CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

MARKETPLACE
ASSISTER TOOLKIT

Standard Operating Procedures Manual for Assisters in the Individual Federally-facilitated Marketplaces: Introduction & Instructions for Use

Version 5.0 November 2016. This information is intended only for the use of entities and individuals that are certified to serve as Navigators, certified application counselors, or non Navigator assistance personnel in a Federally facilitated Marketplace. The terms "Federally facilitated Marketplace" and "FFM," as used in this document, include FFMs where the state performs plan management functions and State Partnership Marketplaces. Some information contained in this manual may also be of interest to individuals helping consumers in State based Marketplaces and Federally supported State based Marketplaces.

Table of Contents

List of Exhibits

Introduction & Instructions for Use

A. Welcome

The Centers for Medicare & Medicaid Services (CMS) aims to ensure that all consumers have access to high-quality, affordable health coverage options through a Health Insurance Marketplace℠. Assisters play a critical role in meeting this goal, and CMS appreciates your support in this effort.

As an assister, you serve as a trusted resource to educate consumers and answer their questions about health coverage offered through a Federally-facilitated Marketplace (FFM).[1] Assisters help to ensure that consumers have positive and successful experiences as they complete FFM eligibility and enrollment activities.

B. Purpose of the Manual

The Standard Operating Procedures Manual for Assisters in the Individual Federally-facilitated Marketplaces is an instructional guide intended for assisters. In this Manual, the term "assisters" refers to certified application counselors (CACs), Navigators, and non-Navigator assistance personnel who help consumers in the Federally-facilitated Marketplaces. The term "you" is also often used to refer to FFM assisters, but is also sometimes used to refer to consumers (especially in Frequently Asked Questions (FAQs) sections). This Manual contains standard operating procedures (SOPs) for assister activities within a Federally-facilitated Marketplace for the individual market (also referred to in this document as an "Individual Federally-facilitated Marketplace," "Individual FFM," or "Individual Marketplace"). The SOPs reflect requirements, policies, and best practices under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (referred to collectively as the Affordable Care Act), CMS regulations, and CMS guidance.

This Manual is not intended to take the place of the statutes, regulations, and formal policy guidance upon which it is based. It summarizes current policy and operations as of the date it was published. We encourage assisters to refer to these statutes, regulations, and interpretive guidance for complete and current information about the requirements that apply to them.

DISCLAIMER: This manual contains screenshots from https://www.healthcare.gov that are intended only as an example of what you and/or the consumer may see when the consumer is completing an application on HealthCare.gov. All names and contact information used in the screenshots are fictional; and the use of health insurer names and/or health plan names are for demonstration purposes only and should not be construed as an endorsement by CMS of any specific health insurer or health plan.

[1] The terms "Federally-facilitated Marketplace" and "FFM," as used in this document, include FFMs where the state performs plan management functions and State Partnership Marketplaces. The terms "Health Insurance Marketplace℠," and "Marketplace," as used in this document, generally refer to an FFM, and frequently refer to an Individual FFM.

The instructions and information included in this Manual provide guidance on how to help consumers in an Individual FFM with activities and issues such as:

- Preparing, completing, and updating Individual FFM applications for health coverage;
- Enrolling in health coverage through an Individual FFM;
- Understanding eligibility determinations for enrollment in health coverage through an Individual FFM application;
- Resolving data-matching issues (DMIs);
- Renewing eligibility and enrollment for health coverage through an Individual FFM;
- Certain issues related to exemptions from the individual shared responsibility payment and the requirement to maintain minimum essential coverage; and
- Understanding the process of filing Individual FFM eligibility appeals.

C. Updates to the Manual

The Center for Consumer Information & Insurance Oversight (CCIIO) within CMS maintains this Manual in its entirety. CCIIO may alter, delete, suspend, or discontinue the procedures in this Manual in the future. Procedural changes will be communicated to assisters through the Assister Newsletter and Assister Webinar, as well as through federal regulations and guidance. CCIIO will also periodically update the Manual as relevant regulations, guidance, or policies are released, and disseminate updated versions of the Manual to assister organizations. As an assister, you should refer to your assister organization's policies and guidelines for specific instructions on how to obtain new versions of the Manual. CMS plans to provide updated versions of the Manual on Marketplace.CMS.gov.

D. Instructions for Use

The Manual can either be used as an electronic document or as a stand-alone paper document. Key features such as the Table of Contents, Index, and color-coding allow for easy navigation of the document in either format.

1. Electronic Document Use

When using the electronic version of the Manual, click on the hyperlinked words to navigate to a new section within the document or to open an external website. To identify hyperlinks in the body of the Manual, look for underlined words in blue font. In the Table of Contents, hyperlinks appear as normal text. In all instances, hovering over a hyperlink changes the mouse pointer to indicate the hyperlink's presence.

