Assisting Consumers with Enrollment Video Transcript

This document is a transcript of the Marketplace Assister Technical Assistance Webinar.

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Disclaimer

Welcome to today's Assister Readiness Webinar Series training video. Let's get started.

This presentation is intended as training and technical assistance for Marketplace assisters, including Navigator grantees and certified application counselors. In this lesson, the terms "Federally-facilitated Marketplace," "FFM," and "individual market FFM" include FFMs where the state performs plan management functions and State-based Marketplaces using the federal platform.

This presentation is not a legal document.

- Each video module summarizes complex statutes and regulations and does not create any rights or obligations.
- Complete and current legal standards are contained in the applicable statutes and regulations.
- Members of the press should contact the CMS Media Relations Group at press@cms.hhs.gov.

The 2022 Assister Readiness Webinar Series is designed as a supplement to the web-based Assister Certification Training.

This series is being delivered in two weekly installments to familiarize assisters with the online Marketplace application process ahead of the 2022 Open Enrollment Period.

Each weekly installment includes three pre-recorded educational modules and a LIVE webinar that recaps the week's topics, checks for understanding, and gives assisters a chance to ask questions.

Week 1 - Helping Consumers Apply at HealthCare.gov

- Preparing Consumers to Apply
- Creating and Submitting Applications
- Application Assistance Simulation
- LIVE Recap with CMS SME Q&A

Week 2 - Helping Consumers Enroll at HealthCare.gov

- Assisting Consumers with Enrollment
- Plan Comparison and Selection Simulation
- Redetermination, Re-enrollment, and changes in Circumstances
    - LIVE Recap with CMS SME Q&A

Introduction

Hi, my name is Blair, and I'll be guiding you through today's training, Assisting Consumers with Enrollment.

After consumers submit a Marketplace application at HealthCare.gov, they must complete several tasks to enroll in health coverage and begin using it. In this module, we will review the plan comparison and selection process in the FFMs. We will cover:

Interpreting Eligibility Results

Explain consumers' Marketplace eligibility results.

APTC and CSRs

Confirm consumers' understanding of advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs).

Plan Comparison & Selection

Assist consumers with plan comparison and selection.

Assessment & Determination States

Describe how the FFMs assess or determine consumers' eligibility for Medicaid and the Children's Health Insurance Program, known as CHIP.

Eligibility Results

The FFMs verify each consumer's submitted Marketplace application for eligibility. You should review consumers' Marketplace eligibility determination notices with them and explain their results. Sometimes this will be a simple conversation, and applicants will quickly move to the next step of shopping for a qualified health plan (QHP). Other times applicants may need help with tasks like resolving a data matching issue, or DMI. If the information on consumers' Marketplace application doesn't match Marketplace records, consumers' eligibility results will list next steps for resolving outstanding DMIs and ask consumers to provide additional supporting documents.

- Qualified health plan (QHP) coverage with APTC and CSRs
- QHP coverage without APTC and CSRs—either because consumers haven't applied for these savings or are ineligible.
- A Special Enrollment Period (SEP)
- Medicaid
- CHIP

Consumers who wish to enroll in a QHP outside of Open Enrollment must qualify for a Special Enrollment Period, or SEP.

Newly enrolling consumers must provide supporting documents to the Marketplace during one of the SEPs listed here. For more details about SEPs, visit HealthCare.gov/coverage-outside-open-enrollment/special-enrollment-period.

Advance Payments of the Premium Tax Credit

You should be prepared to explain consumers' options if their eligibility determinations show that they qualify for APTC 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.

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

Consumers who anticipate changes throughout the year, like an increase in income, may want to reduce the amount of APTC they apply to their monthly premium.

For example, if a consumer will have an uncertain or variable income or plans to use a Qualified Small Employer Health Reimbursement Arrangement, or QSEHRA, that is considered unaffordable, you may want to discuss the idea of applying only part of the premium tax credit for which they are eligible as an advance payment. This may reduce the amount of money the consumer may owe at tax filing time in the event the consumer's actual income is higher than anticipated or they did not subtract their monthly QSEHRA amount from the monthly APTC they would otherwise be eligible for.

For Plan Year 2020 only, under the American Rescue Plan Act of 2021 (ARP), consumers do not need to repay excess APTC they received when filing federal income tax returns for the 2020 tax year. The IRS is providing taxpayers with additional guidance on those provisions that may affect their 2020 tax return.

APTC Reconciliation

Always make sure consumers understand the importance of reporting changes in household income and other eligibility factors during the year.

When consumers with Marketplace coverage file federal income tax returns, they need to use **Form 8962** to figure out the amount of premium tax credit they were eligible for based on their actual income during that year and reconcile that amount with any APTC they received.

