MARKETPLACE
ASSISTER TOOLKIT

Standard Operating Procedures Manual for Assisters in the Individual Federally-facilitated Marketplaces

SOP 10 – REQUEST AN ELIGIBILITY APPEAL

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.

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SOP 10—Request an Eligibility Appeal

A. Introduction

Assisters are not required to help consumers through the entire eligibility appeals process, and must not act as tax advisers or attorneys when providing assistance as Navigators, non-Navigator assistance personnel, or certified application counselors. This SOP provides guidance on how to assist consumers with understanding the process of filing Marketplace eligibility appeals. The Marketplace allows consumers to request an appeal of the following:

- Eligibility or redetermination of eligibility to: purchase a Marketplace QHP (including a catastrophic plan); a child only plan; or eligibility for an employer to participate in a SHOP employer plan.
- An eligibility determination for a special enrollment period.
- Eligibility or redetermination of eligibility for advance payments of the premium tax credit or cost-sharing reductions, including the amount of advance payments of the premium tax credit and cost-sharing reductions for which the consumer was determined or re-determined eligible. Note that consumers who have outstanding data matching issues (DMIs) will need to resolve those issues or wait for them to expire before they will be able to file an appeal regarding the eligibility determination for which there is a DMI. Consumers cannot appeal eligibility determinations that still have open DMIs.
- Eligibility for an exemption from the individual shared responsibility payment that is granted by the Marketplace.
- Eligibility for Medicaid or CHIP.[1]
- Eligibility for Basic Health Programs.
- A Marketplace individual or SHOP application that had not been acted on with reasonable promptness such that the consumer did not receive timely notice of an eligibility determination.

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[1] Consumers may file appeals from Medicaid and CHIP determinations with FFM only under limited circumstances.

(i) MAGI-related Medicaid denials by the FFM.

a. The following states have delegated MAGI-related Medicaid determinations to the FFM and delegated authority to conduct appeals to CMS – AL, AK, AR, LA, MT, NJ, TN, WV, WY (for MAGI-related Medicaid, not CHIP). When the FFM denies MAGI-related Medicaid to residents of those states who apply to the FFM, they may appeal those denials to the Federal Marketplace Appeals Entity (Marketplace Appeals Center).

b. Option to Transfer to State Entity. Consumers in these states have a right to have their state entity conduct a Medicaid Fair Hearing. They may request their MAGI-related Medicaid appeal through the Marketplace Appeals Center but can ask that their Fair Hearings be held by their state by checking the appropriate box on their appeal request or otherwise asking for this option. Marketplace Appeals Center will transfer such appeals to the applicable state Medicaid agency Fair Hearing entity. This option does not exist for CHIP appeals.

(ii) Appeals in Assessment States. For consumers in all other states, the FFM assesses eligibility for MAGI-related Medicaid and CHIP. The state Medicaid agency makes the final eligibility determination and aggrieved consumers may appeal through their state's Fair Hearing process.

(iii) Non-MAGI-Related Appeals. The FFM does not render eligibility determinations for non-MAGI-related Medicaid. If a state Medicaid agency denies non-MAGI Medicaid, aggrieved consumers may appeal through their state's Fair Hearing process. Consumers whose eligibility is determined on a non-MAGI basis include the aged, blind, or disabled, as well as the medically needy, present or former foster youth, consumers with long-term care needs, and some others.

- The appeal decision of a state-based appeals entity or the refusal of a state-based appeals entity to vacate dismissal of an appeal request (that is, to reinstate the appeal).

Consumers who disagree with an eligibility determination made by the FFM may appeal to the Federal Marketplace Appeals Entity (Marketplace Appeals Center) within 90 days of the date of their eligibility notice. Upon receipt, the Marketplace Appeals Center will review the appeal request and validate the appeal based on whether it was submitted within the 90-day timeframe and whether it concerns a matter over which the Marketplace Appeals Center has jurisdiction. For example, if the appeal request is about a matter where no jurisdiction exists, such as a dispute the consumer has with a QHP issuer over a claim denial, the consumer will receive a notice explaining why the appeal request was invalid and what other options the consumer may have. The Marketplace Appeals Center may accept an untimely appeal if a consumer sufficiently demonstrates within a reasonable timeframe that failure to submit the appeal request timely was due to exceptional circumstances that should not preclude the appeal.