2. Paper Document Use

When using the paper version of the Manual, refer to the Table of Contents and the Index to navigate to the page containing the information you need. The Table of Contents provides an overview of the document by sections and subsections, while the Index catalogues a list of keywords and topics found within the document.

Appendix A: Acronyms & Definitions

The proceeding sections describe the commonly used acronyms and terms that appear throughout the Manual.

Frequently Used Acronyms

Exhibit 1—Frequently Used Acronyms

Acronyms	Descriptions
APTC	Advance payments of the premium tax credit
CAP	Consumer Assistance Program
CCIIO	Center for Consumer Information & Insurance Oversight
COBRA	Consolidated Omnibus Budget Reconciliation Act
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CSR	Cost-sharing Reduction
DHS	Department of Homeland Security
DMI	Data-matching Issue
EHB	Essential Health Benefits
FAQ	Frequently Asked Questions
FFM	Federally-facilitated Marketplace
FPL	Federal Poverty Level
HDHP	High Deductible Health Plan
HHS	Department of Health & Human Services
HMO	Health Maintenance Organization
HSA	Health Savings Account
ID	Identification
IHS	Indian Health Service
IRS	Internal Revenue Service
MAGI	Modified Adjusted Gross Income
MEC	Minimum Essential Coverage
PII	Personally Identifiable Information
QHP	Qualified Health Plan
SBC	Summary of Benefits and Coverage
SEP	Special Enrollment Period
SHIP	State Health Insurance Assistance Program
SHOP	Small Business Health Options Program
SOP	Standard Operating Procedure
SSI	Supplemental Security Income
SSN	Social Security Number

Acronyms	Descriptions
VA	Veterans Affairs
VHA	Veterans Health Administration

Definitions

The following is a list of terms from HealthCare.gov, CCIIO, and the Affordable Care Act explained in plain language that you may reference to assist consumers.

List of Vocabulary in SOP:

Affordable Care Act: The comprehensive health care reform law enacted in March 2010. Congress passed the law in two parts. The President signed the Patient Protection and Affordable Care Act into law on March 23, 2010, which was amended by the Health Care and Education Reconciliation Act of 2010 on March 30, 2010. The name "Affordable Care Act" refers to the amended version of the law. (Reference: HealthCare.gov/glossary/affordable-care-act)

Agent: When registered with a Marketplace, an individual or entity that helps individuals and businesses apply for and enroll in QHPs through the Marketplace and may assist in applying for advance payments of the premium tax credit and cost-sharing reductions. States grant licenses to agents to sell insurance in their respective jurisdictions. They may receive compensation from insurance companies with whom they have a contractual relationship to enroll consumers in a QHP or non-QHP. (Reference: Affordable Care Act §1312(e) and 45 CFR §155.20)

Broker: When registered with a Marketplace, an individual or entity that helps individuals and businesses apply for and enroll in a QHP through the Marketplace and may assist in applying for advance payments of the premium tax credit and cost-sharing reductions. States grant licenses to brokers to sell insurance in their respective jurisdictions. They may receive compensation from an insurance company with whom they have a contractual relationship to enroll consumers into a QHP or non-QHP. (Reference: Affordable Care Act § 1312(e) and 45 CFR §155.20)

Center for Consumer Information & Insurance Oversight (CCIIO): A part of the Department of Health & Human Services that helps to implement many provisions of the Affordable Care Act, the historic health reform bill that became law in March 2010. CCIIO oversees the implementation of the provisions related to private health insurance. (Reference: CMS.gov/CCIIO)

Centers for Medicare & Medicaid Services (CMS): The federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs, as well as the Federally-facilitated Marketplaces. For more information, visit CMS.gov. (Reference: HealthCare.gov/glossary/centers-for-medicare-and-medicaid-services)

Certified Application Counselor (CAC): In an FFM, an individual (affiliated with an organization designated by CMS, as operator of the FFMs) who is trained and able to help consumers as they look for health coverage options through the Marketplace, including helping them complete eligibility and enrollment forms. Their services are free to consumers. (Reference: HealthCare.gov/glossary/certified-applicant-counselor)

Certified Application Counselor Designated Organization (CDO): In an FFM, an organization designated by CMS, as operator of the FFMs, to certify staff members or volunteers to act as certified application counselors. (Reference: 45 CFR §155.225)

Eligibility Appeal: In an Individual Marketplace, a request by an individual for a reevaluation of a Marketplace eligibility decision or an eligibility decision by a state Medicaid or CHIP agency. (Reference: HealthCare.gov/can-i-appeal-a-marketplace-decision)

Health Coverage: Consumers' legal entitlement to payment or reimbursement for their health care costs for covered services or items generally under a contract with a health insurance company, a group health plan offered in connection with employment, or a government program like Medicare, Medicaid, or CHIP. (Reference: HealthCare.gov/glossary/health-coverage)

