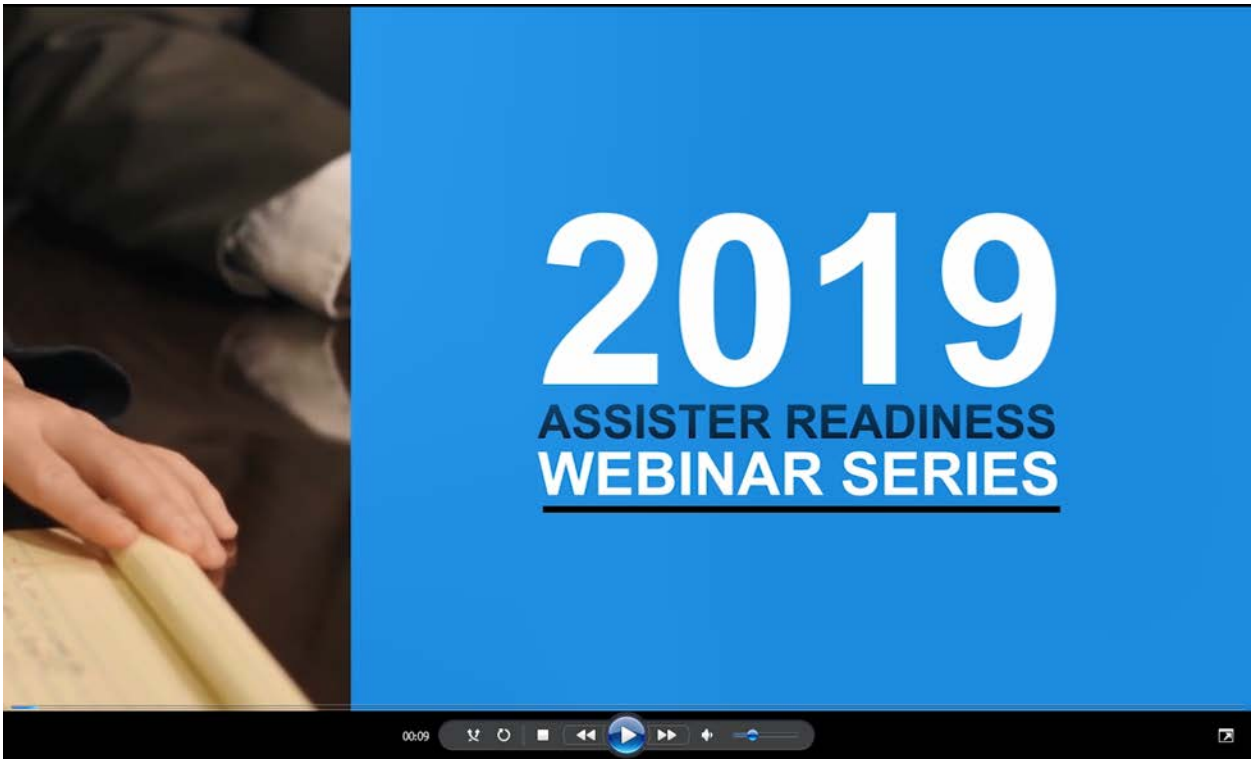
Special Circumstances for Marketplace Eligibility



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

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Disclaimer

Hi my name is Dan, welcome to the 2019 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.

Also remember that this series is designed as a supplement. This will be delivered in weekly installments. And each weekly installment will include several pre-recorded educational modules and a corresponding LIVE Friday webinar.

Introduction

When you help consumers apply for health coverage through the individual market FFMs, you should be aware of special circumstances that may affect eligibility for individuals in certain common situations**.**

In this module, we will cover Marketplace eligibility criteria and other considerations for the following:

- Households that include immigrants,
- American Indians and Alaska Natives,
- Married same-sex couples,
- Consumers living with HIV and AIDS,
- Consumers eligible or ineligible for Medicaid,
- Consumers with disabilities,
- Older consumers,
- Veterans,
- Consumers experiencing homelessness, and
- College students.

Marketplace Insurance Affordability Programs for Households that Include Immigrants

You probably recall that consumers must be U.S. citizens, U.S. nationals, or lawfully present noncitizens to be eligible for Marketplace coverage.

