Affordable Care Act Basics

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Hello, my name is Taniya. How has the Affordable Care Act (ACA) made health coverage more accessible and affordable to consumers? You'll learn more details in this course.

Can you answer these questions?

- How does the ACA protect consumers and help them get affordable health coverage?
- What responsibilities do health insurance companies now have?
- How does the ACA affect consumers who are eligible for public health coverage like Medicare and Medicaid?
You need to be aware of these training disclaimers.

**Assister Training Content:**

The information provided in this training course is not intended to take the place of the statutes, regulations, and formal policy guidance that it is based upon. This course summarizes current policy and operations as of the date it was uploaded to the Marketplace Learning Management System. Links to certain source documents have been provided for your reference. We encourage persons taking the course to refer to the applicable statutes, regulations, CMS assister webinars, and other interpretive materials for complete and current information.

This course includes references and links to nongovernmental third-party websites. CMS offers these links for informational purposes only, and inclusion of these websites should not be construed as an endorsement of any third-party organization's programs or activities.

**Coronavirus (COVID-19):**

This training does not address COVID-19-related guidance or related requirements for assisters. CMS will communicate applicable information to assisters and assister organizations through separate channels.

To learn more about how we're responding to coronavirus, visit HealthCare.gov/coronavirus/.

For preventive practices and applicable state/local guidance, visit CDC.gov/coronavirus.

**Remote Application Assistance:**

Navigators in FFMs are not required to maintain a physical presence in their Marketplace service area. In some cases, Navigators may provide remote application assistance (e.g., online or by phone), provided that such assistance is permissible under their organization's contract, grant terms and conditions, or agreement with CMS and/or their organization.

Certified application counselors in FFMs may also provide remote application assistance if such assistance is permissible with their certified application counselor designated organization (CDO).

For guidance on obtaining consumers' consent remotely over the phone, visit: Marketplace.cms.gov/technical-assistance-resources/obtain-consumer-authorization.pdf.
In this course, the terms "you" and "assister" refer to the following types of assisters:

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Note: In some cases, "you" is also used to refer to a consumer but it should be clear when this is the intended meaning.

The terms "Federally-facilitated Marketplace" and "FFM," as used in this training course, include FFMs where the state performs plan management functions. The terms "Marketplace" or "Marketplaces," standing alone, often (but not always) refer to FFMs.

In this course, the terms "you" and "assister" refer to the following types of assisters:

- **Navigators** in Federally-facilitated Marketplaces
- **Certified application counselors** in Federally-facilitated Marketplaces

Note: In some cases, "you" is also used to refer to a consumer but it should be clear when this is the intended meaning.

The terms "Federally-facilitated Marketplace" and "FFM," as used in this training course, include FFMs where the state performs plan management functions. The terms "Marketplace" or "Marketplaces," standing alone, often (but not always) refer to FFMs.
Congress enacted the Affordable Care Act on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 on March 30, 2010. Together, these two laws are referred to as the ACA.

**Goal:**
This course provides an overview of the ACA, including major provisions, consumer protections, health insurance company and consumer responsibilities, and how consumers can lower their health coverage costs.

This course also introduces basic eligibility and benefit information for Medicaid, the Children’s Health Insurance Program (CHIP), and Medicare coverage.

**Topics:**
- Using the Marketplaces to obtain coverage
- Common misconceptions about the ACA
- Consumer protections (coverage for preventive services, pre-existing conditions, etc.)
- New requirements for insurers
- Minimum essential coverage (MEC)
- Employer responsibilities
- Options for lowering coverage costs
- Advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs)
- Modified adjusted gross income (MAGI)
- Medicaid expansion
- Medicaid, CHIP, and Medicare eligibility and benefits
- Medicare premiums and help with costs
- Consumers in the coverage gap
The ACA is a comprehensive health care reform law that provides numerous rights and protections to consumers.

**Major Provisions**
Identify the major provisions of the ACA

**Marketplaces**
Describe how the Marketplaces can help consumers obtain health coverage

**Misconceptions**
State common misconceptions about the ACA
Major Provisions of the ACA

The ACA gives consumers the tools they need to make informed choices about their health care coverage.

The law provides:

- Options for individuals, families, small employers, and their employees to enroll in health coverage
- Legal protections that help consumers get coverage—even if they're sick
The ACA also established the Health Insurance Marketplaces. Eligible consumers can get coverage through the Marketplaces for individuals and families.