Consumers who receive APTC during the year can find the total amount they used on Form 1095-A, which they should receive in the mail no later than mid-February. Consumers can also access Form 1095-A online through their Marketplace account at HealthCare.gov. You can learn more about APTC reconciliation in the optional *Assister Standard Operating Procedures* course in the Marketplace Learning Management System.

Helping Consumers Compare and Select Plans

The "Enroll To-Do List" in a Marketplace application includes six steps. After you help consumers who qualify for APTC set the amount of APTC they would like to use to lower their monthly premium costs, if any, they will report tobacco use, compare plans, and choose a QHP that meets their needs. Consumers may also choose a dental plan if they wish. Consumers will:

1. Set the amount of APTC they would like to use, if eligible.
2. Report tobacco use.
3. If desired, check whether QHPs cover their doctors, hospitals, and prescription drugs.
4. Choose a QHP.

5. If desired, compare and select dental coverage.
6. Review and confirm health and dental coverage choices before they sign the application.

Plan Comparison

When consumers are ready to choose a QHP, remember to show them all QHP options they're eligible for. You should never provide recommendations about which plan or plans consumers should select. However, you can help consumers filter QHPs based on the factors listed.

Help consumers filter QHPs based on factors such as:

- Premium price range;
- Annual deductible;
- Health plan type, which generally includes Health Maintenance Organizations, or HMOs, and Preferred Provider Organizations, or PPOs;
- Marketplace health plan category, which may include Bronze, Silver, Gold, Platinum, and Catastrophic plans;
- Dental coverage;
- Estimated yearly costs; and
- Health Savings Account (HSA)-eligible plans.

Key Tip:
Monthly premium amounts shown in Plan Compare are reduced by the APTC amount the eligible consumer selects. Remind consumers that they can change this amount later if they wish to.

Side-by-side Comparison Tool

Consumers can use the side-by-side comparison tool at HealthCare.gov to explore different QHP features, compare plans, and check for medical management programs that are important to them.

Helping Consumers Enroll

Once consumers make health and dental coverage selections, you can help them complete their enrollment. When consumers sign a Marketplace application, remind them that their QHP enrollment may *not* be complete until their issuer receives their first month's premium payment in full by the due date. This payment is also known as a “binder payment.”

If an issuer does not receive consumers’ binder payment on time, the issuer may cancel consumers’ enrollment.

You should never enter consumers' payment information into an issuer’s website, such as credit card numbers or bank account numbers. Instead, encourage consumers to carefully provide this information to the issuer themselves.

Grace Periods for Non-Payment of Premiums

Consumers who are enrolled and receiving APTC and who haven't made a monthly premium payment by the due date will be granted a three-month grace period to avoid losing coverage. An issuer must continue to pay claims made during the first month of a grace period; however, it may delay payments for any claims made in the second and third months until consumers pay any overdue amounts.

At the end of the third month, if these consumers still haven't paid their premiums in full, their issuer must terminate their coverage, effective retroactively to the end of the first month of the grace period. This means consumers could be responsible for paying any claims made on their behalf during the second and third months of the grace period.

Medicaid and the Marketplace: Assessment Versus Determination

Remember that all Marketplaces and state Medicaid and CHIP agencies use modified adjusted gross income, or MAGI, to determine whether individuals qualify for APTC, most categories of Medicaid, and CHIP, as applicable. You should be able to explain how the FFM assesses or determines consumers' eligibility for Medicaid and CHIP.

Consumers whom the FFM assesses or determines (depending on their state's rules) to be eligible for Medicaid or CHIP will receive an eligibility determination notice from the Marketplace with this information. As applicable, the notice will indicate that the consumer's state Medicaid or CHIP agency may ask the consumer to provide additional information. This request could ask consumers to provide specific documents to verify attested information such as income or citizenship status.

In both assessment and determination states, consumer applications are transferred to the state Medicaid or CHIP agency for a determination on a non-MAGI basis if applicants answer "yes" to specific screening questions indicating that they have a disability, need long-term care, or are over age 65. Assessment and determination state Medicaid and CHIP agencies complete final determinations for non-MAGI-based Medicaid.

Medicaid Determination

For determination states, the FFM may make a final determination of eligibility for MAGI-based Medicaid and CHIP.

Medicaid Assessment

For assessment states, the FFM may make a preliminary assessment of eligibility for MAGI-based Medicaid and CHIP.

The FFM provides all applicants an opportunity to request a "full determination"—that is, a non-MAGI-based determination—from the state Medicaid or CHIP agency. In **assessment states**, full determination requests are sent to the state Medicaid/CHIP agency for a final MAGI-based determination (for applicants the FFM does not assess as potentially MAGI-based Medicaid- or CHIP-eligible) and for non-MAGI Medicaid. In **determination states**, full determination requests are only sent to a state Medicaid agency to complete a determination for non-MAGI-based Medicaid, as the FFM has already made the final determination for MAGI-based Medicaid and CHIP. Consumers may appeal their FFM Medicaid or CHIP eligibility determination if they believe there was a mistake or disagree with the decision.