Health Insurance: A contract that requires a consumer's health insurer to pay some or all of the consumer's health care costs in exchange for a premium. (Reference: HealthCare.gov/glossary/health-insurance)

Health Insurance Issuer (Issuer): An insurance company, insurance service, or insurance organization that must have a license to engage in the business of insurance in a state and that is subject to state laws that regulate insurance. (Reference: 45 CFR §144.103)

Individual Marketplace: The Marketplace for individuals to purchase health insurance plans for themselves or their families other than through an employer-sponsored group health plan. (Reference: Affordable Care Act §1304(a)(2))

Individual Shared Responsibility Payment (also referred to as a "Fee"): Starting January 1, 2014, if applicable individuals do not maintain health coverage that qualifies as MEC or obtain an exemption, they may have to pay a fee, known as the individual shared responsibility payment, that increases every year from 1% of household income (or $95 per adult, whichever is higher) in 2014, 2.0% of household income (or $325 per adult) in 2015, to 2.5% of household income (or $695 per adult) in 2016, up to a maximum of $2,085. The fee for children is half the adult amount. If applicable, consumers will pay this fee on their annual tax return. People with very low incomes and others may be eligible for exemptions. (Reference: HealthCare.gov/glossary/fee)

Marketplace: A marketplace for health insurance, also known as an "Exchange," operated by a governmental agency or non-profit entity that meets applicable government standards. A Marketplace makes QHPs available to qualified individuals and/or qualified employers. Generally, in CMS documents, this term is often used to refer both to Marketplaces serving the individual market for qualified individuals and to Small Business Health Options Program (SHOP) Marketplaces serving the small group market for qualified employers, and is often used regardless of whether a Marketplace is established and operated by a State or by HHS. However, in this document, the term Marketplace generally is used to refer only to the Federally-facilitated Marketplaces (FFMs), and frequently is used to refer only to the FFMs for the individual market. (Reference: 45 CFR §155.20)

Minimum Essential Coverage (MEC): The type of health coverage individuals need to have to avoid having to make the individual shared responsibility payment (unless they qualify for an exemption) when they file a federal income tax return. Many types of coverage qualify as MEC, including qualified health plans offered through the Marketplace, job-based coverage, Medicare, Medicaid, CHIP, and TRICARE. (Reference: Section 5000A(f) of the Internal Revenue Code)

Navigator: An individual or organization that receives a grant from the Marketplace and that is trained and able to help consumers, including small employers and their employees, as they look for health coverage options through the Marketplace, including helping them complete the eligibility and enrollment process. These individuals and organizations are required to be unbiased. Their services are free to consumers. (Reference: HealthCare.gov/glossary/navigator)

Non-Navigator Assistance Personnel: Individuals or organizations that are trained and able to provide help to consumers, including small employers and their employees, as they look for health coverage options through a Marketplace, including helping them complete the eligibility and enrollment process. These individuals and organizations are required to be unbiased. Their services are free to consumers. Also referred to as "in-person assisters." (Reference: HealthCare.gov/glossary/in-person-assistance-personnel-program)

Open Enrollment Period: The period of time during which individuals who are eligible to enroll in a QHP can enroll in a plan through the Marketplace. For coverage starting in 2017, the individual market Open Enrollment period is November 1, 2016 – January 31, 2017. Individuals may also qualify for special enrollment periods if they experience certain qualifying events. Consumers can apply for Medicaid or CHIP at any time of the year. (Reference: HealthCare.gov/glossary/open-enrollment-period)

Qualified Health Plan (QHP): Under the Affordable Care Act, an insurance plan that is certified by a Health Insurance Marketplace℠, provides essential health benefits, follows established limits on cost- sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. Each QHP is certified by the Marketplace through which the plan is offered. (Reference: HealthCare.gov/glossary/qualified-health-plan)

Appendix B: Support Resources

If consumers require assistance that is outside of assister activities, refer consumers to other organizations and resources as appropriate. Exhibit 2 provides a list of external resources.

Exhibit 2—External Resources

Resource	Contact Information	What does this resource do?	How should consumers use this resource?
Center for Consumer Information & Insurance Oversight (CCIIO)	http://www.CMS.gov/cciio/index.html	This entity implements many provisions of the Affordable Care Act, the health reform bill signed into law in March 2010. CCIIO oversees the implementation of the provisions related to private health insurance.	To gather more information on the Affordable Care Act by referencing detailed fact sheets, FAQs, and other resources.
HealthCare.gov	http://www.HealthCare.gov	This website allows consumers to access information about the Affordable Care Act and to enroll in health coverage through an FFM.	To find out about health coverage options available through an FFM. To apply for health coverage online. To get real-time answers to questions using the online chat function.