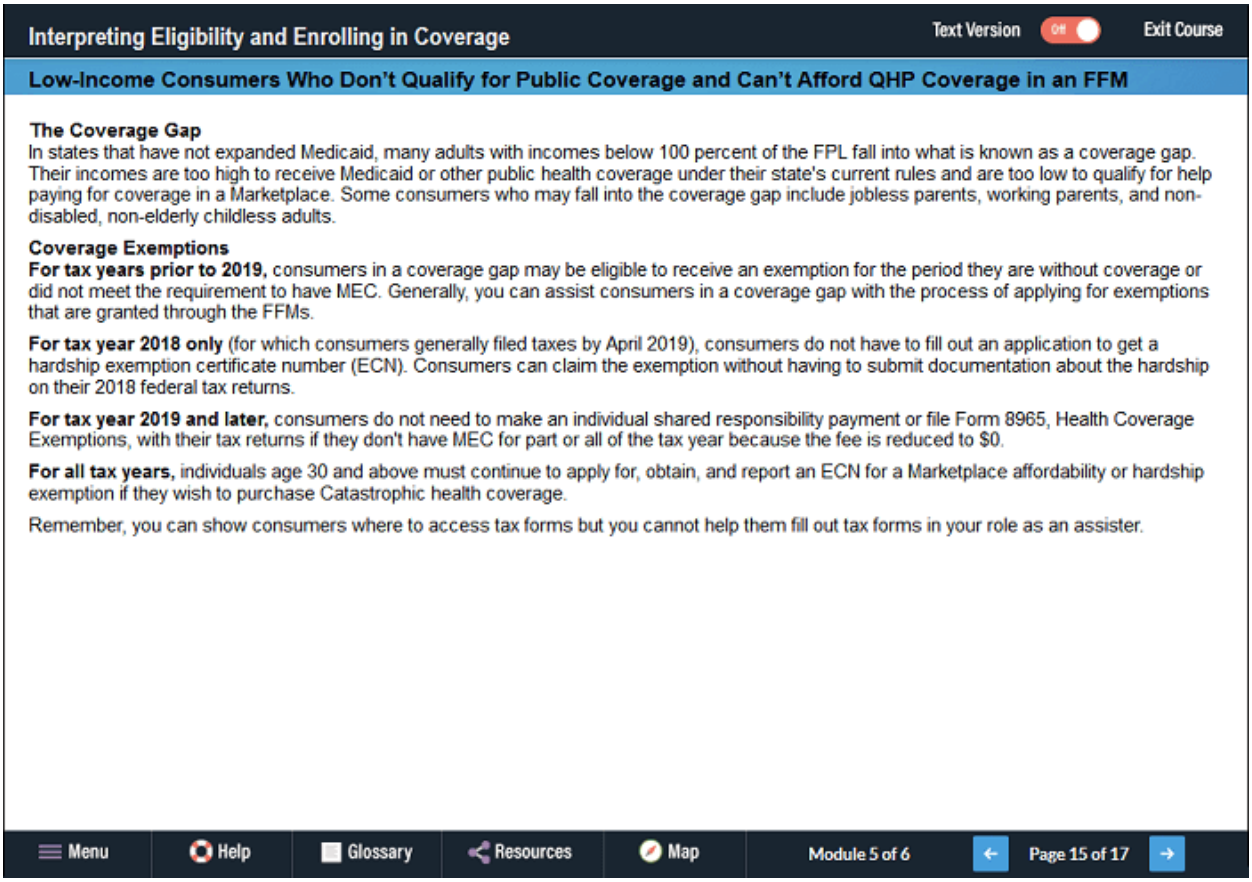
Assisting Consumers Who Want to Switch to a Different QHP



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

Consumers who are eligible to change to a different QHP during an SEP may be limited in the type of QHP they can choose.

Low-Income Consumers Who Don’t Qualify for Public Coverage and Can’t Afford QHP Coverage in an FFM



The Coverage Gap

In states that have not expanded Medicaid, many adults with incomes below 100 percent of the FPL fall into what is known as a coverage gap. Their incomes are too high to receive Medicaid or other public health coverage under their state's current rules and are too low to qualify for help paying for coverage in a Marketplace. Some consumers who may fall into the coverage gap include jobless parents, working parents, and non-disabled, non-elderly childless adults.

Coverage Exemptions

For tax years prior to 2019, consumers in a coverage gap may be eligible to receive an exemption for the period they are without coverage or did not meet the requirement to have MEC. Generally, you can assist consumers in a coverage gap with the process of applying for exemptions that are granted through the FFMs.

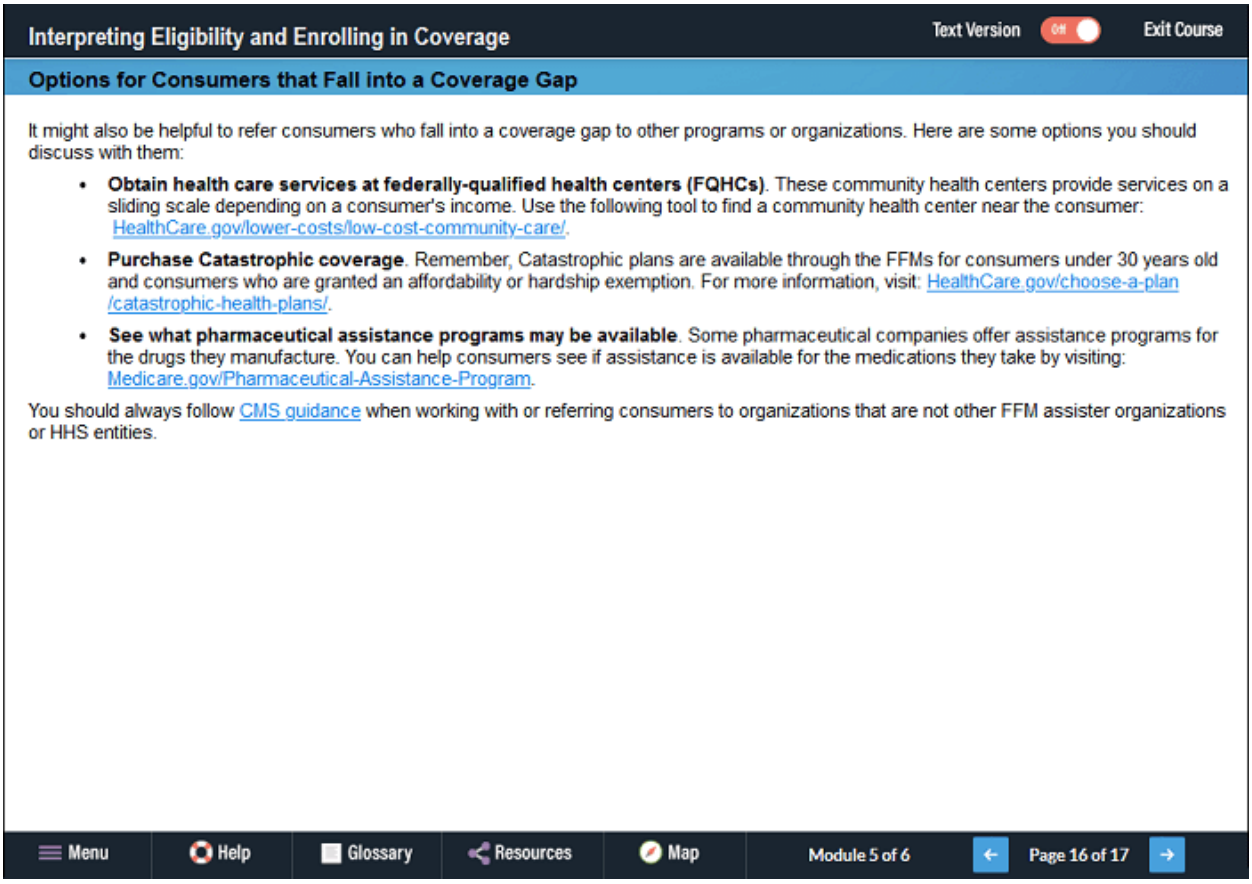
For tax year 2018 only (for which consumers generally filed taxes by April 2019), consumers do not have to fill out an application to get a hardship exemption certificate number (ECN). Consumers can claim the exemption without having to submit documentation about the hardship on their 2018 federal tax returns.

For tax year 2019 and later, consumers do not need to make an individual shared responsibility payment or file Form 8965, Health Coverage Exemptions, with their tax returns if they don't have MEC for part or all of the tax year because the fee is reduced to $0.

For all tax years, individuals age 30 and above must continue to apply for, obtain, and report an ECN for a Marketplace affordability or hardship exemption if they wish to purchase Catastrophic health coverage.

Remember, you can show consumers where to access tax forms but you cannot help them fill out tax forms in your role as an assister.

Options for Consumers that Fall into a Coverage Gap



It might also be helpful to refer consumers who fall into a coverage gap to other programs or organizations. Here are some options you should discuss with them:

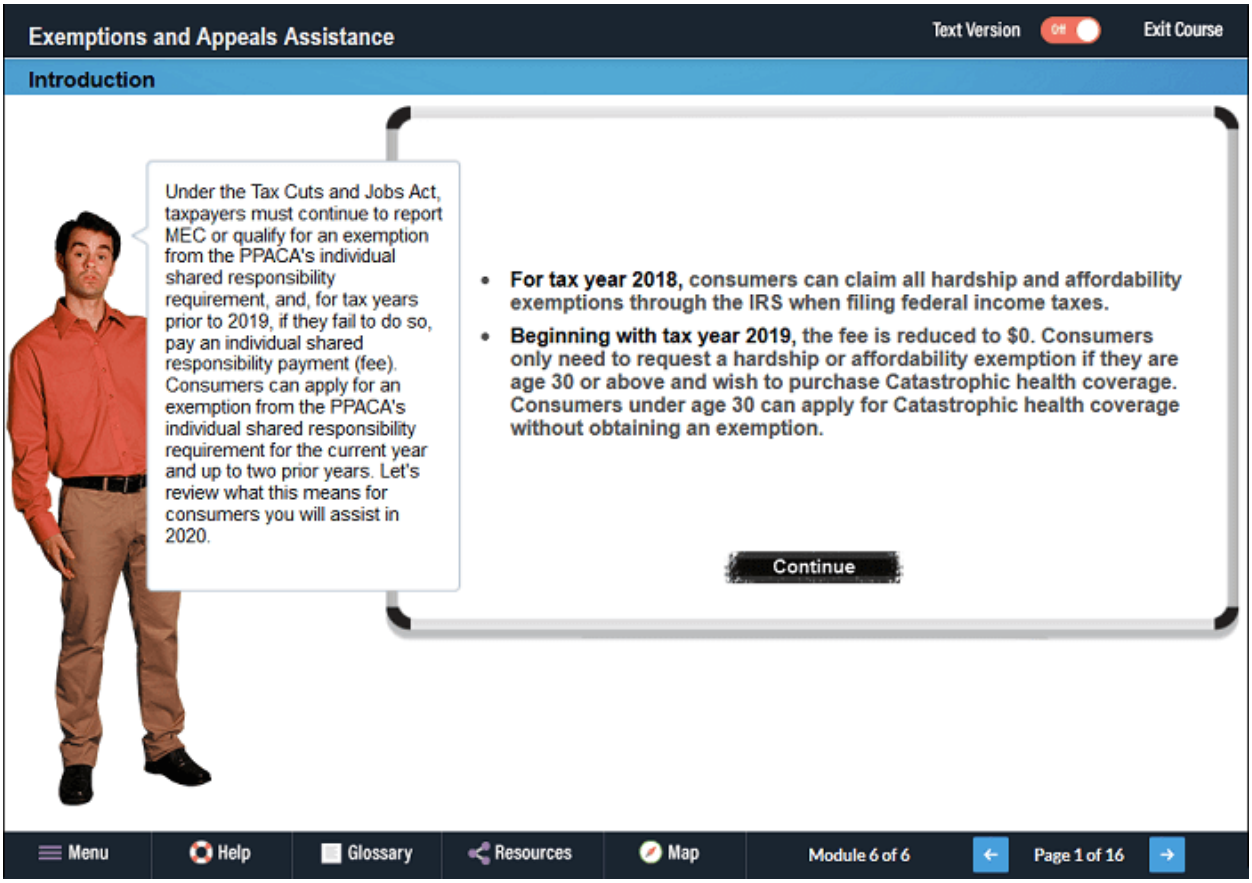
- **Obtain health care services at federally-qualified health centers (FQHCs)**. These community health centers provide services on a sliding scale depending on a consumer's income. Use the following tool to find a community health center near the consumer: HealthCare.gov/lower-costs/low-cost-community-care/.
- **Purchase Catastrophic coverage**. Remember, Catastrophic plans are available through the FFMs for consumers under 30 years old and consumers who are granted an affordability or hardship exemption. For more information, visit: HealthCare.gov/choose-a-plan/catastrophic-health-plans/.
- **See what pharmaceutical assistance programs may be available**. Some pharmaceutical companies offer assistance programs for the drugs they manufacture. You can help consumers see if assistance is available for the medications they take by visiting: Medicare.gov/Pharmaceutical-Assistance-Program.

