MARKETPLACE
ASSISTER TOOLKIT

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

## *SOP 2—Assess Consumers' Knowledge & Needs*

Version 6.0 June 2018. 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. Some information contained in this manual may also be of interest to individuals helping consumers in State-based Marketplaces and State-based Marketplaces on the Federal Platform. This document is intended only as a summary of legal requirements and to provide operational information, and does not itself create any legal rights or obligations. All legal requirements are fully stated in the applicable statutes and regulations. This material was produced and disseminated at U.S. taxpayer expense.

# Table of Contents

# List of Exhibits

# SOP 2—Assess Consumers' Knowledge & Needs

## A. Introduction

Standard Operating Procedure (SOP) 2 will assist you in understanding the type of support consumers require so that you can assist them.

## B. Procedures

### 1. Assess Consumers' Knowledge

As a best practice, have a conversation with consumers to gauge their knowledge of health coverage, the Patient Protection and Affordable Care Act (PPACA), and the Marketplace. The Knowledge Checks and Sample Questions listed in Exhibit 1 provide ideas to help you start a conversation to assess consumers' understanding.

**Exhibit 1—Knowledge Assessment Guide**

| Knowledge Category | Knowledge Checks | Sample Questions |
|---|---|---|
| **Health Coverage** | Determine if consumers:<br>• Understand the basics of health coverage.<br>• Know that for individual market health insurance, consumers and insurance companies pay for health care.<br>• Understand key terms, such as premiums, deductibles, coinsurance, and copayments.<br>• Know that insurance companies contract with different networks of doctors, and that their health care provider may not be included in some insurance networks. | • What questions do you have about health coverage?<br>• How have you managed your health care costs in the past?<br>• Do you understand how premiums, deductibles, coinsurance, and copayments function?<br>• Do you have a doctor you see regularly? How would you feel if you had to see a new or different doctor? |

| Knowledge Category | Knowledge Checks | Sample Questions |
|---|---|---|
| **Affordable Care Act** | Determine if consumers:<br>• Are aware of the preventive services available to them without cost sharing when they have non-grandfathered coverage.<br>• Understand that there are limits on the amount they will pay in cost sharing for essential health benefits each year under individual market coverage (excluding grandfathered coverage). However, be aware that consumers may be eligible for non-inidivdual market coverage that are not required to cover essential health benefits (e.g. Medicare, a large group employer plan, or an Association Health Plan.<br>• Are aware that they can no longer be denied coverage or charged more in the individual market for having a pre-existing medical condition.<br>• Understand the individual shared responsibility payment.[i]<br>• Know the exemptions available from the individual shared responsibility payment and the requirement to maintain minimum essential coverage and how to apply for an exemption if they think they might be eligible. Even when the individual shared responsibility payment is set at $0 for months beginning after December 31, 2018, consumers may still seek a affordability or hardship exemption to be eligible for catastrophic coverage. | • What questions do you have about how the Affordable Care Act can lower the cost of your coverage?<br>• What questions do you have about the requirement to maintain minimum essential coverage?<br>• Are you aware that some consumers may be exempt from the requirement to maintain minimum essential coverage? |

| Knowledge Category | Knowledge Checks | Sample Questions |
|---|---|---|
| **Marketplace** | Determine if consumers:<br>• Understand the eligibility requirements for health coverage, premium tax credits, and cost sharing reductions available through a Marketplace.<br>• Are aware of the key dates for the Marketplace annual Open Enrollment period, during which any consumer can apply for health coverage.<br>• Are aware of the different health coverage options.<br>• Are aware of the available programs to lower the costs of health coverage.<br>• Understand the essential health benefits covered by all QHPs offered through a Marketplace (as well as most individual and small group coverage outside the Marketplace). | • What questions do you have about applying for and enrolling in health coverage through a Marketplace?<br>• Are you aware of the start and end dates for the Marketplace annual Open Enrollment period?<br>• How can I help you apply for health coverage through a Marketplace?<br>• What questions do you have about the health coverage available through a Marketplace?<br>• What are your concerns about paying for coverage?<br>• Are you aware of the types of services covered by health coverage available through a Marketplace? |

### 2. Assess Consumers' Needs

**Step 1.** As a best practice, have conversations with consumers to learn about their health coverage status, any questions they might have about the enrollment process, and problems they might have with completing their Marketplace applications. During this discussion, you should attempt to find out:

a. Whether consumers have existing health coverage and, if so, whether that coverage continues to meet their needs (e.g., if it is ending, benefits are changing, costs are changing);

b. Who is in need of health coverage (e.g., consumers and/or family members);

c. Whether consumers have started the Marketplace eligibility application process, and if they have, what stage in the application process they have reached (e.g., submitted the application, received an eligibility determination, ready to select a QHP);

d. How consumers intend to pay for the coverage (e.g., with advance payments of the premium tax credit, with personal income); and

## C. Next Steps

1. If consumers require additional information about health coverage, the Affordable Care Act, or the Marketplace, a good place to start is to refer to the resources on Marketplace.cms.gov.