To be eligible for coverage through a Marketplace, individuals and families must:

- Be United States (U.S.) citizens or U.S. nationals, or noncitizens who are lawfully present in the U.S. for the entire time they plan to have health coverage
- Not be incarcerated (unless pending the disposition of charges)
- Live in the U.S. and meet state residency requirements for the Marketplace where they want to get coverage

Learn about **eligible immigration statuses**

The Marketplaces allow consumers to:

- Use a single streamlined application to find out if they're eligible for coverage
- Conduct an apples-to-apples comparison of **qualified health plans** (QHPs)

Individuals and families can also apply for programs to help lower their costs through the Marketplaces.

*Qualified Health Plan*

Under the ACA, a health insurance plan that is certified by a Marketplace is called a QHP. A QHP:

- Provides essential health benefits (EHB), including certain recommended preventive services that are covered with no additional out-of-pocket cost to the consumer
- Follows established limits on cost sharing (e.g., deductibles, copayments, coinsurance, and out-of-pocket maximum amounts) and meets other requirements
- Must be certified by each Marketplace in which it is sold
Using the Health Insurance Marketplaces

Eligible consumers can enroll in QHPs during the annual Open Enrollment Period (OEP) or during a Special Enrollment Period (SEP).

In the Marketplaces for individuals and families, the OEP starts on November 1, 2022, and ends January 15, 2023. Coverage can begin as soon as January 1, 2023 for consumers who enroll by December 15, 2022.

In the Small Business Health Options Program (SHOP) Marketplaces, eligible small employers determine their group’s annual OEP for themselves and their eligible employees/dependents. Small employers can generally complete a group enrollment at any point throughout the year by working with a QHP issuer or SHOP-registered agent or broker.

Consumers who experience certain life events at any time during the year, like getting married or having a child, may qualify for an SEP to enroll in or change QHPs.

Additionally, consumers can apply for Medicaid and CHIP at any time during the year. Medicare and other public health coverage options have different annual OEPs. Refer to Medicare.gov for the Medicare Open Enrollment dates.

In your capacity as an assister, you must provide fair, accurate, and impartial information when you help consumers:

- Apply for health coverage through the FFMs, including QHPs, Medicaid, and CHIP;
- Compare QHPs; and
- Apply for programs to help lower their QHP costs.
Consumers can learn more about the ACA and the Health Insurance Marketplaces at HealthCare.gov, including information like:

- Types of health coverage available,
- Consumer protections and benefits, and
- Other information they need to make informed choices when applying for and enrolling in health coverage.

For technical information about the Marketplaces or other information about the ACA, consumers can also visit:

- HHS.gov/HealthCare: For information about the benefits and progress of the ACA, and
- CMS.gov/CCIIO: For regulations, policy, and guidance from the Center for Consumer Information and Insurance Oversight (CCIIO).

The Marketplaces and other Marketplace-related resources are covered in detail in other training courses.
Susan, a freelance beautician, comes to you to find out how the ACA can help her enroll in health coverage. Which of the following do you tell her?

- A. The ACA may give Susan access to health coverage through a Marketplace if she is eligible.
- B. Susan can compare QHPs through the Marketplace in her state.
- C. The ACA requires plans to charge consumers (via cost sharing) for all preventive services.
- D. Susan can only sign up for health coverage through her state’s Marketplace for individuals and families during the annual OEP—even if she experiences a life event.

The correct answers are A and B. The PPACA allows consumers to compare QHPs and enroll in health coverage through the Marketplaces if they’re eligible. For individual market coverage starting in 2023, Open Enrollment starts November 1, 2022, and ends January 15, 2023. Consumers may qualify for SEPs if they experience certain life events.
There are some common misconceptions about the ACA. To set the record straight, you can tell consumers that the law:

- Makes prescription drug coverage more affordable for Medicare beneficiaries and doesn’t reduce Medicare benefits.
- Requires many employers to offer health coverage to their full-time employees and their dependents but does not affect all employers.
- Requires most individuals to have MEC or qualify for an exemption.
- Offers consumer protections and makes coverage more affordable for eligible consumers.

There are some common misconceptions about the ACA. To set the record straight, you can tell consumers that the law:

- Makes prescription drug coverage more affordable for Medicare beneficiaries and doesn’t reduce Medicare benefits.
- Requires many employers to offer health coverage to their full-time employees and their dependents but does not affect all employers.
- Requires most individuals to have MEC or qualify for an exemption.
- Offers consumer protections and makes coverage more affordable for eligible consumers.
The ACA enables eligible consumers to get health coverage through the Marketplaces.