You should always follow CMS guidance when working with or referring consumers to organizations that are not other FFM assister organizations or HHS entities.

Key Points

- Eligible consumers can set the amount of premium tax credit they would like to use in advance to lower their premium costs when they apply for or renew QHP coverage in an FFM. Consumers must reconcile the difference between any APTC they received during the year and the actual premium tax credit amount they qualified for based on their final income and household size.
- When helping consumers with plan comparison, show them all the QHP options they're eligible for and never provide recommendations about which plan or plans they should select.
- Some changes in circumstances are considered "qualifying life events" and may allow consumers to enroll in or change QHPs during an SEP.

Exemptions and Appeals Assistance
Introduction



Under the Tax Cuts and Jobs Act, taxpayers must continue to report MEC or qualify for an exemption from the PPACA's individual shared responsibility requirement, and, for tax years prior to 2019, if they fail to do so, pay an individual shared responsibility payment (fee). Consumers can apply for an exemption from the PPACA's individual shared responsibility requirement for the current year and up to two prior years. Let's review what this means for consumers you will assist in 2020.

- **For tax year 2018**, consumers can claim all hardship and affordability exemptions through the IRS when filing federal income taxes.
- **Beginning with tax year 2019**, the fee is reduced to $0. Consumers only need to request a hardship or affordability exemption if they are age 30 or above and wish to purchase Catastrophic health coverage. Consumers under age 30 can apply for Catastrophic health coverage without obtaining an exemption.

In this training module, we will review important policies and procedures that are in place in all states for which the FFMs are performing exemption determinations and eligibility appeals. As of the date this training was uploaded to the Marketplace Learning Management System, the FFMs are making exemption determinations in all states except California, Connecticut, Maryland, and the District of Columbia.

What counts as MEC?

- Any QHP sold in a Marketplace
- Individual health plans sold outside the Marketplaces
- Any "grandfathered" individual insurance plan you've had since March 23, 2010 or earlier
- Any job-based plan, including retiree plans and COBRA coverage, other than excepted benefits
- Medicare Part A or Part C (but Part B coverage by itself doesn't qualify)
- Most Medicaid coverage except for limited coverage plans

- CHIP, including coverage under CHIP buy-in programs
- Coverage under a parent's plan
- Most student health plans (check with your school to see if the plan counts as qualifying health coverage)
- Health coverage for Peace Corps volunteers
- Certain types of veterans' health coverage through the Department of Veterans Affairs
- Most TRICARE plans
- Department of Defense Nonappropriated Fund Health Benefits Program
- Refugee Medical Assistance
- State high-risk pools for plan or policy years that started on or before December 31, 2014 (check with your high-risk pool plan to see if it counts as qualifying health coverage)

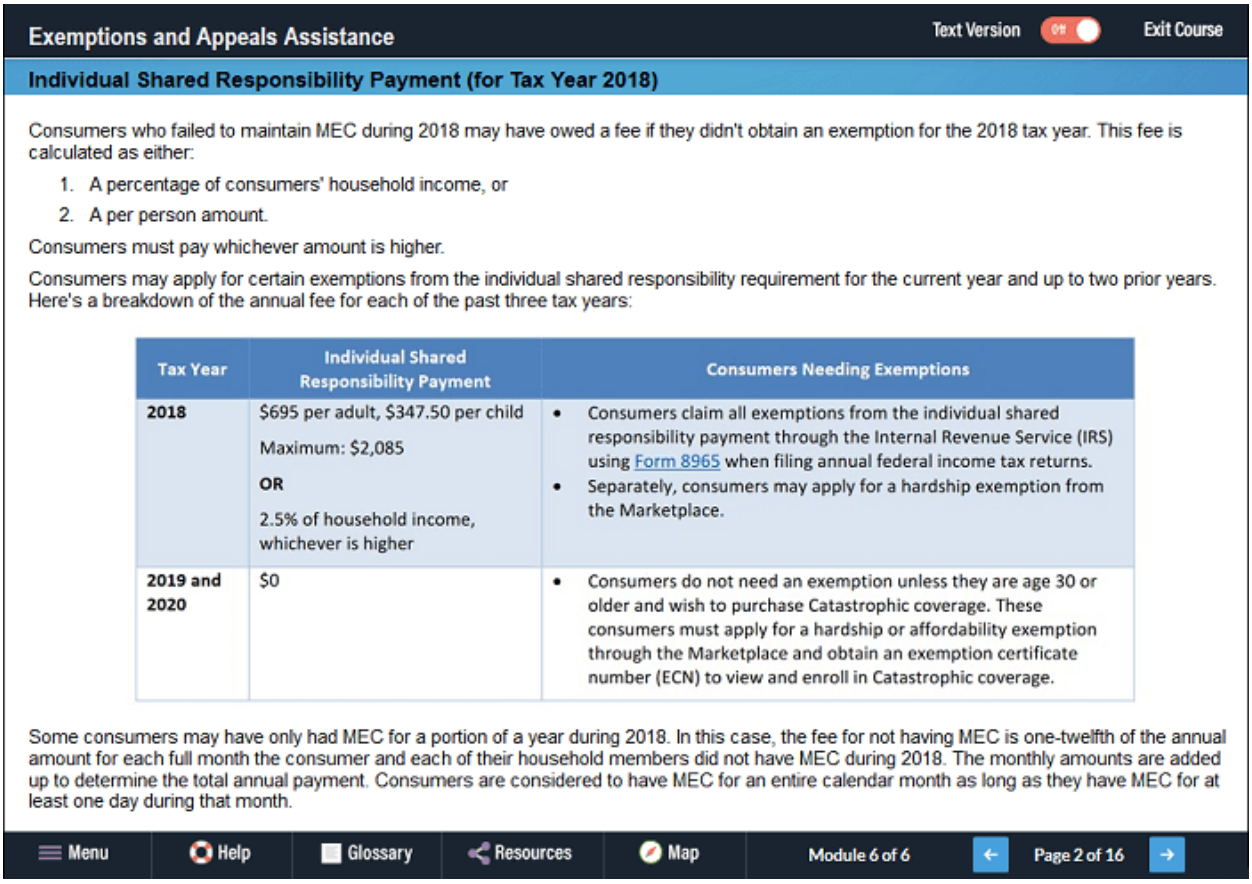
What does not count as MEC?

Some products that help consumers pay for medical services do not qualify as MEC.

Examples include:

- Coverage only for vision care or dental care
- Workers' compensation
- Coverage only for a specific disease or condition
- Plans that offer only discounts on medical services
- Short-term, limited-duration insurance policies designed for people who experience a temporary gap in health coverage

Individual Shared Responsibility Payment (for Tax Year 2018)



Consumers who failed to maintain MEC during 2018 may have owed a fee if they didn't obtain an exemption for the 2018 tax year. This fee is calculated as either:

1. A percentage of consumers' household income, or
2. A per person amount.

Consumers must pay whichever amount is higher.

Consumers may apply for certain exemptions from the individual shared responsibility requirement for the current year and up to two prior years. Here's a breakdown of the annual fee for each of the past three tax years:

Here's how the fee is calculated for tax year **2018**:

$695 per adult, $347.50 per child - Maximum: $2,085 OR 2.5% of household income, whichever is higher

Consumers needing exemptions:

- Consumers claim all exemptions from the individual shared responsibility payment through the Internal Revenue Service (IRS) using Form 8965 when filing annual federal income tax returns.
- Separately, consumers may apply for a hardship exemption from the Marketplace.

For tax years **2019 and 2020**:

$0

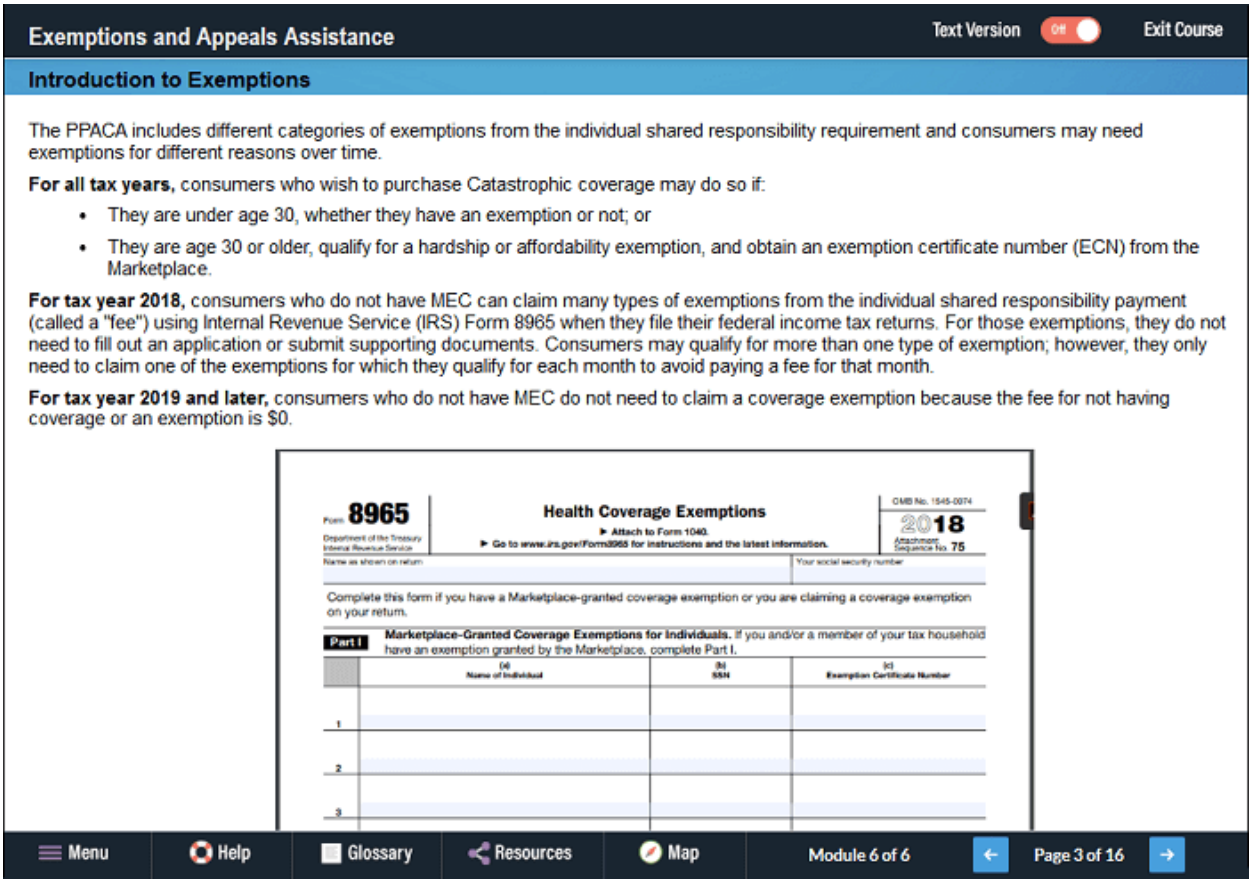
Consumers needing exemptions:

- Consumers do not need an exemption unless they are age 30 or older and wish to purchase Catastrophic coverage. These consumers must apply for a hardship or affordability exemption through the Marketplace and obtain an exception certificate number (ECN) to view and enroll in Catastrophic coverage.