Once an appeal has been validated, the Marketplace Appeals Center will review the appeal, including all documentation provided by the consumer and available in the consumer's Marketplace eligibility record. The consumer may be asked in writing to submit additional information or be contacted by phone to discuss the appeal. In many cases, the Marketplace Appeals Center will work with the consumer to resolve the appeal informally. If the consumer is satisfied with the informal resolution, a decision will be sent in the mail. Conversely, if the consumer is not satisfied with the informal resolution, the consumer can request a hearing conducted by telephone of the appeal before afederal hearing officer. After the hearing, the consumer will receive a final appeal decision in the mail. If the appeal decision states that the contested eligibility determination was incorrect, the consumer will be able to choose whether the appeal decision will be effective in the future or retroactively to the coverage effective date associated with the incorrect eligibility determination.

The following rights are afforded to consumers as part of the appeals process:

- Consumers can ask for an expedited appeal review if they believe that they have an immediate need for health services and a delay could seriously jeopardize their health.
- Consumers may have an authorized representative to help them with their appeal. An authorized representative is a person who has the permission of the consumer to talk with the Marketplace Appeals Center about their appeal, see their information, and act for them on matters related to their appeal, including getting information about them and signing their appeal request on their behalf.
- Consumers also can have someone help them with their appeal, including at the hearing like a friend, relative, or lawyer. This person does not have to be formally designated as an authorized representative, but if they are not, they will not be allowed to act for the consumer on matters related to the consumer's appeal.
- Consumers who are appealing a redetermination of eligibility resulting in a loss or reduction of eligibility for advance payments of the premium tax credit and, if applicable, cost-sharing reductions can request a continuation of the previous level of benefits pending their appeal. This is sometimes called "aid-paid-pending." If they do not prevail in their appeal, they would be liable for any advance payments of the premium tax credit that they had received during the appeal, which would be reconciled when they file their taxes.
- Consumers can ask the Marketplace Appeals Center to provide them a copy of their appeal record free of charge.

- Consumers can bring witnesses to testify.
- Consumers may request an auxiliary aid or service and language assistance services to make the appeals process accessible to them.

The sections that follow in this SOP provide guidance on how to assist consumers with requesting an appeal.

B. Procedures

All consumer eligibility determination notices contain instructions on how consumers may request an appeal. Consumers can mail or fax their appeal requests to the Marketplace. The appeal request may either be in the form of a letter or consumers may send a completed and signed appeal request form. Depending on consumers' preferred method for requesting an appeal, see the corresponding section below.

1. Complete and Mail or Fax an Appeal Request Form to the Marketplace

Step 1. If consumers choose to complete an appeal request form, they can find the correct appeal request form for their state by visiting HealthCare.gov/Marketplace-Appeals.

Step 2. Consumers should complete their state's appeal request form and then mail or fax their completed form, a copy of the eligibility notice they would like to appeal, and copies of any supporting documentation to:

Health Insurance Marketplace℠ Dept. of Health and Human Services
465 Industrial Blvd.
London, KY 40750-0061
Fax line: 1-877-369-0129

2. Write and Mail or Fax a Letter to the Marketplace

Step 1. If consumers choose to write a letter to the Marketplace to request an appeal, they should include the following information:

a. Name;

b. Address;

c. Reason for appeal request;

d. Name of the person (or people) on the application who is (are) appealing their eligibility determination(s); and

e. Copy of the eligibility notice (optional, but encouraged).

Step 2. Consumers may also include copies of any supporting documentation, such as pay stubs or W2 forms, to demonstrate household income. If they do not choose to submit documents with the appeal request, the Marketplace Appeals Center will notify the consumer about what, if any, information or documents it needs to adjudicate the appeal. Consumers should never send original documents but should be sure the copies they send to the Marketplace are legible.