The Marketplaces consider an immigrant or noncitizen "lawfully" present if he or she meets the following:

- Has been admitted into the U.S. legally and is still present within the legally approved period, or
- Has permission from the U.S. Citizenship and Immigration Services, known as USCIS, to stay or live in the U.S.

Like other types of consumers, lawfully present immigrants may apply for advance payments of the premium tax credit and cost-sharing reductions, or APTC and CSRs, when they apply for Marketplace coverage in the following cases:

- If their estimated annual household income is at or below 400 percent of the Federal Poverty Level or FPL but above 100 percent of the FPL, lawfully present immigrants may be eligible for APTC.
- If their estimated annual household income is between 100 and 250 percent of the FPL, lawfully present immigrants may be eligible for APTC and CSRs.
- If their estimated annual household income is below 100 percent of the FPL, lawfully present immigrants may be eligible for APTC and CSRs as long as they meet all other eligibility requirements and are not eligible for Medicaid based on their immigration status.

Medicaid and CHIP Eligibility for Immigrants

Depending on their specific circumstances, some or all members of immigrant households may be eligible for health coverage through Medicaid and the Children's Health Insurance Program, or CHIP. Consumers who are eligible for these programs may not be eligible to enroll in a qualified health plan or QHP through a Marketplace with financial assistance. Medicaid- and CHIP-eligible immigrants include the following:

- Qualified non-citizens who entered the U.S. before August 1996;
- Qualified immigrants who reach the end of the five-year waiting period, such as lawful permanent residents and Green Card holders; and
- Qualified immigrants who are exempt from a five-year waiting period for Medicaid and CHIP, including refugees, asylees, Cuban or Haitian entrants, trafficking victims, and veteran families.

Other immigrants who are eligible for Medicaid and CHIP include:

- Recipients of Supplemental Security Income, or SSI, as well as
- Individuals who are granted U.S. entry with conditional entrant status —either because of a natural catastrophe or because they are asylees who fear persecution in their home country due to race, religion, or political opinions, and
- Certain victims of human trafficking.

- If non-citizens are age 18 or older, they must be certified as victims of trafficking by the U.S. Department of Health and Human Services, or HHS. Children younger than age 18 need an HHS eligibility letter.
- T-visa holders' spouses and children are also eligible for Medicaid and CHIP. A T-visa is a special visa for victims of human trafficking and their families.
- In some states, lawfully present children and pregnant women are also eligible for Medicaid and CHIP. Approximately half of the states and Washington, D.C. grant eligibility to this group, but specific eligibility rules vary by state.

You should note that federal funding does not cover undocumented immigrants except payment for limited emergency services. For more information, refer to the optional course on *Serving Vulnerable and Underserved Populations* in the Marketplace Learning Management System (MLMS).

Scenario: Mixed-Immigration Status Households

In a mixed immigration status household, one or more members of the same family are lawfully present noncitizens, qualified noncitizens, or U.S. citizens while other members aren't. Let's look at an example of a mixed immigration status household seeking health coverage.

Mixed Immigration Status

Pierre and LaGrande aren't lawfully present in the U.S. They have a daughter, Matou, who was born in the U.S. and is a U.S. citizen.

Matou lives in a state served by an FFM, and she is not incarcerated.

While Matou is eligible to purchase health coverage through the FFM, her parents are not.

Keep in mind that those who aren't lawfully present can still apply for health coverage for their family members who are in the U.S. legally without being asked to provide a Social Security Number or other proof of being lawfully present.

Parents like Pierre and LaGrande, who aren't lawfully present, can apply for coverage for their daughter Matou because she is a U.S. citizen.

Best Practices for Working with Immigrant Populations

Consumers' immigration status may be a sensitive topic. Some consumers who are immigrants may not know their immigration status or have correct information about their status, while others may not have a Social Security Number or a Green Card even when they're lawfully present. You should be mindful of this during your conversations with consumers. When you work with immigrant families, you can use these best practices to help you.

Provide information about eligible immigration statuses and acceptable immigration documents.
Consumers then have the information they need to decide who in their family may have an eligible immigration status to apply for health coverage.

Share information about other resources.
Share information with consumers about other resources in the community that might be able to help them.

Identify the applicant.
Be sure to correctly identify the consumer or consumers who are applying for health coverage by asking whether they're seeking coverage for themselves or on behalf of someone else.