Some consumers may have only had MEC for a portion of a year during 2018. In this case, the fee for not having MEC is one-twelfth of the annual amount for each full month the consumer and each of their household

members did not have MEC during 2018. The monthly amounts are added up to determine the total annual payment. Consumers are considered to have MEC for an entire calendar month as long as they have MEC for at least one day during that month.

Introduction to Exemptions



The PPACA includes different categories of exemptions from the individual shared responsibility requirement and consumers may need exemptions for different reasons over time.

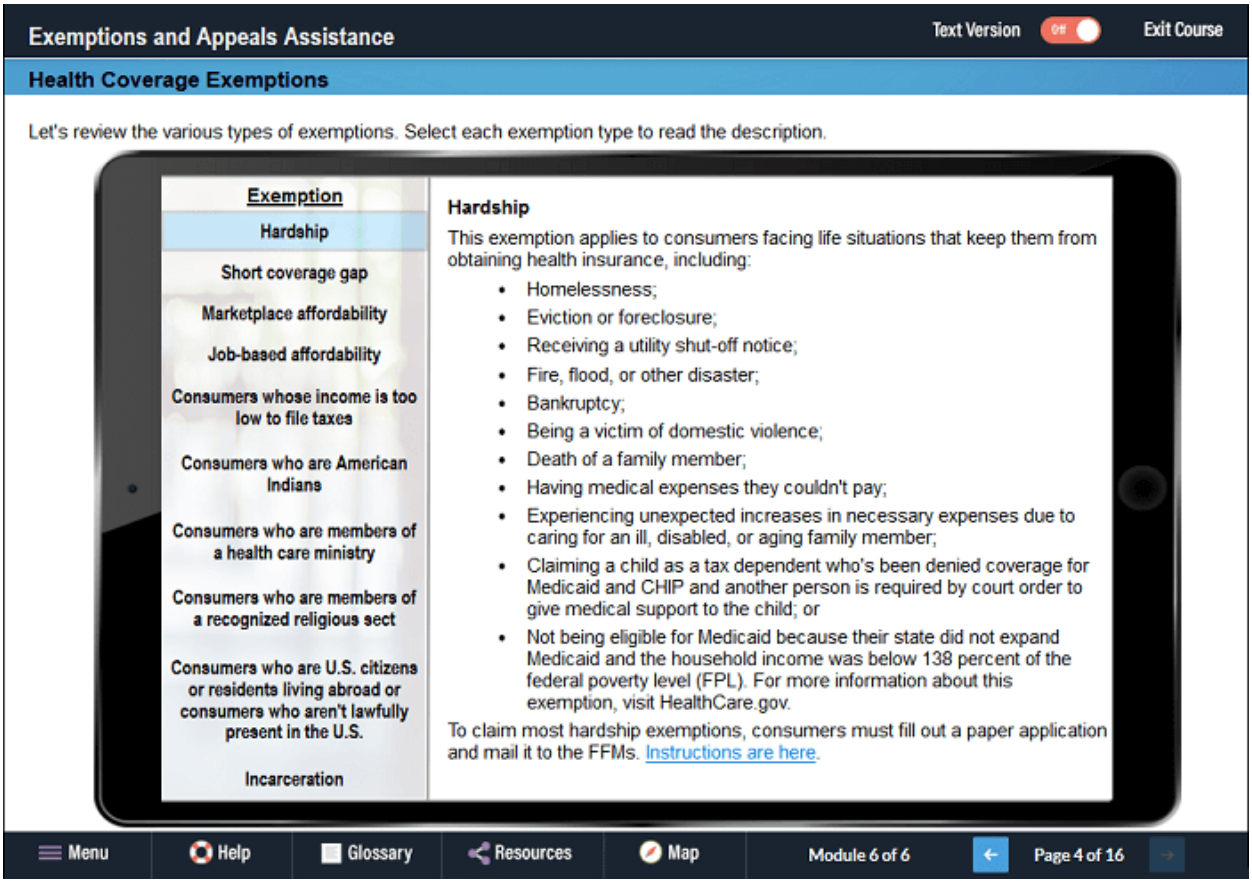
For all tax years, consumers who wish to purchase Catastrophic coverage may do so if:

- They are under age 30, whether they have an exemption or not; or
- They are age 30 or older, qualify for a hardship or affordability exemption, and obtain an exemption certificate number (ECN) from the Marketplace.

For tax year 2018, consumers who do not have MEC can claim many types of exemptions from the individual shared responsibility payment (called a "fee") using Internal Revenue Service (IRS) Form 8965 when they file their federal income tax returns. For those exemptions, they do not need to fill out an application or submit supporting documents. Consumers may qualify for more than one type of exemption; however, they only need to claim one of the exemptions for which they qualify for each month to avoid paying a fee for that month.

For tax year 2019 and later, consumers who do not have MEC do not need to claim a coverage exemption because the fee for not having coverage or an exemption is $0.

Health Coverage Exemptions



Let's review the various types of exemptions.

- Hardship
- Short coverage gap
- Marketplace affordability
- Job-based affordability
- Consumers whose income is too low to file taxes
- Consumers who are American Indians
- Consumers who are members of a health care sharing ministry
- Consumers who are members of a recognized religious sect
- Consumers who are U.S. citizens or residents living abroad or consumers who aren't lawfully present in the U.S.
- Incarceration

Hardship
This exemption applies to consumers facing life situations that keep them from obtaining health insurance, including:

- Homelessness;
- Eviction or foreclosure;
- Receiving a utility shut-off notice;
- Fire, flood, or other disaster;
- Bankruptcy;
- Being a victim of domestic violence;

- Death of a family member;
- Having medical expenses they couldn't pay;
- Experiencing unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member;
- Claiming a child as a tax dependent who's been denied coverage for Medicaid and CHIP and another person is required by court order to give medical support to the child; or
- Not being eligible for Medicaid because their state did not expand Medicaid and the household income was below 138 percent of the federal poverty level (FPL). For more information about this exemption, visit HealthCare.gov.

To claim most hardship exemptions, consumers must fill out a paper application and mail it to the FFMs. Instructions are here.

Short Coverage Gap
This exemption applies to each consumer in a household who failed to maintain MEC for a period less than three consecutive months. Consumers are considered covered for any month they had MEC for even one day. Consumers who have two or more coverage gaps during the year can claim this exemption only for the months of their first coverage gap.

Marketplace Affordability
If for 2018 the lowest-priced Bronze-level plan available through a Marketplace would have cost more than 8.05 percent of a consumer's household income, the consumer may claim this exemption through IRS when filing taxes for the applicable tax year. The consumers' total cost must have exceeded these percentages after any premium tax credit amount they would have been eligible for. Consumers claim the exemption on their tax return, and the exemption applies to everyone on the consumer's tax return.

Consumers age 30 or over who wish to enroll in Catastrophic coverage apply for this exemption through the Marketplace based on their projected annual household income at the beginning of a plan year. They qualify for the exemption if the lowest-priced Bronze-level plan available through a Marketplace would cost more than 8.24 percent (2020) of the consumer's projected household income.

You can find affordability exemption application information here.

Job-based affordability
Job-based health insurance is considered unaffordable in different ways depending on how the coverage is offered:

- For an employee: If the annual premium for the lowest-cost self-only plan (a plan that covers only the employee and not members of the employee's family) is more than 8.05 percent (2018), 8.3 percent (2019), or 8.24 percent (2020) of their annual household income.
- For the employee's spouse and dependents: If the annual premium for the lowest-cost family plan is more than 8.05 percent (2018), 8.3 percent (2019), or 8.24 percent (2020) of their annual household income.

If a consumer can claim this exemption for 2018, it may apply to everybody on the consumer's tax return who doesn't have coverage during the applicable tax year. This will depend on the cost of the coverage and who it's offered to.

Notes:

1. It's possible that an employee won't be eligible for this exemption because the self-only plan available to them is affordable. But other members of the household could be eligible for this exemption if family coverage offered to them is unaffordable.
2. If the lowest-price self-only plan an employer offers costs more than 9.86 percent (2019), 9.78 percent (2020), or 9.83 percent (2021) of an employee's total household income, the employee may be eligible for a premium tax credit if they buy a Marketplace insurance plan.

Consumers Whose Income is Too Low to File Taxes
This exemption applies to consumers whose household income is below the tax filing threshold. Consumers who don't file federal income tax returns because their gross household income is below the filing threshold are

automatically exempt. If a consumer qualifies, it's likely that the consumer's family members who did not have health coverage will also qualify for this exemption.

Consumers who are American Indians
This exemption applies to consumers who are members of a federally recognized tribe or are Indians eligible for services through the Indian Health Service, tribes or tribal organizations, or urban Indian organizations.