Step 3. Consumers should either mail or fax their completed letter to:

Health Insurance Marketplace℠
Dept. of Health and Human Services
465 Industrial Blvd.
London, KY 40750-0061
Fax line: 1-877-369-0129

Things You Should Know

- Consumers should be sure to include the ZIP code extender (the "0061") when mailing documents or letters to the Marketplace.

3. Additional Information

Consumers may receive various notices during the appeals process. Exhibit 55 lists sample notices commonly used throughout the appeals process and their corresponding descriptions.

Exhibit 1—Appeals Notices

Notice Type	Description
Acknowledgment of Your Marketplace Eligibility Appeal	Notice explaining the appeal request has been received.
Notice of Informal Resolution	Notice explaining how CMS proposes to resolve the appeal informally, without a hearing.
Notice of Hearing	Notice explaining a hearing request has been received and details on the hearing (e.g., format, date, and time).
Appeals Decision Notice	Notice explaining the outcome of the hearing.
Notice of Marketplace Eligibility Appeal Dismissal	Notice explaining why the appeal has been dismissed. This notice includes a form to use if the consumer disagrees with the dismissal and wants to request that the appeal be reopened.
Notice Granting (or Denying) Request to Vacate an Appeal Dismissal	Notice explaining whether an appellant demonstrated 'good cause' to reopen an appeal that has been dismissed.

For more information on appeals, assisters and consumers can visit HealthCare.gov/Marketplace-Appeals.

For an overview of the appeals process, see this presentation on Marketplace Eligibility Appeals. An overview of the appeals process is also available at https://marketplace.cms.gov/technical-assistance-resources/assister-webinars.html.

Additional information is available at https://marketplace.cms.gov/outreach-and-education/appeals-eligibility-and-health-plan-decisions.pdf and https://marketplace.cms.gov/technical-assistance-resources/logo-and-infographics/steps-for-a-marketplace-appeal.pdf.

C. Next Steps

1. If consumers require further assistance with the appeals process, consider referring them to the Consumer Assistance Program or legal services program available in their state.[2]
2. For more help answering consumers' specific questions, see the Frequently Asked Questions (FAQs) related to SOP-10 Request an Eligibility Appeal.
3. Appellants with questions about their eligibility appeals may call the Marketplace Appeals Center at 1-855-231-1751 (TTY: 1-855-739-2231). The call center is available 7:30 AM to 8:45 PM (EST) Monday through Friday, and 10:00 AM to 5:30 PM (EST) Saturday.

Appendix A: Frequently Asked Questions (FAQs)

FAQ 1. How will I know when the Marketplace receives my appeal?

- Answer: You will receive a notice about your appeal request via mail or through your account in the Message Center. If you do not receive a notice, you can contact the Marketplace Call Center for assistance.

FAQ 2. How long will it take to receive a decision on my appeal?

- Answer: The time required to make a decision on your appeal will vary, based on factors including the reason for your appeal and whether you submit additional documentation to support your appeal.

FAQ 3. I cannot attend my hearing request date. Can I reschedule?

- Answer: Yes, you can reschedule if you have a conflict and cannot make the date and time scheduled for your eligibility appeal hearing. As soon as you know you have a conflict with when your hearing is scheduled, you should call the Marketplace Appeals Center to ask for a new date and time. The information on how to do this and the number to call is on your Notice of Hearing. Hearing Officers carefully prepare for hearings to be ready to appropriately conduct each appellant's hearing and then correctly decide the case. If you do not request a rescheduled hearing and fail to appear at your hearing, your appeal will be dismissed.

[2] For more information on Consumer Assistance Programs, visit http://www.CMS.gov/CCIIO/Resources/Consumer-Assistance-Grants. For more information on legal services, visit http://www.lsc.gov/find-legal-aid.