- Eligible consumers can enroll in QHPs during the annual OEP or during an SEP.
- Consumers who enroll in a QHP through the Marketplaces for individuals and families may also be eligible for programs that lower the costs of coverage.
The ACA makes health coverage more accessible to consumers.

**Consumer Protections**
State the consumer protections established by the ACA

**Preventive Services**
State the preventive services usually available without cost sharing

**Pre-existing Conditions & Young Adults**
Describe protections for individuals with pre-existing conditions and for young adults
There are several key consumer protections under the ACA that make health coverage more accessible to consumers.

Qualified individuals are generally able to:

- Get affordable health coverage regardless of any pre-existing conditions they have
- Access health coverage through the Marketplace in their state
- Keep existing health coverage for young adults under a parent's health plan
- Obtain certain preventive services included in their health coverage without cost sharing
Previously, consumers with health coverage generally paid a copayment or other cost-sharing amount for common preventive health care services.

Now most health plans — whether offered inside or outside of the Marketplaces — must cover certain recommended preventive services (e.g., annual physicals, vaccines, and mammograms) without cost sharing.

Previously, consumers with health coverage generally paid a copayment or other cost-sharing amount for common preventive health care services.

Now most health plans — whether offered inside or outside of the Marketplaces — must cover certain recommended preventive services (e.g., annual physicals, vaccines, and mammograms) without cost sharing.
Before the ACA, federal law generally didn’t prohibit health insurance companies from denying health coverage to consumers in the individual market based on pre-existing conditions.

Pre-existing conditions are health problems (e.g., diabetes or cancer) that started before an individual’s health insurance went into effect.

The ACA guarantees that consumers with pre-existing conditions – including diabetes and cancer – can apply for and purchase health insurance if they are otherwise eligible. Consumers may generally renew an existing policy regardless of their health status.
Previously, states could limit how long young adults were allowed to remain enrolled in coverage through a parent’s health insurance plan.

Now, the ACA generally requires issuers in all states to allow children and young adults up to age 26 to stay on their parents’ health insurance plans (if the plans cover dependent children).

Consumers should check with their plans to be sure. Some states and plans have different rules.
The ACA provides consumers with several rights and protections. Which of the following is NOT a right or protection included in the ACA?

Select the correct answer and then select Check Your Answer.

- A. Health plans may not refuse to sell coverage to consumers because they have pre-existing conditions.
- B. Children may be covered under their parents’ plans only up to age 18.
- C. Consumers can receive annual physicals at no cost.
- D. Most health plans must cover certain preventive health services without cost sharing.

The correct answer is B. Under the ACA, consumers who have pre-existing conditions can't be sold health coverage that excludes their pre-existing conditions. In addition, the law requires most health plans to cover certain preventive health services without cost sharing to consumers—including annual physicals. The ACA requires most plans that offer dependent child coverage to allow children and dependents to be covered under their parents’ plans up to age 26 or other allowable age as defined by the plan or state.
Key Points

The ACA:

- Provides consumer protections and coverage options.
- Provides a way for qualified individuals to get health coverage through a Marketplace.
- Provides access to coverage for certain preventive services without cost sharing under most health plans.
- Provides a way for qualified small employers to offer coverage to their employees, former employees, and dependents of employees/former employees through a SHOP Marketplace.
In addition to making health coverage more accessible, the ACA makes it easier for consumers to understand.

**Requirements**
State the requirements established for health insurance companies under the ACA

**Understanding Coverage**
Describe the requirement for helping consumers understand their coverage

**Required Coverage**
Describe the requirement for providing coverage for pre-existing conditions and essential health benefits
Major features of the ACA require most health insurance companies and the plans they offer to:

- Provide a standardized Summary of Benefits and Coverage (SBC) so consumers can easily understand their coverage and compare it to other available options;
- Provide coverage for consumers with pre-existing conditions;
- Refrain from terminating coverage after they’ve already agreed to cover consumers (unless an exception applies);
- Offer a core comprehensive set of benefits, EHB, when offering coverage to individual consumers and small employers; and
- Prohibit annual and lifetime dollar limits on coverage of EHB.
Help Consumers Understand Their Health Coverage

Previously, health insurance companies weren't required by federal law to explain the benefits and cost of coverage to consumers in ways that were clear and easy to understand. Health insurance companies are now required to provide clear, consistent, and comparable information about consumers' health benefits and coverage by providing a standard SBC for each plan they offer.