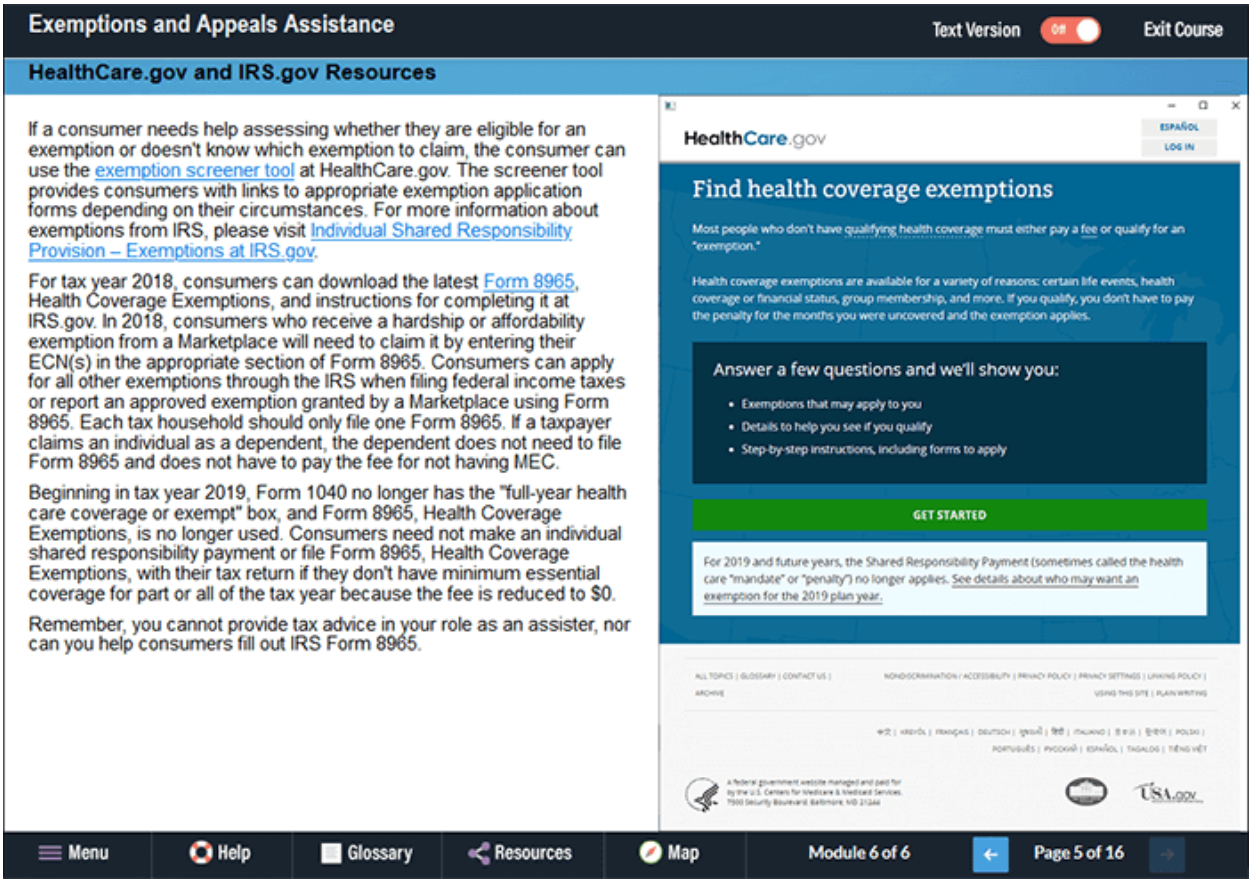
Consumers who are Members of a Health Care Sharing Ministry
This exemption applies to members of a tax-exempt organization whose members share a common set of ethical or religious beliefs and share medical expenses in accordance of those beliefs, even after a member develops a medical condition. The health care sharing ministry must have been in existence and sharing medical expenses continuously since December 31, 1999.

Consumers who are Members of a Recognized Religious Sect
This exemption applies to members of a religious sect or division that is recognized by the Social Security Administration as conscientiously opposed to accepting any insurance benefits, including Social Security and Medicare. The religious sect must have been in existence since December 31, 1950.

Consumers who are U.S. Citizens or Residents Living Abroad or Consumers who aren't Lawfully Present in the U.S.
This exemption is available for U.S. citizens who lived outside the U.S. for 330 days in the past 12 months or were bona fide residents of a foreign country for a full tax year, resident aliens meeting certain requirements, and "Dreamers."

Incarceration
This exemption is for consumers who were in prison, jail, or similar institution or correctional facility during the month. Incarceration doesn't include probation, parole, home confinement, or being held but not convicted of a crime. Consumers can apply for this exemption for any month they were incarcerated for at least one day.

HealthCare.gov and IRS.gov Resources



If a consumer needs help assessing whether they are eligible for an exemption or doesn't know which exemption to claim, the consumer can use the exemption screener tool at HealthCare.gov. The screener tool provides consumers with links to appropriate exemption application forms depending on their circumstances. For more information about exemptions from IRS, please visit Individual Shared Responsibility Provision – Exemptions at IRS.gov.

For tax year 2018, consumers can download the latest Form 8965, Health Coverage Exemptions, and instructions for completing it at IRS.gov. In 2018, consumers who receive a hardship or affordability exemption from a Marketplace will need to claim it by entering their ECN(s) in the appropriate section of Form 8965. Consumers can apply for all other exemptions through the IRS when filing federal income taxes or report an approved exemption granted by a Marketplace using Form 8965. Each tax household should only file one Form 8965. If a taxpayer claims an individual as a dependent, the dependent does not need to file Form 8965 and does not have to pay the fee for not having MEC.

Beginning in tax year 2019, Form 1040 no longer has the "full-year health care coverage or exempt" box, and Form 8965, Health Coverage Exemptions, is no longer used. Consumers need not make an individual shared responsibility payment or file Form 8965, Health Coverage Exemptions, with their tax return if they don't have minimum essential coverage for part or all of the tax year because the fee is reduced to $0.

Remember, you cannot provide tax advice in your role as an assister, nor can you help consumers fill out IRS Form 8965.

Applying for Exemptions through the Marketplace to Purchase Catastrophic Coverage

Remember, consumers under the age of 30 do not need to claim an exemption or obtain an ECN and will automatically see available Catastrophic health plan options when shopping for coverage. Consumers age 30 and older must apply for a hardship or affordability exemption through the Marketplace and obtain an ECN if they wish to view and enroll in Catastrophic coverage.

You should help these consumers identify and complete the appropriate hardship or affordability exemption application through the Marketplace. The applications are available at HealthCare.gov/exemption-form-instructions/.

Review the Marketplace exemption application process.

- Step 1: Personal Information
- Step 2: Household Information
- Step 3: Documents for Proof of Income
- Step 4: Read, Print, and Sign
- Step 5: Submit Application

Step 1: Personal Information
The application asks the consumer to fill out his or her personal information, including name, address, phone number, and whether the consumer wants to get information by email. If a consumer has a preferred spoken or written language other than English, the consumer should indicate that as well.

Step 2: Household Information
This section asks the consumer which household members they would like to include on the application. Consumers should provide demographic information for each household member, including income, any offers of job-based coverage, the type of hardship they're applying for, and dates of the hardship.

Key Tip: Consumers may need to claim all members of their tax household on an exemption application for their household to be considered for an exemption. .

Step 3: Documents for Proof of Income

To claim an affordability exemption, "proof of income" documents are needed, such as a recent pay stub and/or a letter from the consumer's employer verifying his or her income. Consumers may need to submit different documents depending on the type of exemption they're applying for.

Even if a consumer doesn't have all the required documents, you can encourage the consumer to start filling out the exemption application and identifying the documents he or she will need to gather and submit with the application.

Step 4: Read, Print, and Sign the Application
Remind the consumer to sign the application and confirm that all the information provided is accurate.

Step 5: Submit Application
Mail the completed application with supporting documents. Remember, the Marketplaces don't accept online or telephone exemption applications at this time. Consumers must mail all exemption applications to the Marketplaces with copies of their supporting documents at the following address:

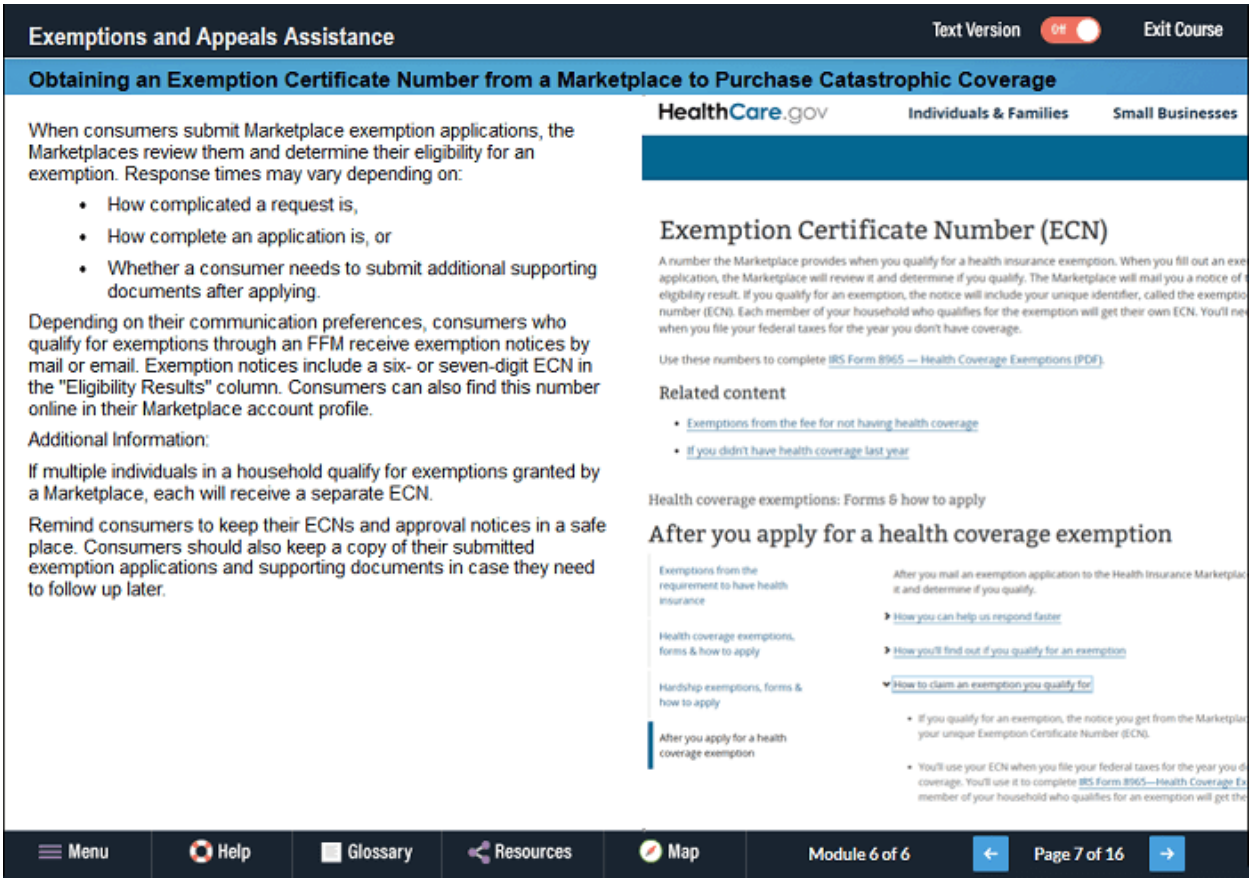
Health Insurance Marketplace®

Attn: Exemption Processing

465 Industrial Blvd.

London, KY 40741

Obtaining an Exemption Certificate Number from a Marketplace to Purchase Catastrophic Coverage



When consumers submit Marketplace exemption applications, the Marketplaces review them and determine their eligibility for an exemption. Response times may vary depending on:

- How complicated a request is,
- How complete an application is, or
- Whether a consumer needs to submit additional supporting documents after applying.