Avoid unnecessary questions.
Don't ask unnecessary questions, especially questions about the immigration status of consumers who aren't applying for health coverage and live in mixed immigration status households. Avoid words such as “undocumented,” “unauthorized,” or “illegal.” Instead, show consumers a list of immigration status types and documents at HealthCare.gov.

Marketplace Insurance Affordability Programs for American Indians and Alaska Natives

The FFMs provide special health coverage protections and benefits for American Indians and Alaska Natives, who are sometimes referred to as American Indians and Alaska Natives. Take a moment to review this information on American Indians and Alaska Natives.

- Like all Americans, American Indians and Alaska Natives who enroll in a QHP generally must pay monthly premiums and may qualify for APTC to lower their premium costs through the FFMs. However, American Indians and Alaska Natives whose household income is between 100 and 300 percent of the FPL can enroll in a “zero cost sharing” plan within any metal level health plan category. This means they won’t have to pay any additional costs like deductibles, copayments, and coinsurance when they get care.

  In addition, American Indians and Alaska Natives whose household income is below 100 percent of the FPL and above 300 percent of the FPL can enroll in a limited cost sharing plan. American Indians and Alaska Natives with limited cost sharing plans need a referral from an Indian health care provider when getting essential health benefits through a Marketplace plan to avoid paying copayments, deductibles, or coinsurance.
- American Indians and Alaska Natives can also receive a Special Enrollment Period to enroll in or change QHPs every month. They don’t have to wait for the yearly Open Enrollment Period.
- Even if they enroll in a QHP through the Marketplace or get Medicare, Medicaid, or CHIP coverage, American Indians and Alaska Natives don’t pay out-of-pocket costs for Indian health programs. Regardless of income, they won’t have any out-of-pocket costs for items or services they receive from the Indian Health Service, tribal programs, or urban Indian programs (known as I/T/Us).
- If American Indians and Alaska Natives don’t have health insurance, they can claim an Indian health coverage exemption and won't have to pay an individual shared responsibility payment.

Here’s a key tip. Beginning with tax year 2019, remember that all individuals who choose to go without insurance will no longer be subject to making shared responsibility payments.

Working Effectively with American Indians and Alaska Natives

To show that they meet certain eligibility criteria for Marketplace coverage, American Indians and Alaska Natives may need to provide a copy of a document issued by a federally recognized tribe, the Bureau of Indian Affairs, or an Alaska Native Claims Settlement Act Corporation. This document should show their membership, enrollment, or shareholder status and must have a signature and seal on it.

For a complete list of acceptable tribal documents American Indians and Alaska Natives may provide, visit HealthCare.gov/american-indians-alaska-natives.

If American Indians and Alaska Natives consumers and their families apply for help paying for coverage through the FFMs, the Marketplace application asks them to provide income information that is reportable on their federal income tax returns.

In general, American Indians and Alaska Natives income from Indian trust land, natural resources, and items of cultural significance aren't counted for Medicaid or CHIP eligibility if the income isn't reported on a federal income tax return, such as income from treaty fishing rights.

However, per capita income derived from gaming is taxable and American Indians and Alaska Natives should include it on a Marketplace application when applying for QHP coverage, Medicaid, and CHIP.

For more information about American Indians and Alaska Natives eligibility and working with American Indians and Alaska Natives consumers, refer to the *Serving Vulnerable and Underserved Populations* and *Advance Marketplace Issues* courses in the MLMS.

Married Same-Sex Couples

Next we'll discuss a few considerations for married same-sex couples.

As long as a couple is legally married under the laws of the jurisdiction where the marriage occurred, insurance companies can't discriminate against them when offering coverage.

This means insurance companies must offer the same coverage to same-sex spouses that they offer to opposite-sex spouses.

In addition, federal regulations prohibit health insurance companies that offer non-grandfathered group or individual health insurance coverage from using marketing practices or benefit designs that discriminate on the basis of certain factors, including a consumer's sexual orientation.

Here's an important tip about the premium tax credit and same-sex couples. The FFMs treat married same-sex couples the same as married opposite-sex couples when they apply for APTC, CSRs, Medicaid, and CHIP. Like married opposite-sex couples, married same-sex couples must file a joint federal income tax return for the year that they're seeking help paying for coverage to be eligible for APTC and CSRs.

Assisting Consumers living with HIV/AIDS

Additional resources are available to consumers living with HIV and AIDS that can affect how these consumers pay for Marketplace coverage.

