

Assisting Consumers with Enrollment Video Transcript



2021

Assister Readiness
— Webinar Series —

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

Table of Contents

Disclaimer.....	3
Introduction	4
Eligibility Results	4
Advance Payments of the Premium Tax Credit	5
APTC Reconciliation	5
Helping Consumers Compare and Select Plans	6
Plan Comparison	6
Side-by-side Comparison Tool	6
Helping Consumers Enroll.....	7
Grace Periods for Non-Payment of Premiums.....	7
Medicaid and the Marketplaces: Assessment Versus Determination.....	7
Medicaid Expansion	8
CHIP Eligibility and the FFMs	9
Key Points.....	9
Conclusion.....	9

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 2021 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 2021 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:

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

When consumers submit Marketplace applications, the FFMs verify information about each household applicant and may assess or determine their eligibility for:

- 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

You should review consumers' Marketplace Eligibility Determination Notices with them and explain their results. Sometimes this will be a simple conversation and an applicant will quickly move to the next step of shopping for a QHP. Other times an applicant might need help with tasks like resolving a data matching issue, or DMI. If the information on a consumer's Marketplace application doesn't match Marketplace records, the consumer's eligibility results will list next steps for resolving outstanding DMIs and ask the consumer to provide additional supporting documents.

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

Consumers who enroll in or change plans using one of the SEPs listed here must provide supporting documents to the Marketplace:

- Loss of qualifying health insurance coverage;
- Change in primary place of living;
- Certain Medicaid or Children's Health Insurance Program (CHIP) denials;

- Adoption, placement for adoption, placement for foster care, or child support or other court order; and
- Marriage.
- Newly gaining access to an individual coverage Health Reimbursement Account (HRA) or being provided a qualified small employer health reimbursement arrangement (QSEHRA).

For more details about SEPs, visit [HealthCare.gov/coverage-outside-open-enrollment/special-enrollment-period/](https://www.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.

You should help consumers make informed decisions about the amount of premium tax credit they want to use in advance. Eligible consumers can choose to:

- Receive the entire amount of APTC they are eligible for each month.
- Apply a smaller amount of APTC to their monthly premiums than they are eligible for each month, or
- Apply none of their APTC to their monthly premiums in advance, and receive their entire premium tax credit at the end of the year when they file federal income taxes.

Explain to consumers that the amount of APTC they use 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.

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 is mailed to them at the beginning of the tax filing season. Consumers can also access Form 1095-A online through their Marketplace account at [HealthCare.gov](https://www.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, they will report tobacco use, compare plans, and choose a qualified health plan (QHP) that meets their needs. Consumers may also choose a dental plan if they wish.

1. Help eligible consumers set the amount of APTC they would like to use.
2. Report tobacco use.
3. Check whether 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 consumers are ready to choose a health plan, 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.

However, you can 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 discounted by the APTC amount an 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;
- See how plans differ in categories like costs for medical care, prescription drug coverage, and in-network providers; and

- Check for medical management programs that are important to them, such as pain management, diabetes care, and psychiatric care for depression.

For more detailed information about QHP coverage and costs, consumers can review a plan's Summary of Benefits and Coverage (SBC).

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 health insurance company receives their first month's premium payment in full by the due date. This payment is also known as a "binder payment."

If a health insurance company does not receive a consumer's binder payment on time, the issuer may cancel the consumer's enrollment.

You should never enter consumers' payment information into a QHP provider's website, such as credit card numbers or bank account numbers. Instead, encourage consumers to carefully provide this information to issuers themselves.

Grace Periods for Non-Payment of Premiums

A consumer receiving APTC who hasn't made a premium payment by the due date will be granted a three-month grace period to avoid losing coverage.

To get a grace period, consumers must have paid at least the first full month's premium, known as the binder payment. An issuer must continue to pay claims 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 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.

For consumers not receiving APTC, the applicable grace period is determined by state law.

Medicaid and the Marketplaces: 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. You should be able to explain how the FFM in your state assesses or determines consumers' eligibility for Medicaid and CHIP.

The FFM uses Medicaid and CHIP rules and state-specific rules, as applicable, to evaluate consumers' MAGI-based eligibility for Medicaid and CHIP.

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 gives all consumers an opportunity to request a “full determination”—that is, a non-MAGI determination—from the state Medicaid or CHIP agency. In assessment states, full determination requests are sent to the state agency for a final MAGI-based determination (for applicants the FFM does not assess as potentially MAGI-eligible) and for non-MAGI groups. In determination states, full determination requests are only sent to state agencies to complete a determination for non-MAGI coverage, as the FFM has already made the final determination for MAGI-based coverage.

Consumers may appeal their FFM eligibility determination.

If the FFM assesses or determines a consumer to be Medicaid- or CHIP-eligible, their application information is securely transferred to the state Medicaid or CHIP agency for further review, as applicable (this may include requesting additional information from the consumer), processing, a final eligibility determination, and enrollment, as applicable.

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.

Some states have expanded their Medicaid programs to cover adults with household incomes below a certain level, while others haven’t. Be sure you know whether the state you are working in has expanded Medicaid eligibility for adults, and the applicable federal poverty guidelines.

- **In all states**, consumers can qualify for Medicaid based on income, household size, disability, family status, and/or other factors. Eligibility rules differ among states.
- **In states that have expanded Medicaid coverage**, for adults, consumers can qualify based on their income and household size. In most Medicaid expansion states, if consumers’ household income is at or below 138 percent of the Federal Poverty Level (FPL), they qualify for Medicaid under the Patient Protection and Affordable Care Act, if otherwise eligible. A few states use a different income limit.

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

CHIP Eligibility and the FFM

If a child is eligible for CHIP or Medicaid coverage and wants to enroll in QHP coverage in the FFM, remind consumers that the child cannot receive APTC or CSRs to help lower their QHP costs. 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 CHIP agency that they're enrolled in Marketplace coverage, as they may no longer be eligible for CHIP.

Key Points

- Once consumers apply for health 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.

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*.

Also, 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.

If you have topical questions about this presentation:

- Navigators please contact your Project Officer directly.
- CACs please 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!