2. If consumers are ready to begin eligibility and enrollment activities or have questions about exemptions from the individual shared responsibility payment requirement to maintain minimum essential coverage, proceed to the appropriate SOP(s) in this Manual.

3. For more help answering consumers' specific questions, refer to the Appendix A: Frequently Asked Questions (FAQs) related to SOP-2 Assess Consumers' Knowledge & Needs.

## Appendix A: Frequently Asked Questions (FAQs)

The FAQs below are designed to help assisters answer consumers' specific questions on how assisters assess consumers' knowledge of and needs within the Individual Marketplace. For more information on this topic, see SOP-2 Assess Consumers' Knowledge & Needs.

FAQ 1. Why do assisters ask questions to assess my knowledge and needs before helping me with eligibility and enrollment activities in the Individual Marketplace?

- Answer: For an assister to help you make the most informed choices about your health coverage, an assister needs to understand how much you know about health coverage, the Affordable Care Act, and the Marketplace. You might also have specific health needs that should be taken into consideration when you are comparing health coverage options. Therefore, assisters want to understand your needs to tailor their assistance to meet your unique circumstances.

FAQ 2. How do assisters assess my knowledge and needs?

- Answer: Assisters will have an informal conversation with you and ask you a number of questions designed to evaluate your knowledge and needs for health coverage. For example, an assister might ask if you have concerns about paying for coverage and whether you know that you may be eligible for help paying for coverage. They may also ask you whether you understand how premiums, deductibles, coinsurance, and copayments work.

## 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**

| 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:

**Advance Payments of the Premium Tax Credit: (APTC)** The Affordable Care Act provides a premium tax credit to help consumers afford health coverage purchased through a Marketplace. Consumers can use advance payments of the premium tax credit to lower their monthly premium costs. If consumers qualify, they may choose how much in advance payments of the premium tax credit to apply to their premiums each month, up to a maximum amount. If the amount of advance payments of the premium tax credit consumers get for the year is less than the premium tax credit they're due based on their annual household income, they'll get the difference as a refundable credit when they file their federal income tax return. If their advance payments of the premium tax credit for the year are more than the amount of the premium tax credit for which they are eligible, they may be required to repay the excess advance payments with their tax return. (Reference: HealthCare.gov/glossary/advanced-premium-tax-credit)

**Affordable Care Act:** The comprehensive health care reform law enacted in March 2010. Congress passed the law in two parts. Former President Obama 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)

**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)

**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)

**Marketplace Catastrophic Health Plan:** Health plans that meet all of the requirements applicable to other individual market plans but that don't cover any benefits other than three primary care visits per year before the plan's deductible is met, and that comply with the requirement to cover certain preventive services without cost sharing obligations. The premium amount consumers pay each month for catastrophic health plans is generally lower than that for other plans 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 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 understand the eligibility and enrollment process. 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)

**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)

**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)

**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 Marketplace, 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 Marketplace, 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)

**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")[ii]:** Under the Tax Cuts and Jobs Act of 2017, taxpayers must continue to report minimum essential coverage (MEC), qualify for an exemption, or pay an individual shared responsibility payment for tax years prior to 2019. Taxpayers should continue to file their tax returns as they normally would.

Beginning with coverage year 2019, individuals who choose to go without insurance will no longer be subject to making shared responsibility payments. Although tax reform legislation enacted in December 2017 reduces to $0 the individual shared responsibility payment for months beginning after December 31, 2018, individuals may still have reason to seek a other types of exemptions, like an affordability or hardship exemption for purposes of obtaining catastrophic coverage for 2019 and future years.

In previous years, the individual shared responsibility was phased in according to the following schedule: 1% of household income (or $95 per adult, whichever is higher) in 2014; 2.0% of household income (or $325 per adult) in 2015; 2.5% of household income (or $695 per adult) in 2016 and 2017, up to a maximum of $2,085. The fee for children was half the adult amount. (Reference: HealthCare.gov/glossary/fee; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019)

**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 making the individual shared responsibility payment (unless they qualify for an exemption) when they file a federal income tax return.[iii] 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)

**In Person Assistance Personnel Program**: 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 2019, the individual market Open Enrollment period is November 1, 2018 – December 15, 2018.[iv] 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)

**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 Patient Protection and Affordable Care Act, an insurance plan that is certified by the 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)

[i] Tax reform legislation enacted in December 2017 reduces to $0 the individual shared responsibility payment for months beginning after December 31, 2018.
[ii] Final 2018 amounts will be published when available. https://www.healthcare.gov/glossary/penalty/.
[iii] Under tax reform legislation that was enacted on December 22, 2017 (Pub. L. 115-97, 131 Stat. 2054), the individual shared responsibility payment is reduced to $0, effective for months beginning after December 31, 2018.
[iv] Open enrollment for 2018 coverage was November 1, 2017 through December 15, 2017 for a January 1, 2018 effectuation date. https://www.healthcare.gov/blog/2018-open-enrollment-is-here/.