Many consumers living with HIV and AIDS receive assistance from the Ryan White HIV/AIDS Program or RWHAP. The RWHAP provides care and services for people with HIV or AIDS who are uninsured or underinsured, serving as a payer of last resort.

This means RWHAP provides services and coverage that are not already covered by other payment sources like Medicaid, CHIP, or private health insurance. The RWHAP provides federal funding to states, cities, and providers of HIV and AIDS coverage and treatment but not directly to consumers.

While some consumers living with HIV and AIDS may also be eligible for Medicaid or CHIP, those who receive RWHAP assistance while enrolled in a QHP may be eligible to have their QHP premiums paid directly to their issuer by the RWHAP. If these consumers get APTC, the RWHAP may pay for premium

amounts that APTC do not already cover. RWHAP funds may also be used to help pay copayments, deductibles, and coinsurance, as well as other medical or prescription drug benefits.

When you encounter consumers living with HIV or AIDS, it's a best practice to advise them to contact their local RWHAP office with detailed questions. If consumers have questions about using RWHAP assistance to help cover their QHP premiums and additional costs, they can generally ask their healthcare provider or a RWHAP representative.

Medicaid Assessment States: Consumers Newly Eligible for Medicaid or CHIP

Now let's review some special circumstances for consumers who might be eligible for Medicaid or CHIP. Remember, you can review the *Affordable Care Act Basics* course in the MLMS for a more comprehensive overview of Medicaid and CHIP eligibility.

Medicaid Determination States

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 States

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 application to the state Medicaid or CHIP agency for a final eligibility determination.

If you serve consumers in a Medicaid assessment state and the state notifies them that they are in fact eligible to enroll in Medicaid, you should advise them to terminate Marketplace coverage with APTC immediately for any individuals who are determined eligible for these programs. Once an individual becomes eligible for Medicaid, CHIP, or a CHIP buy-in program that qualifies as minimum essential coverage or MEC, that individual is no longer eligible to receive APTC and CSRs in an FFM.

However, consumers who wish to remain enrolled in a Marketplace plan at full cost should:

1. Update their existing applications and attest that they are currently enrolled in Medicaid or CHIP. The Marketplace will end their financial assistance.
2. Then, they should confirm their enrollment in the same Marketplace plan without financial assistance.

If consumers have a waiting period before they can get Medicaid or CHIP coverage, they will be notified by their state. Consumers should call their state Medicaid or CHIP agency directly if they don't receive a call or letter within 30 days of applying. Consumers may still be eligible for financial assistance for their Marketplace plan while they are in a waiting period.

Medicaid Assessment States: Consumers Ineligible for Medicaid or CHIP

If consumers in Medicaid assessment states are determined ineligible for Medicaid or CHIP, they have a few options.

If a state agency determines an individual is ineligible for Medicaid or CHIP, it will return the application to the state's FFM. The FFM will then process the application and determine whether the individual qualifies for APTC and CSRs.

If a consumer disagrees with a state's eligibility determination, the consumer has the right to appeal through the state's Medicaid or CHIP agency.

Medicaid Determination States: Important Considerations

If consumers in a Medicaid determination state are determined eligible for Medicaid or CHIP and they don't have any other household members on their Marketplace application, they should terminate QHP coverage with financial assistance immediately. If newly Medicaid- or CHIP- eligible consumers do have other household members on their Marketplace application, the other household members should confirm their enrollment in Medicaid or CHIP on their behalf and change their status on the application from **applying for coverage** to **non-applicant**.

Medicaid- or CHIP-eligible consumers may choose to continue QHP coverage through an FFM instead of enrolling in Medicaid or CHIP; however, the FFM will cancel their financial assistance and send them a notice confirming their continued enrollment in a QHP at full price.

Dual Coverage

Consumers who have dual coverage through the FFMs and either Medicaid or CHIP must update their applications and coverage. If a consumer has both a QHP through an FFM with APTC and CSRs **and** Medicaid or CHIP coverage, the consumer may receive a notice from the FFM asking them to verify their coverage and update their application. Consumers who don't take any action will lose any APTC and CSRs they currently receive.

If anyone on an application is newly eligible for Medicaid or CHIP, these individuals are no longer eligible to receive APTC and CSRs. Therefore, they should terminate their Marketplace coverage with financial assistance. Consumers need to understand when their new Medicaid or CHIP coverage begins before setting the termination date of Marketplace coverage. That way, they will avoid any gaps in coverage. Remember, consumers who are eligible for Medicaid or CHIP may generally remain enrolled in Marketplace coverage, but they will be responsible for the full premium amount and for full cost sharing when they receive covered services.