Appendix B: Acronyms & Definitions

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

Frequently Used Acronyms

Exhibit 2 – Frequently Used Acronyms

Acronym	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

Acronym	Descriptions
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
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)

Authorized Representative: Someone whom consumers designate in writing to act on their behalf with the Marketplace, like a family member or other trusted person. (Reference: 45 CFR §155.227)

Benefits: The health care items or services covered under a health plan. The health plan's coverage documents define the covered benefits and excluded services. In Medicaid or CHIP, the state program rules define covered benefits and excluded services. (Reference: HealthCare.gov/glossary/benefits)

Catastrophic Health Plan: Health plans that meet all of the requirements applicable to other QHPs but that don't cover any benefits other than three primary care visits per year before the plan's deductible is met, and complies with the requirement to cover certain preventive services without cost sharing obligations. The premium amount consumers pay each month for health care is generally lower than for other QHPs but the amounts for deductibles, copayments, and coinsurance are generally higher. To qualify for a catastrophic plan, consumers must be under 30 years old at the time of enrollment OR get an exemption because the Marketplace determined that they're unable to afford health coverage or have certain other hardships. (Reference: HealthCare.gov/glossary/catastrophic-health-plan)

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)

Children's Health Insurance Program (CHIP): Program jointly funded by state governments and the federal government that provides health coverage to low-income children and, in some states, pregnant women in families who earn too much income to qualify for Medicaid but cannot afford to purchase private health insurance coverage. (Reference: HealthCare.gov/glossary/childrens-health-insurance-program-chip)

Claim: A request for payment that a consumer, his or her authorized representative, or his or her health care provider submits to the consumer's health insurer when the consumer gets items or services he or she thinks are covered. (Reference: HealthCare.gov/glossary/claim)

Coinsurance: The consumer's share of the costs of a covered health care service calculated as a percent (for example, 20%) of the allowed amount for the service. Consumers pay coinsurance plus any deductibles they owe. For example, if the health insurance or plan's maximum allowed amount for a covered office visit is $100 and the consumer has met the plan's deductible, the consumer's coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. (Reference: HealthCare.gov/glossary/co-insurance)

Copayment: Also referred to as a copay, this is a fixed amount (for example, $15) a consumer pays for a covered health care service, usually when they receive the service. The amount can vary by the type of covered health care service. (Reference: HealthCare.gov/glossary/co-payment)

Cost-sharing Reduction: A discount that lowers the amount consumers have to pay out-of-pocket for deductibles, coinsurance, and copayments. Consumers also have a lower out-of-pocket maximum. Consumers are eligible for cost-sharing reductions if they get health insurance through a Marketplace, they meet household income requirements, and if they enroll in a health plan from the Silver plan category (See Health Plan Categories). Consumers may qualify for additional cost-sharing benefits if they are a member of a federally recognized tribe. (Reference: HealthCare.gov/glossary/cost-sharing-reduction)

Deductible: The amount consumers owe for covered health care services before their health insurance or plan begins to pay. For example, if a consumer's deductible is $1,000, the plan won't pay anything for covered health care services subject to the deductible until the consumer has met the $1,000 deductible. The deductible may not apply to all services. (Reference: HealthCare.gov/glossary/deductible)

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)

Employer-sponsored Health Insurance Plan (Group Health Plan): A group health plan or health coverage offered by an employer which may be a governmental plan or any other plan, or coverage offered in the small- or large - group marketplace within a state. (Reference: IRC §5000A(f)(2))

Enrollee: In an individual Marketplace, a qualified individual enrolled in a QHP through the Marketplace. (Reference: 45 CFR §155.20)

Essential Health Benefits (EHB): A set of health care service categories that certain plans must cover starting with plan years beginning in 2014.

The Affordable Care Act ensures that non-grandfathered health insurance plans offered in the individual and small-group markets, both inside and outside of the Health Insurance Marketplaces, offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following ten categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Insurance policies must cover these categories of benefits to be certified as qualified health plans that can be offered in the Health Insurance Marketplaces, and alternative benefit plans offered under Medicaid state plans (which must be offered to the new adult population) must cover these services by 2014. (Reference: HealthCare.gov/glossary/essential-health-benefits)

Federal Poverty Level (FPL): FPL represents a threshold level of household income used by the federal government to determine an individual's eligibility to participate in certain federal programs or qualify for advance payments of the premium tax credit or cost-sharing reduction in a Marketplace when enrolling in a QHP.