Each plan's SBC must be written and presented in a standard format and use basic terms. Health insurance companies must also provide consumers with a uniform glossary of commonly used terms.

<table>
<thead>
<tr>
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<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$35 copay/office visit and 20% coinsurance for other outpatient services; deductible does not apply</td>
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<td></td>
<td>Specialist visit</td>
<td>$50 copay/visit</td>
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<td>Preventive care/screening/immunization</td>
<td>No charge</td>
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<td>Diagnostic test (x-ray, blood work)</td>
<td>$10 copay/test</td>
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<td>Imaging (CT/PET scans, MRIs)</td>
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<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs (Tier 1)</td>
<td>$10 copay/prescription (retail &amp; mail order)</td>
<td>40% coinsurance</td>
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<td></td>
<td>Preferred brand drugs (Tier 2)</td>
<td>$50 copay/prescription (retail &amp; mail order)</td>
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<td>Non-preferred brand drugs (Tier 3)</td>
<td>40% coinsurance</td>
<td>50% coinsurance</td>
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<td>Specialty drugs (Tier 4)</td>
<td>50% coinsurance</td>
<td>70% coinsurance</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$100/day copay</td>
<td>40% coinsurance</td>
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<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs (Tier 1)</td>
<td>$10 copay/prescription (retail &amp; mail order)</td>
<td>40% coinsurance</td>
<td>Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Preferred brand drugs (Tier 2)</td>
<td>$30 copay/prescription (retail &amp; mail order)</td>
<td>40% coinsurance</td>
<td>Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).</td>
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<td>Non-preferred brand drugs (Tier 3)</td>
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<td>Specialty drugs (Tier 4)</td>
<td>50% coinsurance</td>
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<td>If you need drugs to treat your illness or condition</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$100/day copay</td>
<td>40% coinsurance</td>
<td>Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.</td>
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<td>If you need drugs to treat your illness or condition</td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>50% coinsurance for anesthesia.</td>
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Pre-existing Conditions and Canceling Coverage

Remember, health insurance companies can no longer refuse to sell coverage to consumers with pre-existing conditions or charge more for that coverage.

Unless an exception applies, health insurance companies must also refrain from canceling consumers’ coverage as long as any premiums are paid.

Previously, federal law didn’t prohibit health insurance companies from retroactively canceling consumers’ coverage because of mistakes on their applications. Under the ACA, insurers can only cancel a consumer’s coverage retroactively if the consumer committed fraud and/or made an intentional misrepresentation of material fact.

Remember, health insurance companies can no longer refuse to sell coverage to consumers with pre-existing conditions or charge more for that coverage.

Unless an exception applies, health insurance companies must also refrain from canceling consumers’ coverage as long as any premiums are paid.

Previously, federal law didn’t prohibit health insurance companies from retroactively canceling consumers’ coverage because of mistakes on their applications. Under the ACA, insurers can only cancel a consumer's coverage retroactively if the consumer committed fraud and/or made an intentional misrepresentation of material fact.
Previously, health insurance companies could sell health plans with different sets of benefits. Now, nearly all health plans that are sold to individuals or small employers must cover comprehensive core services or EHB.

Also, federal law did not prohibit health insurance companies from setting lifetime or annual dollar limits on the benefits they covered under their plans. After a consumer reached their annual or lifetime dollar limit, plans would no longer pay for covered services.

Now, health insurance companies generally can't set dollar limits on what they spend for coverage of EHB, either during the course of the plan year or over the entire period of time that consumers are enrolled in the plan. However, health insurance companies can still set lifetime or annual dollar limits on what they will spend on covered benefits that aren't EHB.

**Lifetime limits** are dollar limits on what plans will pay for covered benefits during the entire time consumers are enrolled in a plan.

**Annual limits** are dollar limits on what plans will pay for covered benefits over the course of the plan year.
Health insurance companies have certain responsibilities under the ACA.

Which of the following is NOT a responsibility for health insurance companies included in the ACA?

A. Nearly all health plans sold to individuals or small employers must cover a core comprehensive package of services known as EHB.

B. Health insurance companies must provide clear, consistent, and comparable information about consumers' health benefits and coverage.