If only some people are newly eligible for Medicaid or CHIP on an application, those consumers who are newly eligible for Medicaid or CHIP need to change their status from **"applying for coverage"** to "**non-applicant".**

Loss of Medicaid Eligibility

Remember that Medicaid eligibility can change based on several factors. Consumers who were once eligible for Medicaid may become ineligible based on their circumstances.

If consumers are found eligible for Medicaid through the FFMs and later become ineligible due to changes in household size or income status, their state Medicaid agency will notify them.

The notification letter indicates that an individual has been newly found ineligible and provides directions on how to appeal the decision.

If consumers become ineligible for Medicaid, they should update their existing FFM application if it is still valid or create a new application. If consumers wish to shop for coverage through the FFMs, they must place a checkmark next to the following Marketplace application question:

> "Were any of these people found not eligible for Medicaid or the Children's Health Insurance Program (CHIP) in the past 90 days? Or, were any of them found not eligible for Medicaid or CHIP due to their immigration status since October 1, 2013?"

Disabilities and Medicaid Eligibility

Federal law provides both mandatory and optional Medicaid coverage for consumers who have disabilities. Several factors affect disabled consumers' eligibility for Medicaid.

Consumers Who Receive SSI

In most states, consumers who receive SSI automatically qualify for Medicaid coverage. However, some states use more restrictive Medicaid eligibility criteria.

State Medicaid Eligibility Based on a Disability

State-specific income and resource rules may apply for consumers who are not subject to determinations based on modified adjusted gross income or MAGI. You should be generally familiar with the income, asset, and disability criteria for Medicaid eligibility for the state or states where you assist consumers. However, the rules are very complex and you shouldn't attempt to give advice to these consumers about whether or not they're eligible for Medicaid. Refer these consumers to their state Medicaid agency.

There are currently 10 states that don't automatically grant Medicaid eligibility when a consumer receives SSI based on a disability (but apply stricter standards): Connecticut, Hawaii, Illinois, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.

Consumers Who Do Not Receive SSI

Consumers who do not receive SSI but are seeking Medicaid coverage based on a disability must demonstrate that they have an impairment that prevents them from performing a "substantial gainful activity" that is expected to result in death or lasts at least one year. Once a disability determination is made, consumers must pass an asset test and meet specific income requirements to be considered for Medicaid eligibility. The Marketplace application asks whether consumers or any of their family members have a disability. It uses this information to indicate whether the applicant should be referred to the state to have the state determine whether the consumer is categorically eligible for Medicaid.

Substantial Gainful Activity

The term "substantial gainful activity" (SGA) is used to describe a level of work activity and earnings. Work is "substantial" if it involves doing significant physical or mental activities or a combination of both. A consumer who earns more than a certain amount and is doing productive work is generally considered to be engaging in SGA. This consumer would not be eligible for disability benefits.

Asset Test

For some categories of Medicaid eligible consumers (e.g., consumers with a disability), assets are counted when determining eligibility. Assets that are too high may disqualify the consumer from Medicaid eligibility. The rules regarding assets are very complex, and you should refer consumers to their state Medicaid agency for more information on asset tests.

Working Effectively with Older Consumers

Older consumers enrolled in QHPs may need your help to transition between QHP coverage and Medicare.

Older consumers include those approaching age 65 and those older than age 65, regardless of whether they're currently eligible for Medicare or will soon become eligible for Medicare.

Eligibility:
Older consumers may be eligible for several health coverage options, including coverage through the Marketplaces, job-based coverage, and public programs such as Medicare and Medicaid.

For example, you may work with:

- Older consumers who already have Medicare and are interested in getting health coverage through the Marketplaces,
- Older consumers applying for health coverage through the Marketplaces and who'll soon be eligible for Medicare, and
- Older consumers applying for health coverage through the Marketplaces who are not yet 65 and so are ineligible for Medicare.

Note that younger consumers with certain disabilities such as end-stage renal disease may also qualify for Medicare and may be in a similar situation.

Considerations for Older Consumers with Incomes Over 138 Percent of the Federal Poverty Level

Older consumers who are ineligible for Medicaid may also ask you for help applying for coverage through the FFMs.