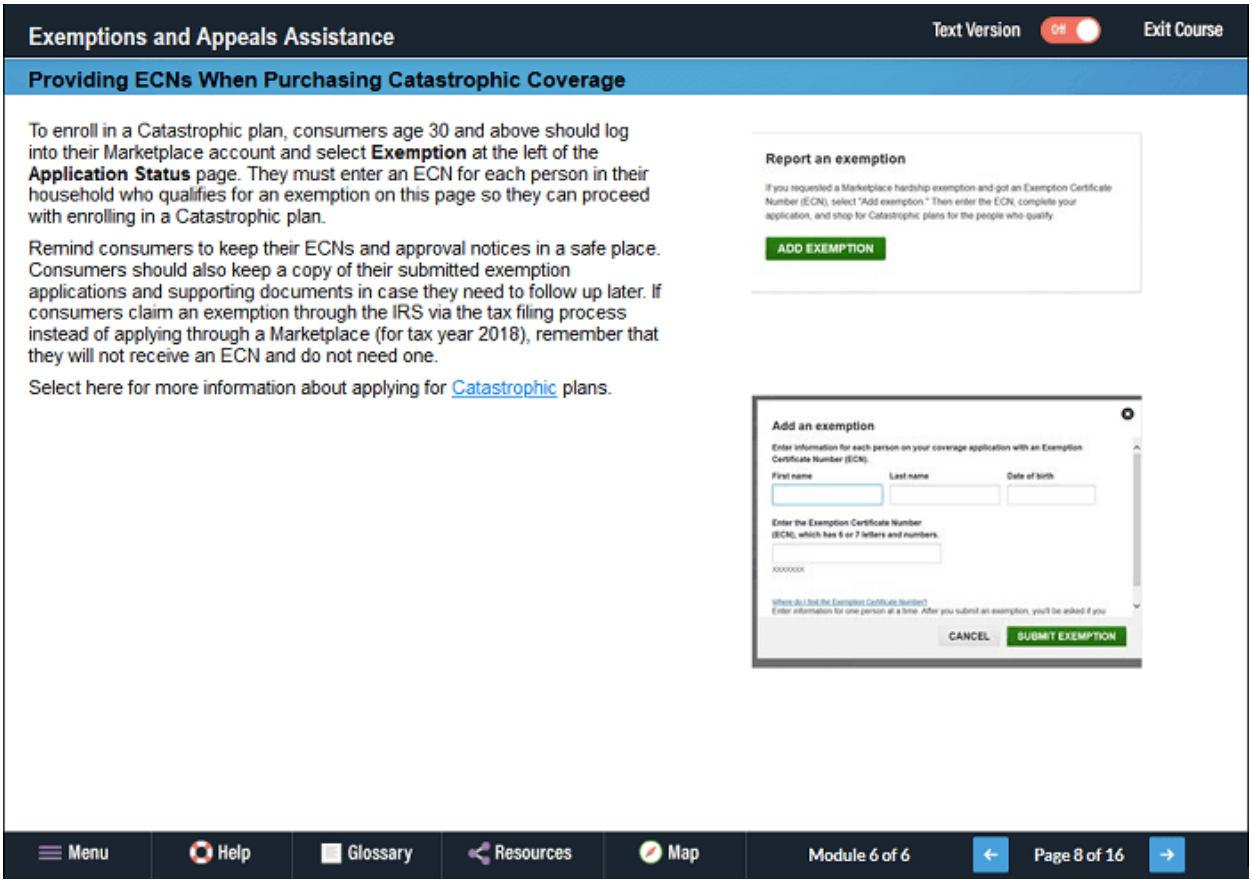
Depending on their communication preferences, consumers who qualify for exemptions through an FFM receive exemption notices by mail or email. Exemption notices include a six- or seven-digit ECN in the "Eligibility Results" column. Consumers can also find this number online in their Marketplace account profile.

Additional Information:

If multiple individuals in a household qualify for exemptions granted by a Marketplace, each will receive a separate ECN.

Remind consumers to keep their ECNs and approval notices in a safe place. Consumers should also keep a copy of their submitted exemption applications and supporting documents in case they need to follow up later.

Providing ECNs When Purchasing Catastrophic Coverage

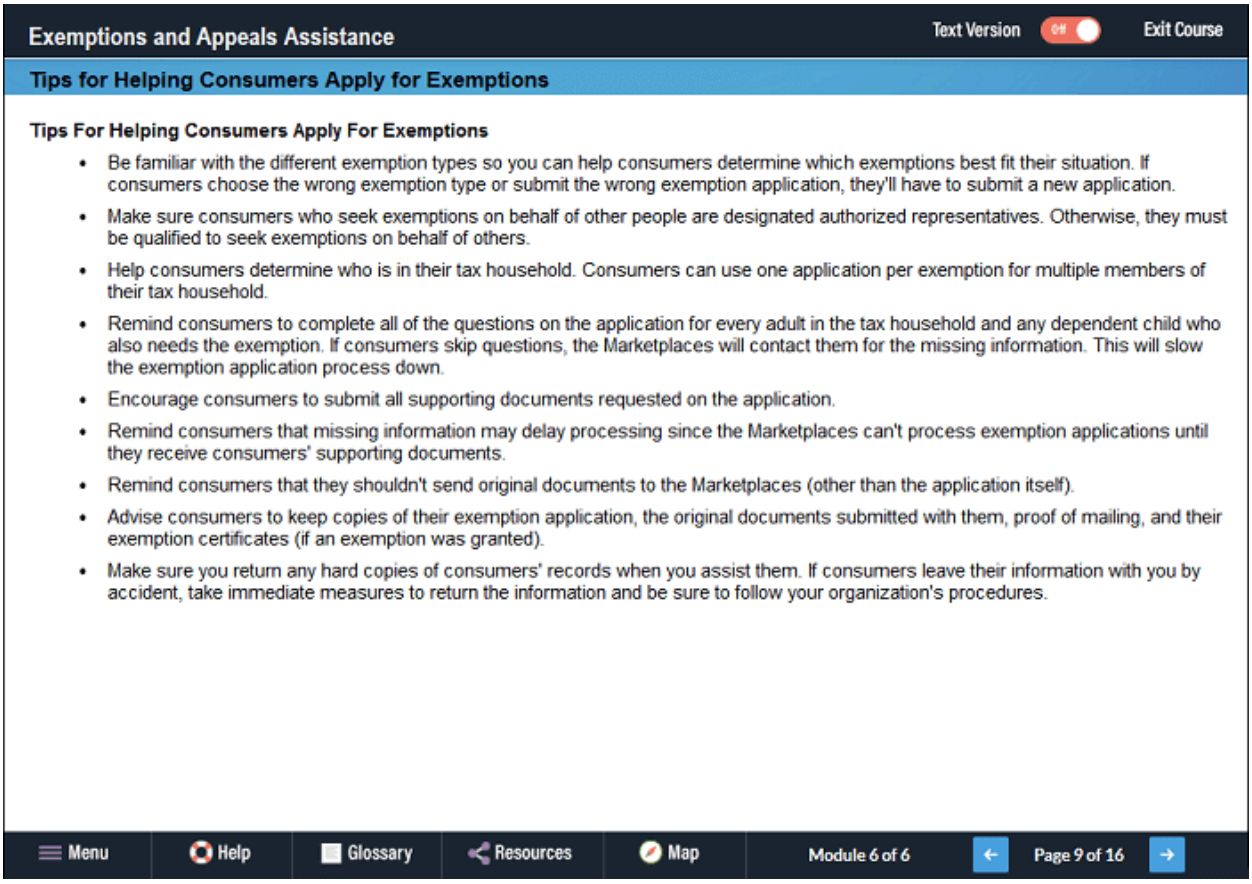


To enroll in a Catastrophic plan, consumers age 30 and above should log into their Marketplace account and select Exemption at the left of the Application Status page. They must enter an ECN for each person in their household who qualifies for an exemption on this page so they can proceed with enrolling in a Catastrophic plan.

Remind consumers to keep their ECNs and approval notices in a safe place. Consumers should also keep a copy of their submitted exemption applications and supporting documents in case they need to follow up later. If consumers claim an exemption through the IRS via the tax filing process instead of applying through a Marketplace (for tax year 2018), remember that they will not receive an ECN and do not need one.

Select here for more information about applying for Catastrophic plans.

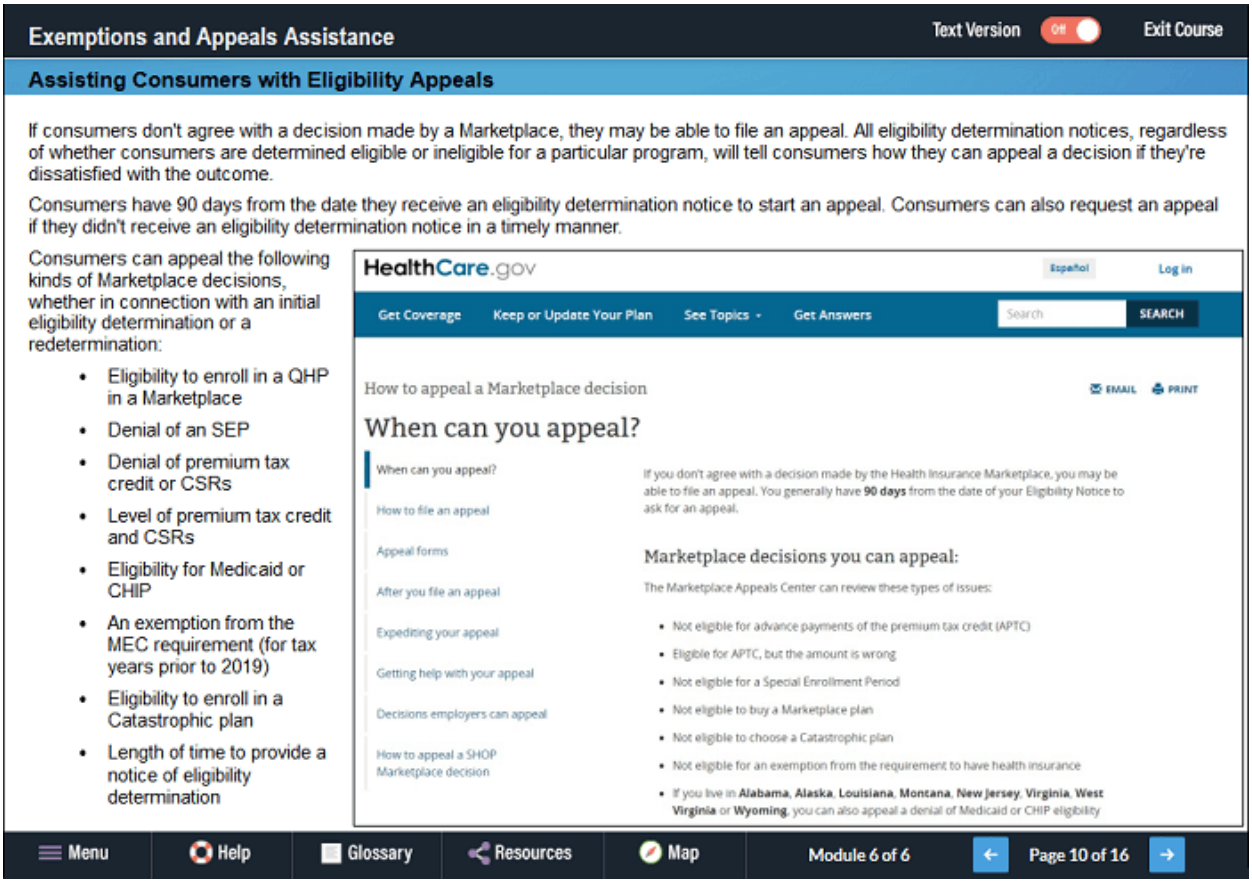
Tips for Helping Consumers Apply for Exemptions



Tips For Helping Consumers Apply For Exemptions

- Be familiar with the different exemption types so you can help consumers determine which exemptions best fit their situation. If consumers choose the wrong exemption type or submit the wrong exemption application, they'll have to submit a new application.
- Make sure consumers who seek exemptions on behalf of other people are designated authorized representatives. Otherwise, they must be qualified to seek exemptions on behalf of others.
- Help consumers determine who is in their tax household. Consumers can use one application per exemption for multiple members of their tax household.
- Remind consumers to complete all of the questions on the application for every adult in the tax household and any dependent child who also needs the exemption. If consumers skip questions, the Marketplaces will contact them for the missing information. This will slow the exemption application process down.
- Encourage consumers to submit all supporting documents requested on the application.
- Remind consumers that missing information may delay processing since the Marketplaces can't process exemption applications until they receive consumers' supporting documents.
- Remind consumers that they shouldn't send original documents to the Marketplaces (other than the application itself).
- Advise consumers to keep copies of their exemption application, the original documents submitted with them, proof of mailing, and their exemption certificates (if an exemption was granted).
- Make sure you return any hard copies of consumers' records when you assist them. If consumers leave their information with you by accident, take immediate measures to return the information and be sure to follow your organization's procedures.