C. Insurers must monitor and cancel consumers' coverage retroactively if information in consumers' Marketplace applications is incorrect.

D. Health insurance companies generally cannot set dollar limits on what they spend for coverage of EHB.

The correct answer is C. Under the ACA, nearly all health plans sold to individuals or small employers must cover a core comprehensive package of items and services known as EHB. Insurers must provide clear, consistent, and comparable information about consumers' health benefits and coverage, and they generally cannot set dollar limits on what they spend for coverage of EHB. Insurers can only cancel a consumer's coverage retroactively if the consumer committed fraud or if the consumer made an intentional misrepresentation of material fact.
The ACA establishes specific responsibilities for health insurance companies. Under the law, they must:

- Provide standard information for consumers so they can easily understand their coverage and compare it to other available options.
- Offer EHB without annual or lifetime limits.
In addition to understanding health insurance companies' responsibilities under the ACA, you should also be able to explain consumers' and employers' responsibilities.

**Minimum Essential Coverage**
Describe the requirement for maintaining minimum essential coverage

**Exemptions**
Understand that consumers age 30 and older must qualify for a hardship or affordability exemption through the Marketplace if they wish to purchase Catastrophic coverage.

**Employer Responsibilities**
State the responsibilities of an employer under the ACA
Minimum Essential Coverage (MEC)

The ACA requires consumers to have health coverage that is considered MEC. Most people in the U.S. are required to have MEC or qualify for an exemption from the individual shared responsibility requirement.

The following consumer responsibilities will be discussed in this training:

- Maintaining MEC
- Individual shared responsibility provision
- Hardship exemptions for Catastrophic coverage
- Employer shared responsibility provisions

![HealthCare.gov](image)

The ACA requires consumers to have health coverage that is considered MEC. Most people in the U.S. are required to have MEC or qualify for an exemption from the individual shared responsibility requirement.

The following consumer responsibilities will be discussed in this training:

- Maintaining MEC
- Individual shared responsibility provision
- Hardship exemptions for Catastrophic coverage
- Employer shared responsibility provisions
Most private health insurance plans are considered MEC. Consumers are required to have coverage that qualifies as MEC but, beginning with tax year 2019, are no longer required to report on their health coverage enrollment when they file their taxes. They are also no longer required to file for an exemption if they did not have MEC for part or all of a tax year.

Consumers can meet the MEC requirement in several ways, including:

- Qualifying for and enrolling in an available QHP
- Qualifying for and enrolling in certain public coverage programs like Medicaid, CHIP, CHIP buy-in programs, or Medicare
- Being covered by programs like TRICARE
- Being covered by job-based health coverage, including retiree or Consolidated Omnibus Reconciliation Act (COBRA) continuation coverage

Other types of coverage that count as MEC can be found at IRS.gov.
• Coverage under a parent's plan (that qualifies as MEC)
• Self-funded health coverage offered to students by universities for plan or policy years that started on or before December 31, 2014 (after 2014, check with the university to see if the plan qualifies as MEC)
• Health coverage for Peace Corps volunteers
• Certain types of veterans' health coverage through the VA
• Most TRICARE plans
• Department of Defense Non-appropriated Fund Health Benefits Program
• Refugee Medical Assistance
• State high-risk pools for plan or policy years that started on or before December 31, 2014 (check with the high-risk pool plan to see if it qualifies as MEC)

The following are types of health coverage that do not qualify as MEC:

• Coverage only for vision care or dental care
• Workers' compensation
• Coverage only for a specific disease or condition
• Plans that offer only discounts on medical services

Excepted benefits
Excepted benefits are health coverage that do not qualify as MEC, including but not limited to:

• Coverage only for accident
• Disability income insurance
• Liability insurance
• Coverage issued as a supplement to liability insurance
• Worker's compensation or similar insurance
• Long-term care benefits
• Limited scope dental or vision benefits
• Coverage only for a specific disease or illness (e.g., cancer policies)
• Medicaid supplemental health insurance (e.g., Medigap or MedSupp insurance)

Exemption
Under the ACA, most people must maintain MEC under the individual shared responsibility requirement. However, beginning with tax year 2019, consumers are no longer required to report on their health coverage enrollment when they file their taxes. They are also no longer required to file for an exemption if they did not have MEC for part or all of a tax year.
Exemptions from the Requirement to Have MEC

Beginning in tax year 2019, consumers who do not have MEC for part or all of the tax year do not need to make an individual shared responsibility payment or file Form 8965, Health Coverage Exemptions, with their tax returns.