In states that expanded their Medicaid programs, non-pregnant, non-disabled, adult consumers under age 65 who have income at or below 133 percent of the FPL may be eligible for Medicaid. Because of the way income is calculated, the Medicaid income threshold is effectively around 138 percent of the FPL, with a few states using a different income limit. Additionally, individuals over age 65 with income around 133 or 138 percent of the FPL may need to contact their state to see if they qualify for Medicaid on a different basis, including Medicare savings programs, which are Medicaid programs that assist individuals with Medicare premiums and cost sharing.

If older consumers cannot afford Marketplace coverage and are ineligible for Medicaid and Medicare, you can also refer them to a local community health center for free or low-cost medical and dental care. At a community health center, consumers can get services such as vaccines, prescription drugs, general primary care, and specialized care for more serious conditions. The amount consumers pay for these services depends on their income.

Helping Veterans with their Health Care Coverage

Now let’s review how you can assist veterans who are seeking health care coverage. Veterans’ premium tax credit eligibility in the FFMs depends on whether they are enrolled in Veterans Affairs or VA health coverage.

- If veterans are eligible for VA health coverage but are not enrolled, they can enroll in a QHP in

an FFM and receive APTC and CSRs depending on their household income.

- If veterans are enrolled in VA health coverage, they may choose to enroll in a QHP in an FFM as well. However, they would not be eligible for APTC and CSRs.
- Veterans who are eligible for and enrolled in VA health coverage can still be found eligible for Medicaid. This would depend on whether their eligibility is based on their income and other factors in their state's rules. Medicaid might be able to pay for services that their VA health coverage doesn't cover.

Helping Consumers Experiencing Homelessness

It's important to note that an address is a required component of the Marketplace application process. Therefore, consumers who are experiencing homelessness or who don't have an address will need to provide one to complete a Marketplace application and get an eligibility determination. Consumers experiencing homelessness in the FFMs can list the address of a shelter, friend, or relative within the state in which they are applying for coverage, as well as a post office box or P.O. box.

Many consumers who are homeless may be eligible for Medicaid and other low-income services. If homeless consumers need additional help, you can direct them to the state Medicaid agency or other homeless service resources, like shelters and free community clinics. Be sure to follow all applicable CMS guidance when making referrals to organizations that are not other FFM assisters or HHS entities available at https://marketplace.cms.gov/technical-assistance-resources/assister-guidance-on-referrals-to-outside-organizations.pdf.

College Students

Finally, consumers who are college students have a few different options for enrolling in health coverage.

Parents' Private Health Coverage

Marketplace issuers must allow students to enroll in or stay on their parents' private health coverage (if dependent coverage is offered) until the day of their 26th birthday.

Purchase Health Coverage/Medicaid

Students may also be eligible to buy a health plan through an FFM during the Open Enrollment Period or during a Special Enrollment Period.

Catastrophic Health Coverage

Finally, students under the age of 30 also have the option to purchase a Catastrophic health plan. Remember, Catastrophic plans generally offer lower premiums and much higher deductibles than other types of QHPs.

Key Points

Take a moment to review these key points from this webinar.

- Lawfully present immigrants may be eligible for APTC and CSRs through the FFMs if their estimated annual household income is below 100 percent of the FPL, they meet all other eligibility requirements, and they are not eligible for Medicaid based on their immigration status.

- American Indians and Alaska Natives have special provisions, options, and exemptions which include SEPs, the Indian health coverage exemption, and specific income-based eligibility for zero cost sharing plans.
- Consumers who report disability-related income to the FFMs must include Social Security payments and should not include SSI, veterans' disability payments, or workers' compensation.
- Some states have specific income, asset, and disability criteria when assessing or determining Medicaid eligibility. Consumers in these states should contact their state Medicaid agency.
- You should be aware of health coverage options for specific populations of consumers, including veterans who are eligible for VA health benefits, individuals living with HIV and AIDS, individuals experiencing homelessness, and college students.

Conclusion

Congratulations, you have reached the end of this webinar.

This completes the pre-recorded content for Week 2: 2019 Individual Marketplace Overview. On Friday, October 19, we will host a LIVE webinar at 2pm EST that will recap the content presented in this week's modules and answer your questions. We hope you will join us then!

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.
- Training materials for Navigators and other assisters: https://marketplace.cms.gov/technical-assistance-resources/training-materials/training.html
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