Assisting Consumers with Eligibility Appeals



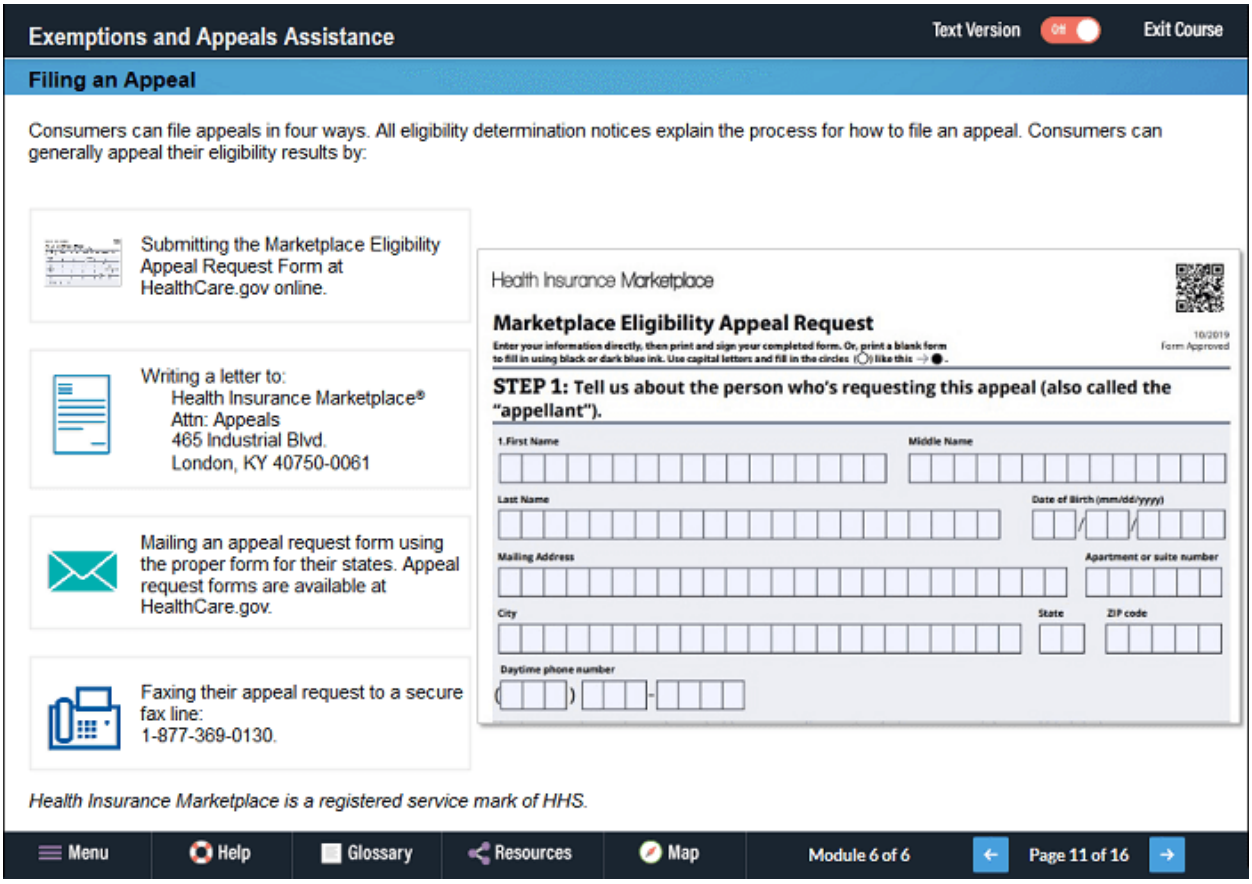
If consumers don't agree with a decision made by a Marketplace, they may be able to file an appeal. All eligibility determination notices, regardless of whether consumers are determined eligible or ineligible for a particular program, will tell consumers how they can appeal a decision if they're dissatisfied with the outcome.

Consumers have 90 days from the date they receive an eligibility determination notice to start an appeal. Consumers can also request an appeal if they didn't receive an eligibility determination notice in a timely manner.

Consumers can appeal the following kinds of Marketplace decisions, whether in connection with an initial eligibility determination or a redetermination:

- Eligibility to enroll in a QHP in a Marketplace
- Denial of an SEP
- Denial of premium tax credit or CSRs
- Level of premium tax credit and CSRs
- Eligibility for Medicaid or CHIP
- An exemption from the MEC requirement (for tax years prior to 2019)
- Eligibility to enroll in a Catastrophic plan
- Length of time to provide a notice of eligibility determination

Filing an Appeal



Consumers can file appeals in four ways. All eligibility determination notices explain the process for how to file an appeal. Consumers can generally appeal their eligibility results by:

- Submitting the Marketplace Eligibility Appeal Request Form at HealthCare.gov online.
- Writing a letter to:

  Health Insurance Marketplace®

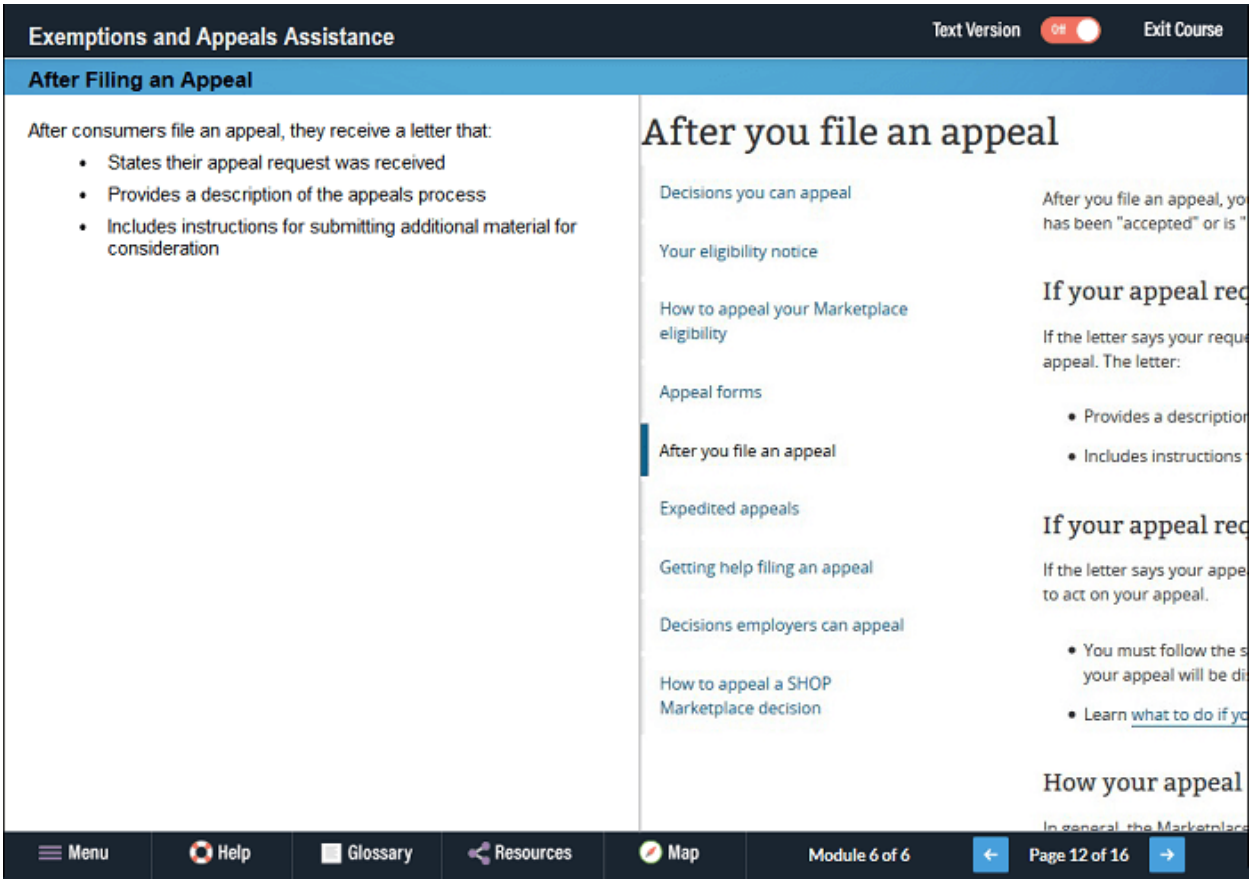
  Attn: Appeals

  465 Industrial Blvd.

  London, KY 40750-0061
- Mailing an appeal request form using the proper form for their states. Appeal request forms are available at HealthCare.gov.
- Faxing their appeal request to a secure fax line: 1-877-369-0130.

Health Insurance Marketplace is a registered service mark of HHS.

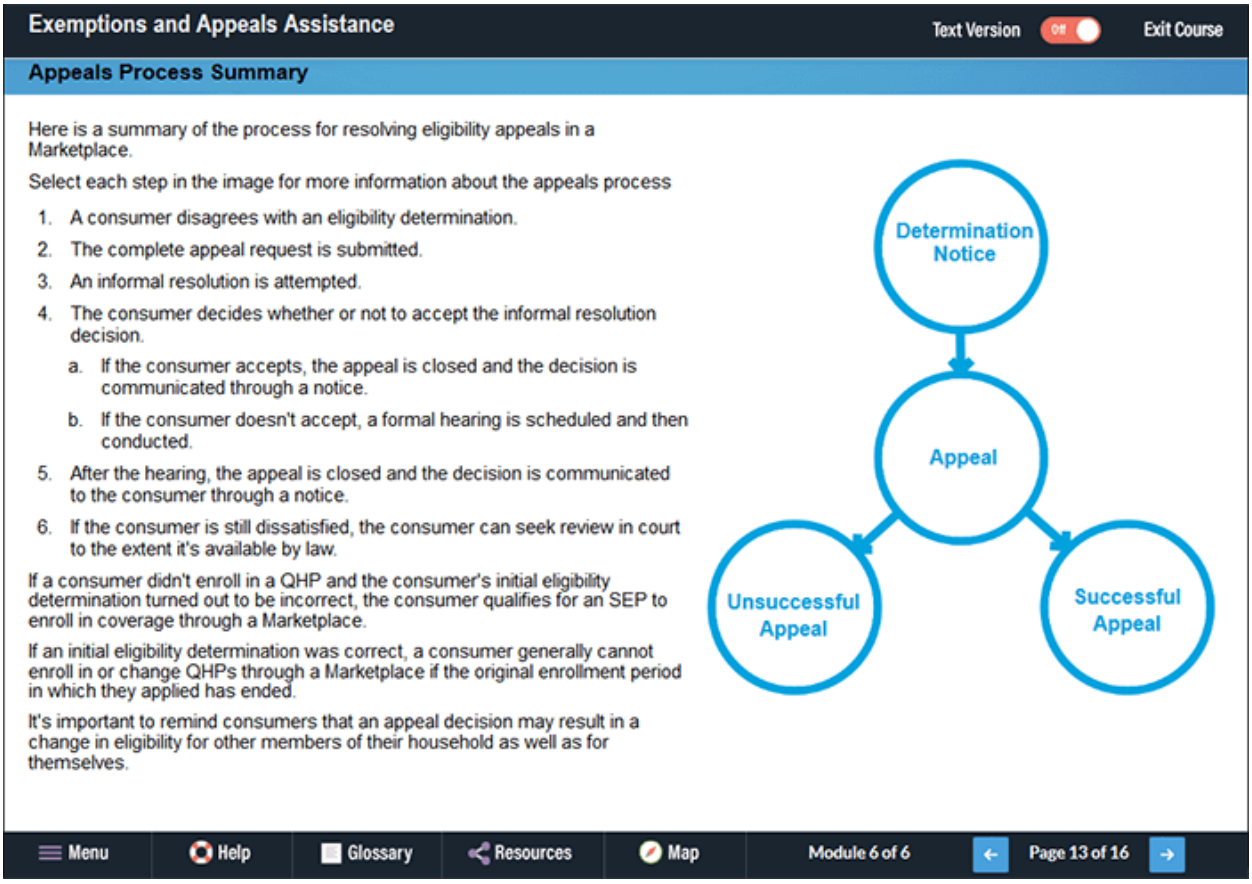
After Filing an Appeal



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

- States their appeal request was received
- Provides a description of the appeals process
- Includes instructions for submitting additional material for consideration

Appeals Process Summary



Here is a summary of the process for resolving eligibility appeals in a Marketplace.