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)

Health Plan Categories: The Individual Marketplace generally separates health plans into four health plan categories — Bronze, Silver, Gold, or Platinum,— based on the amount the plan can be expected to pay of the average overall cost of providing essential health benefits to members. The plan category a consumer chooses affects the total amount the consumer will likely spend for essential health benefits during the year. For the four metal category plans, the percentages the plans will spend on average are 60% (Bronze), 70% (Silver), 80% (Gold), and 90% (Platinum). This is not the same as coinsurance in which a consumer pays a specific percentage of the cost of a specific service. (Reference: HealthCare.gov/glossary/health-plan-categories)

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)

Job-based Coverage: Also referred to as a job-based health plan, group health plan or employer-sponsored health insurance plan, coverage that an employer offers to employees (and may also offer to employees' family members). (Reference: HealthCare.gov/glossary/job-based-health-plan)

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)

Medicaid: A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their programs, in which Medicaid can vary state by state and may have a different name in your state. (Reference: HealthCare.gov/glossary/medicaid)

Medicare: A federal health insurance program for people who are age 65 or older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). (Reference: HealthCare.gov/glossary/medicare)

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)

Modified Adjusted Gross Income (MAGI): The figure used to determine eligibility for lower costs in the Marketplace and for Medicaid and CHIP applicants whose eligibility is based on MAGI. Generally, MAGI is an individual's adjusted gross income plus any tax-exempt Social Security, interest, or foreign income the individual has. (Reference: HealthCare.gov/glossary/modified-adjusted-gross-income-magi)

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)

Plan Year: A consecutive twelve-month period during which a health plan provides coverage for health benefits. A plan year may be a calendar year. (Reference: 45 CFR §155.20)

Premium: The amount that consumers or employers pay for a health insurance or job-based coverage. Premiums are paid by the consumer or employers on a monthly, quarterly, or yearly basis. (Reference: HealthCare.gov/glossary/premium)

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)

Qualified Individual: An individual who has been determined eligible to enroll in a QHP through an Individual Marketplace. (Reference: 45 CFR §155.20)

Special Enrollment Period (SEP): In the individual market, a period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP through the Marketplace outside of the annual individual market open enrollment period. For example, individuals who lose employer-sponsored health coverage, or who lose Medicaid coverage because of an increase in income, would be eligible for a SEP to enroll in a Marketplace plan, if they otherwise qualify. Other triggering events include marriage, divorce, and the birth or adoption of a child. (Reference: 45 CFR §155.20)

TRICARE: A health care program for active-duty and retired uniformed services members and their families. (Reference: HealthCare.gov/glossary/tricare)

Appendix C: Federal Poverty Guidelines

Exhibit 3—2016 Annual Poverty Guidelines for All States (Except Hawaii and Alaska)

Family Size	100%	120%	133%	135%	150%	175%	185%	200%	250 %
1	11,880.00	14,256.00	15,800.40	16,038.00	17,820.00	20,790.00	21,978.00	23,760.00	29,700.00
2	16,020.00	19,224.00	21,306.60	21,627.00	24,030.00	28,035.00	29,637.00	32,040.00	40,050.00
3	20,160.00	24,192.00	26,812.80	27,216.00	30,240.00	35,280.00	37,296.00	40,320.00	50,400.00
4	24,300.00	29,160.00	32,319.00	32,805.00	36,450.00	42,525.00	44,955.00	48,600.00	60,750.00
5	28,440.00	34,128.00	37,825.20	38,394.00	42,660.00	49,770.00	52,614.00	56,880.00	71,100.00
6	32,580.00	39,096.00	43,331.40	43,983.00	48,870.00	57,015.00	60,273.00	65,160.00	81,450.00
7	36,730.00	44,076.00	48,850.90	49,585.50	55,095.00	64,277.50	67,950.50	73,460.00	91,825.00
8	40,890.00	49,068.00	54,383.70	55,201.50	61,335.00	71,557.50	75,646.50	81,780.00	102,225.00