When assisting consumers who may be eligible for Medicaid or CHIP, visit the Medicaid and CHIP Overview for Assisters fact sheet for more information.

If the FFM assesses or determines consumers to be Medicaid- or CHIP-eligible, their application information is securely, electronically transferred to the state Medicaid or CHIP agency for further

review, as applicable (this may include requesting additional information from consumers), processing, a final eligibility determination, and enrollment, as applicable.

Both assessment and determination states' Medicaid and CHIP agencies complete final determinations for non-MAGI-based Medicaid.

When assisting consumers who may be eligible for Medicaid or CHIP, visit the Medicaid and CHIP Overview for Assisters fact sheet at Marketplace.cms.gov/technical-assistance-resources/fast-facts-medicaid-chip.pdf.

Medicaid Expansion

The Patient Protection and Affordable Care Act's MAGI calculation is based on adjusted gross income (AGI) as defined in the Internal Revenue Code. However, the Patient Protection and Affordable Care Act provides for a five-percentage-point income disregard when using MAGI to determine an applicant's eligibility for Medicaid and CHIP—one of several ways in which the AGI is "modified". With this five percent disregard, the Medicaid eligibility threshold in states that have fully expanded Medicaid is effectively 138 percent of the FPL.

The Affordable Care Act (ACA) provides for a five-percentage-point income disregard when using MAGI to determine an applicant's eligibility for Medicaid and CHIP.

In most Medicaid expansion states, the threshold to qualify for the expanded Medicaid group is a household income at or below 133 percent of the federal poverty level (FPL), or 138 percent of the FPL with the five percent disregard.

- **In all states**, consumers can qualify for Medicaid based on income, household size, disability, family status, and/or other factors. Eligibility rules differ between states.
- **In states that have expanded Medicaid coverage**, for adults, consumers can qualify based on their income, household size, and other relevant factors. In most Medicaid expansion states, if consumers' household income is at or below 138 percent of the FPL, they qualify for Medicaid under the ACA, if otherwise eligible. Non-expansion states use a lower income limit.

Under the ARP, for Plan Year 2021 only, consumers receiving unemployment compensation in 2021 who have income under 100 percent of the FPL and who are not otherwise eligible for Medicaid – for example, because they're an adult in a non-Medicaid expansion state – may be eligible for APTC and CSRs in 2021.

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

Medicaid and CHIP Eligibility and the FFMs

If a consumer is eligible for Medicaid or CHIP coverage that counts as qualifying coverage (also known as minimum essential coverage, or MEC) and wants to enroll in QHP coverage with the FFM, remind them that they are not eligible for APTC or CSRs for their share of a Marketplace plan. However, they may enroll in a QHP *without* APTC and CSRs, if otherwise eligible. If they choose to enroll in Marketplace coverage (without financial help), they should tell their state Medicaid or CHIP agency that they're enrolled in Marketplace coverage; they may no longer be eligible for CHIP.

Key Points

Once consumers apply for coverage, the Marketplace generates an eligibility determination notice. You should help consumers review these notices and help them understand their eligibility for SEPs, Medicaid, CHIP, and QHP coverage with or without APTC.

You can help consumers compare QHPs using the side-by-side comparison tool to filter QHPs using factors like premium price range, yearly deductibles, and health plan types.

The FFM uses Medicaid and CHIP rules and state-specific rules, as applicable, to evaluate consumers' MAGI and make a preliminary assessment (for assessment states) or a final determination (for determination states) of Medicaid and CHIP eligibility.

Depending on their state's rules, consumers will receive a Medicaid or CHIP eligibility determination or assessment notice from the Marketplace. The notice may ask consumers to verify their income and submit supporting documents.

Conclusion

Congratulations on completing the *Assisting Consumers with Enrollment* module of the Assister Readiness Webinar Series! Please proceed to the next Week 2 module, *Plan Comparison and Selection Simulation*.

Feel free to visit the Assister Readiness Webinar Series Resources listed here, including training materials for Navigators and other assisters, and the assister webinars webpage.

Next:

Next Week 2 module: *Plan Comparison and Selection Simulation*

Visit:

Assister Readiness Webinar Series Resources

For topical questions about this presentation:

Navigators please contact your Project Officer directly

CACs can email the CAC Inbox at CACquestions@cms.hhs.gov

Training materials for Navigators and other assisters:

https://marketplace.cms.gov/technical-assistance-resources/training-materials/training.html

Assister webinars:

https://marketplace.cms.gov/technical-assistance-resources/assister-webinars.html

We will host a LIVE webinar to recap the content presented in this week's modules and answer your questions. Check your email for information on the day and time of the event.

We hope you will join us then!