1. A consumer disagrees with an eligibility determination.
2. The complete appeal request is submitted.
3. An informal resolution is attempted.
4. The consumer decides whether or not to accept the informal resolution decision.
    a. If the consumer accepts, the appeal is closed and the decision is communicated through a notice.
    b. If the consumer doesn't accept, a formal hearing is scheduled and then conducted.
5. After the hearing, the appeal is closed and the decision is communicated to the consumer through a notice.
6. If the consumer is still dissatisfied, the consumer can seek review in court to the extent it's available by law.

If a consumer didn't enroll in a QHP and the consumer's initial eligibility determination turned out to be incorrect, the consumer qualifies for an SEP to enroll in coverage through a Marketplace.

If an initial eligibility determination was correct, a consumer generally cannot enroll in or change QHPs through a Marketplace if the original enrollment period in which they applied has ended.

It's important to remind consumers that an appeal decision may result in a change in eligibility for other members of their household as well as for themselves.

Determination Notice
Consumers in states that delegated authority to the Marketplace to make final Medicaid and CHIP eligibility determinations may receive eligibility determination notices from the Marketplace that indicate they're eligible to enroll in Marketplace plans but not eligible to enroll in Medicaid or CHIP. If consumers believe they should have qualified for Medicaid or CHIP, they may wish to file an appeal. Most Medicaid and CHIP determination notices state that consumers who are denied Medicaid eligibility can appeal their determination through their state Medicaid or CHIP agency, or they can file an appeal with the Marketplace if their state delegated

authority to the Marketplace to hear such appeals.

Some states don't allow the Marketplaces to make final eligibility determinations for Medicaid and CHIP. In these states, the Marketplaces assess whether consumers are eligible for Medicaid or CHIP. If consumers in assessment states apply for help paying for coverage, they receive a notice from the Marketplace that states whether they are eligible to enroll in a QHP and get APTC/CSRs. The notice includes an initial assessment from the Marketplace of their eligibility for Medicaid or CHIP. However, consumers who are assessed eligible receive final Medicaid or CHIP eligibility determination notices from their state Medicaid or CHIP agency.

If consumers wish to appeal their Medicaid or CHIP eligibility, they should follow the instructions in their eligibility determination notice from the state agency for filing an appeal with the state. Consumers in assessment states cannot file Medicaid or CHIP appeals with the Marketplace.

Appeal
Consumers in Medicaid assessment states should follow the instructions on their Medicaid or CHIP eligibility determination notice if they wish to appeal determinations indicating that they are not eligible for Medicaid or CHIP.

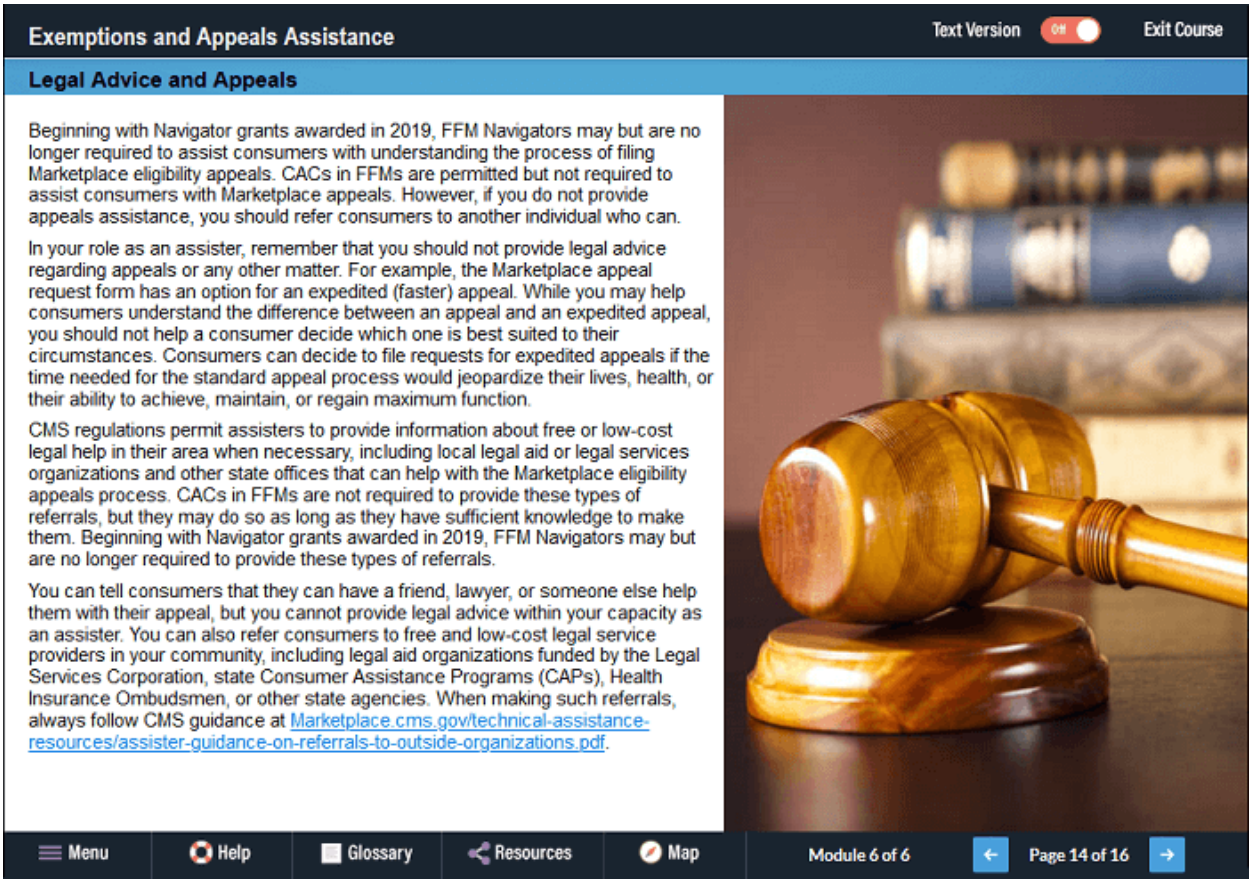
Unsuccessful Appeal
If the appeal process results in a decision that the initial eligibility determination was correct, that determination stands and the consumer is not eligible for Medicaid or CHIP. That concludes the administrative process, but the appeal decision explaining this outcome includes information about any available judicial reviews.

If individuals are unsuccessful in appealing their eligibility for Medicaid or CHIP coverage, they can still enroll in Marketplace insurance through a Special Enrollment Period (SEP) if eligible. Additionally, consumers who were originally determined eligible for APTC/CSRs through a Marketplace remain eligible for those programs. Remember, consumers can appeal their eligibility determinations for PTCs and CSRs as well.

Sometimes consumers may appeal because they think they should have been determined eligible for a larger PTC and don't want to pay the premium for coverage through a Marketplace until they get the larger PTC amount. If it turns out that the initial eligibility determination was correct, the consumer cannot enroll in or change plans through the Marketplace if the original enrollment period in which they applied has ended.

Successful Appeal
If it turns out the initial eligibility determination was wrong and consumers didn't enroll in a plan, they will receive an SEP to enroll in Marketplace insurance.

Legal Advice and Appeals



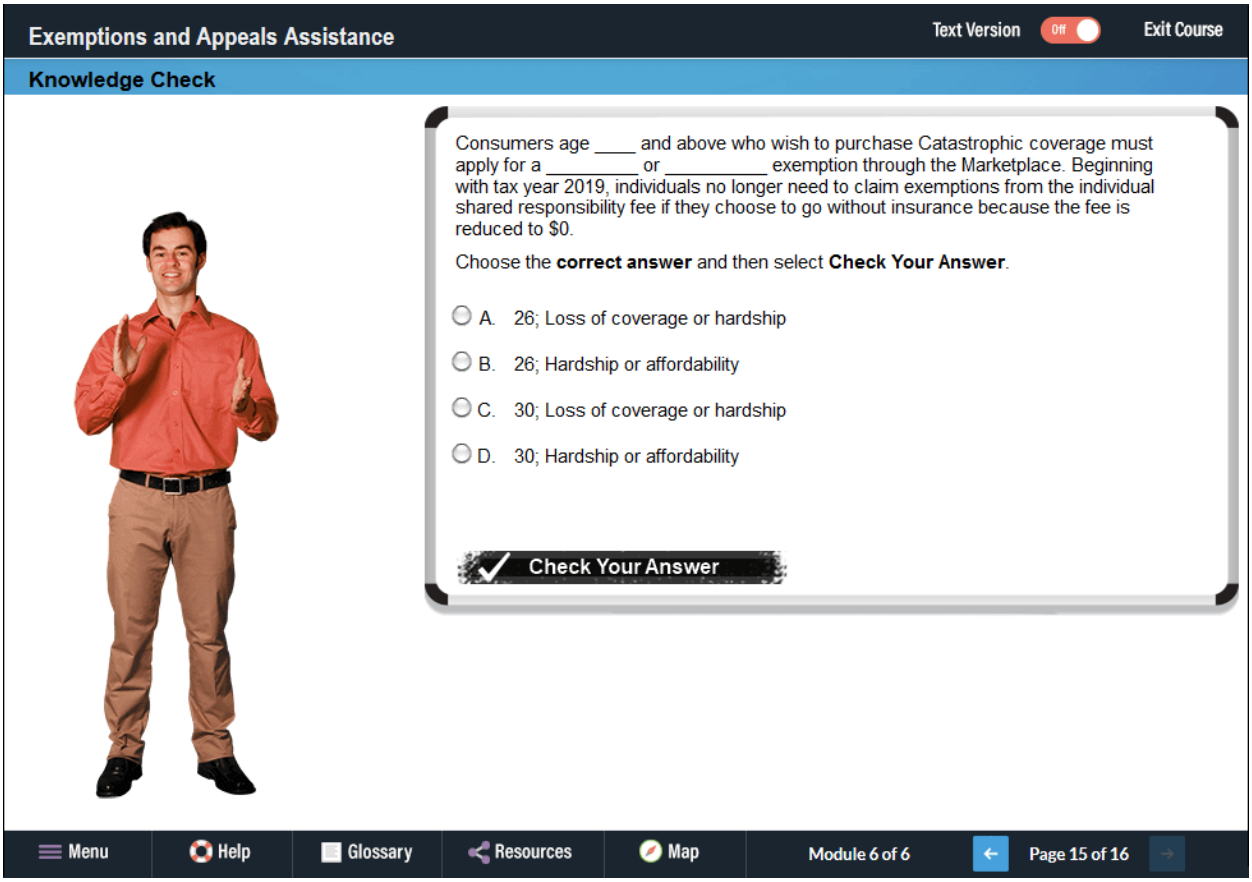
Beginning with Navigator grants awarded in 2019, FFM Navigators may but are no longer required to assist consumers with understanding the process of filing Marketplace eligibility appeals. CACs in FFMs are permitted but not required to assist consumers with Marketplace appeals. However, if you do not provide appeals assistance, you should refer consumers to another individual who can.