**For family units with more than eight members, add $4,160 for each additional family member.*

Exhibit 4—2016 Annual Poverty Guidelines for Alaska Only

Family Size	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	14,840	17,808.00	19,737.20	20,034.00	22,260.00	25,970.00	27,454.00	29,680.00	37,100.00
2	20,020	24,024.00	26,626.60	27,027.00	30,030.00	35,035.00	37,037.00	40,040.00	50,050.00
3	25,200	30,240.00	33,516.00	34,020.00	37,800.00	44,100.00	46,620.00	50,400.00	63,000.00
4	30,380	36,456.00	40,405.40	41,013.00	45,570.00	53,165.00	56,203.00	60,760.00	75,950.00
5	35,560	42,672.00	47,294.80	48,006.00	53,340.00	62,230.00	65,786.00	71,120.00	88,900.00
6	40,740	48,888.00	54,184.20	54,999.00	61,110.00	71,295.00	75,369.00	81,480.00	101,850.00
7	45,920	55,104.00	61,073.60	61,992.00	68,880.00	80,360.00	84,952.00	91,840.00	114,800.00
8	51,120	61,344.00	67,989.60	69,012.00	76,680.00	89,460.00	94,572.00	102,240.00	127,800.00

**For family units with more than eight members, add $5,200 for each additional family member.*

Exhibit 5—2016 Annual Poverty Guidelines for Hawaii Only

Family Size	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	13,670	16,404.00	18,181.10	18,454.50	20,505.00	23,922.50	25,289.50	27,340.00	34,175.00
2	18,430	22,116.00	24,511.90	24,880.50	27,645.00	32,252.50	34,095.50	36,860.00	46,075.00
3	23,190	27,828.00	30,842.70	31,306.50	34,785.00	40,582.50	42,901.50	46,380.00	57,975.00
4	27,950	33,540.00	37,173.50	37,732.50	41,925.00	48,912.50	51,707.50	55,900.00	69,875.00
5	32,710	39,252.00	43,504.30	44,158.50	49,065.00	57,242.50	60,513.50	65,420.00	81,775.00
6	37,470	44,964.00	49,835.10	50,584.50	56,205.00	65,572.50	69,319.50	74,940.00	93,675.00
7	42,230	50,676.00	56,165.90	57,010.50	63,345.00	73,902.50	78,125.50	84,460.00	105,575.00
8	47,010	56,412.00	62,523.30	63,463.50	70,515.00	82,267.50	86,968.50	94,020.00	117,525.00

