Hi, my name is Dan. 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 (i.e., Navigator grantees, certified application counselors (CACs), and other assisters).

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 on 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 2019 Assister Readiness Webinar Series is designed as a supplement to the web-based Assister Certification Training.

This month-long series will be delivered in weekly installments to help ensure that assisters are ready to serve Marketplace consumers during the 2019 open enrollment period. Each weekly installment will include several pre-recorded educational modules and a corresponding LIVE Friday webinar that will recap the week's topics, check for understanding, and give assisters a chance to ask questions.

Hi, my name is Bonnie, and I'll be guiding you through today's training.

Let's review how you can walk consumers through each step of creating a Marketplace account and completing an application.

Interpreting Eligibility Results
Explain consumers' Marketplace eligibility results.

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

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

Plan Comparison & Selection
Assist consumers with plan comparison and selection.

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

- A Special Enrollment Period (SEP)
- Medicaid
- CHIP
- Qualified health plan (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 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, and appealing Marketplace eligibility decisions. 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 an SEP. All consumers who enroll or change plans using an SEP for any of the following triggering events will be directed to provide supporting documents:

- Loss of minimum essential coverage,
- Permanent move,
- Birth,
- Adoption, placement for adoption, placement for foster care or child support or other court order, or
- Marriage.

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

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 eligibility, and CHIP. You should be able to explain how the FFM in your state determines consumers' final eligibility for Medicaid and CHIP.

Medicaid Determination
FFMs in Medicaid determination states use Medicaid rules and applicable state-specific rules to evaluate consumers' MAGI and determine whether they are eligible for Medicaid or CHIP.

Medicaid Assessment
FFMs in Medicaid assessment states make initial decisions about whether consumers are potentially eligible for Medicaid or CHIP based on their household's MAGI and other eligibility criteria. If an FFM believes a consumer may be eligible, it transfers the consumer's applications to the state Medicaid or CHIP agency for a final eligibility determination. Then, the agency sends a final eligibility notice to the consumer or requests additional information if necessary.

Consumers who are not assessed or determined eligible for Medicaid or CHIP based on MAGI may request a full determination from their state agency based on non-MAGI eligibility criteria, like having a disability. Consumers may contact their state Medicaid or CHIP agency directly for more information or to appeal a determination.

Key Tip:
If individuals are assessed or determined **ineligible** for Medicaid and CHIP, their eligibility results will also state whether they 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.

Some states have expanded their Medicaid programs to cover all 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 other factors. Eligibility rules differ among 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 Federal Poverty Level, or FPL, they qualify under the Patient Protection and Affordable Care Act. 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.

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

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, Affordable Care Act 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.

If a child is eligible for QHP **and** CHIP coverage, remind consumers that children who are eligible for CHIP cannot receive APTC or CSRs to help lower their QHP costs. However, they may still enroll in a QHP without APTC and CSRs.

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:

- Distribute the amount equally for each month during the year as APTC,
- Receive a smaller amount of APTC during the year, or
- Use none 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 during the 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. You can learn more about APTC reconciliation in the optional *Assister Standard Operating Procedures* course in the Marketplace Learning Management System (MLMS).

After you help consumers who qualify for a premium tax credit set the amount of APTC they would like to use to lower their monthly premium costs, they will select their health insurance preferences, compare plans, and choose a qualified health plan QHP that meets their needs.

The “Enroll To-Do List” in a Marketplace application includes seven steps:

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. Get an estimate of consumers’ total yearly costs.
5. Consumers choose a QHP.
6. If desired, consumers compare and select dental coverage.

Review and confirm health and dental coverage choices before consumers sign the application.

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.

Consumers can filter QHPs based on factors such as:

- Premium price range
- Yearly 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
- 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 desired.

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, or SBC.

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 is not complete until 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.

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

Effective Date of Coverage
In most cases, the earliest date consumers' coverage can start – that is, their "effective date of coverage"—depends on when they select a plan.

- Consumers who enroll between the first and the 15th day of the month during Open Enrollment will generally begin coverage on the first day of the following month.

- Consumers who enroll between the 16th and the last day of the month during Open Enrollment will generally begin coverage on the first day of the second following month.

Remember to tell consumers that their effective date of coverage is the first date on which they can start receiving covered benefits. It is **not** the first date on which they use their coverage to get care.

Key Tip:
The Open Enrollment Period for 2019 coverage through the individual market FFMs begins on November 1, 2018 and ends December 15, 2018. Consumers must enroll and 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

If a consumer receives APTC and hasn't made a premium payment by the due date, he or she may generally do so during a three-month grace period and avoid losing their health coverage. To get a grace period, consumers must have paid at least the first full month's premium, known as the binder payment, during the benefit year. A QHP 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.

- 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.
- In Medicaid determination states, the FFM uses Medicaid rules and applicable state-specific rules to evaluate consumers' MAGI and determine whether they are eligible for Medicaid or CHIP. In Medicaid assessment states, the FFM transfers consumers' information to the state's Medicaid or CHIP agency for a final determination if the Marketplace believes they may be eligible.

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.

Congratulations on completing the *Assisting Consumers with Enrollment* module of the Assister Readiness Webinar Series!

Please proceed to the next Week 3 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 can email the CAC Inbox at CACquestions@cms.hhs.gov.