In your role as an assister, remember that you should not provide legal advice regarding appeals or any other matter. For example, the Marketplace appeal request form has an option for an expedited (faster) appeal. While you may help consumers understand the difference between an appeal and an expedited appeal, you should not help a consumer decide which one is best suited to their circumstances. Consumers can decide to file requests for expedited appeals if the time needed for the standard appeal process would jeopardize their lives, health, or their ability to achieve, maintain, or regain maximum function.

CMS regulations permit assisters to provide information about free or low-cost legal help in their area when necessary, including local legal aid or legal services organizations and other state offices that can help with the Marketplace eligibility appeals process. CACs in FFMs are not required to provide these types of referrals, but they may do so as long as they have sufficient knowledge to make them. Beginning with Navigator grants awarded in 2019, FFM Navigators may but are no longer required to provide these types of referrals.

You can tell consumers that they can have a friend, lawyer, or someone else help them with their appeal, but you cannot provide legal advice within your capacity as an assister. You can also refer consumers to free and low-cost legal service providers in your community, including legal aid organizations funded by the Legal Services Corporation, state Consumer Assistance Programs (CAPs), Health Insurance Ombudsmen, or other state agencies. When making such referrals, always follow CMS guidance at Marketplace.cms.gov/technical-assistance-resources/assister-guidance-on-referrals-to-outside-organizations.pdf.

Knowledge Check



Consumers age ____ and above who wish to purchase Catastrophic coverage must apply for a _____ or _____ exemption through the Marketplace. Beginning with tax year 2019, individuals no longer need to claim exemptions from the individual shared responsibility fee if they choose to go without insurance because the fee is reduced to $0.

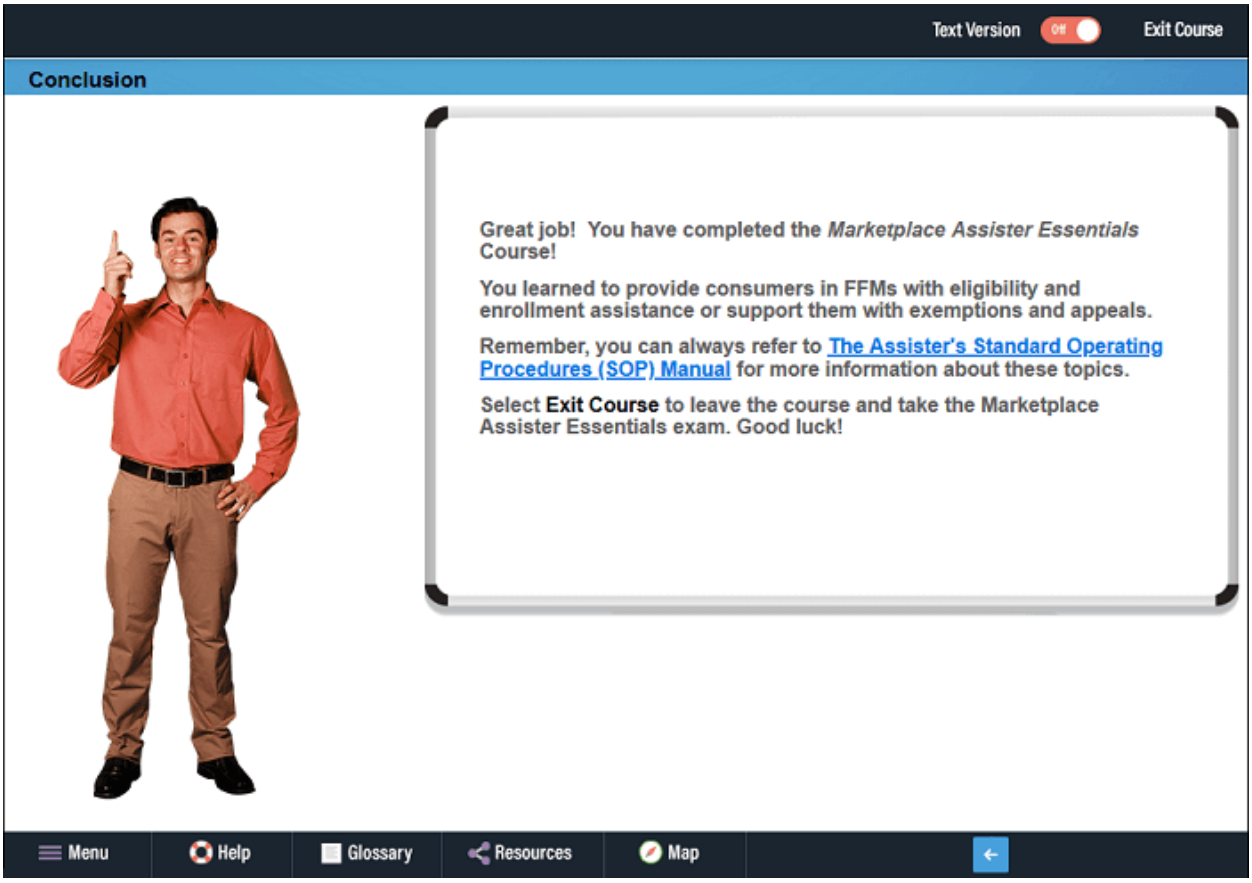
A. 26; Loss of coverage or hardship
B. 26; Hardship or affordability
C. 30; Loss of coverage or hardship
D. 30; Hardship or affordability

The correct answer is D. Consumers age 30 and above who wish to purchase Catastrophic coverage must apply for a hardship or affordability exemption through the Marketplace. Consumers under age 30 do not need an exemption to purchase Catastrophic coverage.

Key Points

- Beginning with tax year 2019, individuals who choose to go without insurance are no longer subject to making individual shared responsibility payments.
- In situations where multiple household members qualify for exemptions, each consumer in the household will receive a separate ECN.
- If consumers don't agree with a decision made by a Marketplace, they may be able to file an appeal.
- When you're assisting consumers, you should never provide tax or legal advice regarding exemptions, appeals, or any other matter.

Conclusion



Great job! You have completed the *Marketplace Assister Essentials* Course!

You learned to provide consumers in FFMs with eligibility and enrollment assistance or support them with exemptions and appeals.

Remember, you can always refer to The Assister's Standard Operating Procedures (SOP) Manual for more information about these topics.

Resources

Resources Page for Assisters on Medicare.gov:

Information on joining a Medicare health plan or drug plan.
https://www.medicare.gov/sign-up-change-plans/when-can-i-join-a-health-or-drug-plan/when-can-i-join-a-health-or-drug-plan.html

SHOP Marketplace Overview
A summary of the Small Business Health Options Marketplace Program.
https://www.healthcare.gov/small-businesses/provide-shop-coverage/shop-marketplace-overview/

The Assister's Standard Operation Procedures (SOP) Manual
The SOP Manual serves as your primary guide to helping consumers with activities within the individual market Federal-facilitated Marketplaces (FFMs, such as enrolling in health coverage).
https://marketplace.cms.gov/technical-assistance-resources/the-assisters-sop-manual.html

Tips to get started in the Health Insurance Marketplace®
Five tips about the Health Insurance Marketplace®.
https://www.healthcare.gov/quick-guide/one-page-guide-to-the-marketplace/

Incarceration
Information regarding incarceration and the Marketplace.
https://www.healthcare.gov/incarcerated-people/

Savings Estimator Tool
Provides consumers with a quick view of income levels that qualify for savings in 2019.
https://www.healthcare.gov/lower-costs

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

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

TRICARE and the PPACA
A summary of how consumers with TRICARE coverage are affected by the PPACA and associated regulations.
https://tricare.mil/About/MEC.aspx

5 Things Assisters Should Know about Data Matching Terminations
Information about how data matching issues impact consumers.
https://marketplace.cms.gov/technical-assistance-resources/data-matching-terminations.pdf

Income Definitions for Marketplace and Medicaid Coverage
Information regarding how Modified Adjusted Gross Income (MAGI) is calculated for the Marketplace and Medicaid.
http://www.healthreformbeyondthebasics.org/key-facts-income-definitions-for-marketplace-and-medicaid-coverage/

Medicaid and CHIP: Fast Facts for Assisters
Summary of important facts regarding Medicaid and CHIP eligibility.
https://Marketplace.cms.gov/technical-assistance-resources/fast-facts-medicaid-chip.pdf

Federal Poverty Level (FPL) Guidelines
Up-to-date information regarding the Federal Poverty Guidelines (FPL) for families and individuals.
https://aspe.hhs.gov/poverty-guidelines

COBRA coverage and the Marketplace
A description of COBRA health coverage and how it relates to the Marketplace.

https://healthcare.gov/unemployed/cobra-coverage/

Tips on Providing Referrals to Consumers
https://marketplace.cms.gov/technical-assistance-resources/assister-guidance-on-referrals-to-outside-organizations.pdf

How to find low-cost health care in your community
Use the following tool to find a community health center near the consumer.
https://www.healthcare.gov/community-health-centers/

Catastrophic Plans
A definition of Catastrophic health plans and their role in the Marketplace.
https://www.healthcare.gov/choose-a-plan/catastrophic-health-plans/

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

If you have job-based insurance
An explanation of how job-based insurance affects Marketplace coverage.
https://www.healthcare.gov/have-job-based-coverage/

Health coverage for retirees
An explanation of the different choices retirees have for health coverage.
https://www.healthcare.gov/retirees/

If you already have Medicare coverage
Information regarding consumers who already have Medicare coverage and how this affects their eligibility for Marketplace coverage.
https://www.healthcare.gov/medicare/

How to get or stay on a parent's plan
An explanation of the PPACA regulations regarding consumers staying on their parent's health coverage plans.
https://www.healthcare.gov/young-adults/children-under-26/

Student health plans & other options
An explanation of the PPACA regulations regarding different health coverage options for students.
https://www.healthcare.gov/young-adults/college-students/

The VA and the PPACA
A summary of how VA coverage is regarded under the PPACA regulations.
https://www.va.gov/health/aca/EnrolledVeterans.asp

Refugee Medical Assistance
A description of refugee medical assistance programs.
https://www.acf.hhs.gov/orr/programs/cma/about

Health Coverage Tax Tool
Use this tool to help you figure out your premium tax credit or claim an "affordability" exemption. This tool can tell you your second lowest cost Silver plan or your lowest cost Bronze plan.
https://www.healthcare.gov/tax-tool/

Exemptions from the requirement to have health insurance
A description of the different types of exemptions available under the PPACA and how to apply for them.
https://www.healthcare.gov/health-coverage-exemptions/exemptions-from-the-fee/

Individual Shared Responsibility Provision
https://www.irs.gov/affordable-care-act/individuals-and-families/individual-shared-responsibility-provision

Individual Shared Responsibility Provision – Exemptions: Claiming or Reporting

https://www.irs.gov/affordable-care-act/individuals-and-families/aca-individual-shared-responsibility-provision-exemptions

Hardship and Affordability Health Coverage Exemption Forms
https://www.healthcare.gov/exemption-form-instructions/
https://www.healthcare.gov/health-coverage-exemptions/hardship-exemptions/

Types of Health Insurance that Count as MEC
https://www.healthcare.gov/fees/plans-that-count-as-coverage/