**For family units with more than eight family members, add $4,780 for each additional family member.*

State	CHIP Program Name	CHIP Program Website	Medicaid Program Website
Indiana	Hoosier Healthwise Package C	http://member.indianamedicaid.com/programs--benefits/medicaid-programs/hoosier-healthwise/hhw-covered-services-.aspx	http://member.indianamedicaid.com/programs--benefits/medicaid-programs/hoosier-healthwise/hhw-covered-services-.aspx
Iowa	Hawk-I	http://www.hawk-i.org	http://dhs.iowa.gov/ime/about
Kansas	KanCare CHIP	http://www.kdheks.gov/hcf/Medicaid/about.html	http://www.kdheks.gov/hcf/Medicaid/about.html
Kentucky	KCHIP	http://kidshealth.ky.gov/en/kchip/	http://www.chfs.ky.gov/dms
Louisiana	LaCHIP	http://www.lachip.org	http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Maine	MaineCare	http://www.maine.gov/dhhs/ofi/services/cubcare/Getting%20an%20Application.htm	http://www.maine.gov/dhhs/oms/
Maryland	Maryland Children's Health Connection Program (MCHP)	https://www.marylandhealthconnection.gov/	https://www.marylandhealthconnection.gov/
Massachusetts	MassHealth	http://www.mass.gov/eohhs/gov/departments/masshealth/	http://www.mass.gov/eohhs/gov/departments/masshealth/
Michigan	MIChild	http://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943_4845_4931---,00.html	http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860---,00.html
Minnesota	Medical Assistance (MA)	http://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp	http://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Mississippi	Mississippi Health Benefits CHIP	https://medicaid.ms.gov/programs/childrens-health-insurance-program-chip/	http://www.medicaid.ms.gov
Missouri	MO HealthNet for Kids	http://www.dss.mo.gov/mhk/index.htm	http://www.dss.mo.gov/mhd
Montana	Healthy Montana Kids	http://www.dphhs.mt.gov/hmk	http://dphhs.mt.gov/montanahealthcareprograms/welcome/memberservices
Nebraska	Nebraska CHIP	http://dhhs.ne.gov/medicaid/Pages/med_CHIP.aspx	http://dhhs.ne.gov/medicaid/Pages/med_medindex.aspx
Nevada	Nevada Check Up	https://www.nevadahealthlink.com/individuals-families/medicaidnevada-check-up/	https://www.medicaid.nv.gov
New Hampshire	Expanded Children's Medicaid	http://www.dhhs.nh.gov/dfa/medical/children.htm	http://www.dhhs.nh.gov/ombp/medicaid/

State	CHIP Program Name	CHIP Program Website	Medicaid Program Website
New Jersey	NJ Family Care	http://www.njfamilycare.org	http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
New Mexico	Centennial Care	http://www.hsd.state.nm.us/LookingforAssistance/centennial-care-overview.aspx	http://www.hsd.state.nm.us/LookingforAssistance/centennial-care-overview.aspx
New York	Child Health Plus	https://www.health.ny.gov/health_care/medicaid/	http://www.health.ny.gov/health_care/medicaid
North Carolina	NC Health Choice for Children	https://dma.ncdhhs.gov/medicaid	https://dma.ncdhhs.gov/medicaid
North Dakota	Healthy Steps	https://www.nd.gov/dhs/services/medicalserv/chip/	http://www.nd.gov/dhs/services/medicalserv/medicaid
Ohio	Healthy Start	http://www.medicaid.ohio.gov/FORROHIOANS/Programs/ChildrenFamiliesandWomen.aspx	http://medicaid.ohio.gov
Oklahoma	SoonerCare	http://www.okhca.org/individuals.aspx?id=52&menu=114&parts=11601_7453	http://www.okhca.org/individuals.aspx?id=52&menu=114&parts=11601_7453
Oregon	Oregon Health Plan	http://www.oregon.gov/oha/healthplan/pages/index.aspx	http://www.oregon.gov/oha/healthplan/pages/index.aspx
Pennsylvania	Pennsylvania CHIP	http://www.chipcoverspakids.com	http://www.dhs.pa.gov/citizens/healthcaremedicalassistance/#.VvQ9Xrz5d90
Rhode Island	HealthSourceRI	http://www.dhs.ri.gov	http://www.dhs.ri.gov
South Carolina	Partners for Healthy Children	https://www.scdhhs.gov/eligibility-groups/partners-healthy-children-phc	https://www.scdhhs.gov
South Dakota	South Dakota CHIP	https://dss.sd.gov/medicaid/generalinfo/medicalprograms.aspx	http://dss.sd.gov/medicaid/
Tennessee	Cover Kids	http://www.tn.gov/coverkids/section/cover-kids	http://www.tn.gov/tenncare
Texas	Texas CHIP	http://www.chipmedicaid.org	http://www.hhsc.state.tx.us/medicaid
Utah	Utah CHIP	http://www.health.utah.gov/chip	http://health.utah.gov/medicaid/provhtml/general_info.html
Vermont	Dr. Dynasaur	http://info.healthconnect.vermont.gov/Medicaid	http://www.greenmountaincare.org
Virginia	Family Access to Medical Insurance (FAMIS)	http://www.famis.org	http://www.dss.virginia.gov/benefit/medical_assistance/
Washington	Apple Health	http://www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage	http://www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage

State	CHIP Program Name	CHIP Program Website	Medicaid Program Website
West Virginia	West Virginia CHIP	http://www.chip.wv.gov	http://www.dhhr.wv.gov/bms/Pages/default.aspx
Wisconsin	BadgerCare Plus	https://www.dhs.wisconsin.gov/badgercareplus/index.htm	https://www.dhs.wisconsin.gov/badgercareplus/index.htm
Wyoming	Kid Care CHIP	http://health.wyo.gov/healthcarefin/chip	https://wyequalitycare.acs-inc.com/

Appendix E: Support Resources

If consumers require assistance that is outside of assister activities, refer consumers to other organizations and resources as appropriate. Exhibit 69 provides a list of external resources.

Exhibit 7—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.
Experian Help Desk	1-866-578-5409	The Experian Help Desk assists consumers with verifying their identity over the phone so that they may proceed with eligibility and enrollment activities after creating an account on HealthCare.gov.	To verify their identity over the phone if they were unsuccessful in their attempt to verify their identity on HealthCare.gov. When necessary, consumers will receive a unique identity verification code and will be instructed to contact the Experian Help Desk.
Marketplace Call Center	1-800-318-2596 TTY: 1-855-889-4325 (all languages available)	The Marketplace Call Center provides assistance to consumers who need information or want to enroll in health coverage through an FFM.	To get answers to questions while applying for health coverage using the online or paper application. To apply for health coverage over the phone.
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.

Resource	Contact Information	What does this resource do?	How should consumers use this resource?
Indian Health Service (IHS)	http://www.IHS.gov	This division of HHS is dedicated to providing federal health services to American Indians and Alaska Natives.	To learn more about the Affordable Care Act provisions that apply to American Indians or Alaskan Natives. To learn more about exemptions and lower health coverage costs available to American Indians or Alaskan Natives.
Internal Revenue Service (IRS)	http://www.IRS.gov	This federal agency collects taxes from individuals and businesses in the U.S.	To learn more about the effects of the Affordable Care Act on consumers' tax returns.
Medicaid	http://www.Medicaid XE "Medicaid" .gov	This state-administered health insurance program is for low-income families and children, pregnant women, the elderly, people with disabilities, and in many states, other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their program, so Medicaid varies state-by-state and may have a different name in your state.	To find answers to questions about health coverage through Medicaid or CHIP. To get further information about their state's Medicaid program and agency contact information.
Medicare	http://www.Medicare XE "Medicare" .gov	This federal program is run by CMS and provides health coverage to qualified individuals who are 65 years of age or older and/or have a disability.	To learn more about eligibility for Medicare or apply for Medicare online. To learn more about or make changes to existing Medicare benefits.
State Health Insurance Assistance Program (SHIP) Office	http://www.shiptacenter.org	The state-based SHIP program offers one-on-one counseling and assistance to people covered by Medicare and their families.	To receive free in-person or telephone counseling on navigating the health care system and Medicare program.

Resource	Contact Information	What does this resource do?	How should consumers use this resource?
Social Security Administration (SSA)	http://www.SSA.gov	This independent federal agency administers Social Security, A system that distributes financial benefits to retired or disabled people, their spouses, and their dependent children based on their reported earnings.	To learn more about available Social Security benefits for which consumers might be eligible. To apply for a Social Security number, which is necessary to apply for health coverage through the Marketplace (except for legal immigrants, who can provide a document number).
Veterans Affairs (VA) Health Benefits	http://www.VA.gov/health/aca	The Department of Veterans Affairs provides comprehensive health care programs, services and benefits to Veterans and other beneficiaries who are enrolled in the following programs: Veterans Health Care Program, VA Civilian Health and Medical Program (CHAMPVA), or Spina Bifida Health Care Benefits Program.	To learn more about or apply for VA health benefits.