However, individuals age 30 and above must continue to apply for, obtain, and report an exemption certificate number (ECN) for a Marketplace affordability or hardship exemption if they wish to purchase Catastrophic health coverage. We will cover Catastrophic health coverage later in this course and in other training courses.
Some employers with 50 or more full-time and full-time equivalent (FTE) employees who don't offer MEC may also be subject to a fee called the employer shared responsibility payment. If they do offer MEC to their employees, they may still have to pay a fee if their offer of coverage:

- Is not affordable, or
- Does not meet the minimum value standard.

Employers may pay a fee if at least one full-time employee enrolls in a plan through a Marketplace and receives advance payments of the premium tax credit (APTC).

Affordable

For 2023, a plan is considered “affordable” if the plan’s premiums do not exceed 9.12 percent of the employee’s household income.

Previously, a job-based plan has been considered affordable for all family members to whom an employer’s offer extends if the premium for the employee’s self-only coverage was affordable. The premium required to cover any family members was not taken into account.

The Internal Revenue Service (IRS) issued new regulations that apply starting in Plan Year 2023. If a consumer has an offer of employer coverage that extends to their family members, the affordability of employer coverage for those family members will be based on the family premium amount, not the self-only employee premium cost. This will help more consumers qualify for APTC and CSRs through the Marketplace.

Minimum Valued

Minimum value is a standard of minimum coverage that applies to job-based health plans. A health plan meets the minimum value standard if:

- It's designed to pay at least 60 percent of the total cost of medical services for a standard population, AND
- Its benefits include substantial coverage of physician and inpatient hospital services.
Jackie is a 28-year-old freelance writer who earned more than $50,000 in 2022. However, she didn't enroll in a QHP or obtain MEC for the year. Jackie is concerned because she heard that she'll have to pay a fee. Which of the following should you explain to Jackie?

Select the correct answer and then select Check Your Answer.

A. Beginning with tax year 2019, individuals who choose to go without insurance will no longer be subject to making individual shared responsibility payments. Jackie will not owe a fee for failing to obtain MEC in 2022.

B. Because Jackie is self-employed and isn't offered job-based coverage, she doesn't have to have MEC in 2022.

C. Because Jackie didn't enroll in a QHP or obtain other MEC in 2022, she may have to pay a fee when she files her 2022 tax return in 2023.

D. If Jackie doesn't want coverage, she doesn't need to do anything.

The correct answer is A. The correct answer is A. Even if Jackie is self-employed and not offered job-based coverage, she is still required to maintain MEC under the ACA. However, Jackie will not owe a fee for failing to obtain MEC. Starting in tax year 2019, individuals who choose to go without insurance will no longer be subject to making shared responsibility payments.
Key Points

Consumers are required to maintain MEC under the ACA.

- Consumers who did not maintain MEC during tax years 2019 and later are no longer subject to making individual shared responsibility payments because the fee is reduced to $0.

- Certain employers may also have to pay a fee if the coverage they offer to employees is not affordable or does not meet minimum value.

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Lowering Consumers' Health Coverage Costs

Introduction

The ACA created insurance affordability programs that can lower eligible consumers’ costs when they enroll in health coverage through a Marketplace.

**Options to Lower Costs**
State the options in the ACA that can help eligible consumers lower their health coverage costs

**Advance Payments of the Premium Tax Credit**
Describe the premium tax credit

**Cost-sharing Reductions**
Describe cost-sharing reductions available to eligible individuals who enroll in a Silver health plan

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**Cost-sharing Reductions**
Describe cost-sharing reductions available to eligible individuals who enroll in a Silver health plan
Consumers' household income and family size can determine whether they qualify for three types of savings when they fill out Marketplace applications:

- Consumers may be eligible to receive premium tax credits (PTCs) that can be used in advance to reduce their monthly premiums when they enroll in a QHP through a Marketplace.
- Consumers may also qualify for lower additional costs like lower copayments, coinsurance, and deductibles.
- Consumers and/or their children may be eligible for coverage through Medicaid or CHIP.
If consumers' projected annual household income falls between 100 percent and 400 percent of the federal poverty level (FPL), they may qualify for a PTC when they file federal income tax returns. While the American Rescue Plan Act of 2021 expanded eligibility to include household income above 400 percent of the FPL and capped how much of a family's household income the family would pay towards the premiums for a benchmark plan at 8.5 percent, these provisions only apply to Plan Years 2021 and 2022. They no longer apply for Plan Year 2023.

Premium tax credits are only available to consumers who enroll in QHPs through a Marketplace. Eligible consumers can use all, some, or none of their PTC in advance to lower their monthly premiums—these are called advance payments of the premium tax credit (APTC).

### Federal Poverty Level (FPL)

The FPL is a measure of income issued every year by the Department of Health and Human Services (HHS). FPLs are used to determine consumers' eligibility for certain programs and benefits, including savings on Marketplace health insurance, Medicaid, and CHIP coverage.

For more information about the FPL, visit [ASPE.hhs.gov/poverty-guidelines](http://ASPE.hhs.gov/poverty-guidelines).
Reconciling Advance Payments of the Premium Tax Credit

If consumers use APTC in excess of the premium tax credit they are determined eligible for, they or their taxpayer may be required to repay the difference when they file their federal income tax returns.

If consumers use less APTC than they qualify for, they may receive the difference as a refundable credit.

Report Changes in Household Income
You should tell consumers who use APTC to report changes in household income or family size to the Marketplaces as soon as possible to avoid owing money to the IRS.

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**Report Changes in Household Income**
You should tell consumers who use APTC to report changes in household income or family size to the Marketplaces as soon as possible to avoid owing money to the IRS.
Consumers with lower incomes or larger household sizes generally qualify for larger PTCs. For example, a family of two with a yearly household income of $35,000 would receive a larger PTC than a family of two with a yearly income of $45,000 if all else is equal.

PTCs may also be available to lawfully residing immigrants with incomes below 100 percent of the FPL if they aren't eligible for Medicaid because of their immigration status.

You will learn more about reconciling APTC in other training courses.
Cost-sharing Reductions: Out-of-pocket Savings Only With a Silver Plan

Some consumers who apply for coverage through the Marketplaces and get APTC might also qualify for additional savings called cost-sharing reductions (CSRs). Consumers who qualify for income-based CSRs and enroll in a Silver plan through a Marketplace may save money a second way – by paying less out of their own pocket when they get certain covered services.

To be eligible for CSRs based on income, consumers must meet the following requirements:

- Have a household income between 100 percent and 250 percent of the FPL
- Be eligible to receive the PTC
- Enroll in a Silver plan through a Marketplace

Silver Plan

Silver plans are designed so that the plan will typically pay an average of 70 percent of the cost of providing EHB. Consumers typically pay an average of 30 percent of their EHB costs for Silver plans in the form of out-of-pocket expenses like deductibles, copayments, and coinsurance.

How CSRs work

If consumers qualify for CSRs and enroll in a Silver plan:

- They will generally have a lower deductible. This means the plan starts to pay its share of consumers' medical costs sooner. For example, if a particular Silver plan has a $750 deductible, a consumer would normally have to pay the first $750 of medical care first before the insurance company pays for anything (other than certain preventive services that are included without cost sharing, like annual physicals). A consumer eligible for CSRs might have a $300 or $500 deductible for that same Silver plan depending on their household income.
- They will generally have lower copayments or coinsurance. These are payments consumers make each time they get care. For example, if a particular Silver plan has a $30 copayment for a doctor visit, a consumer eligible for CSRs might pay a $20 or $15 copayment for doctor visits under that same plan.
- They will generally have a lower "out-of-pocket maximum." This is the maximum amount a consumer could have to pay out of pocket for their health care costs for EHB in a year if the consumer got seriously sick or had an accident. For example, if a particular Silver plan has a $5,000 out-of-pocket maximum, a consumer eligible for CSRs might have a $3,000 out-of-pocket maximum under that same plan.

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George is 30 years old, single, has no dependents, and works at a local coffee shop. His employer doesn't offer health insurance and he's asked you to help him apply for health coverage through the Marketplace. George currently makes $20,000 a year, which is between 150 percent and 200 percent of the FPL.

Based on his income only, which programs will George likely be eligible for when he submits his application through a Marketplace?

Select all that apply and then select Check Your Answer.

- A. The premium tax credit
- B. Cost-sharing reductions
- C. CHIP
- D. Medicaid

Correct!

George is likely above the income levels for Medicaid but within the income range for financial assistance through a Marketplace. It's likely that George will be eligible for the premium tax credit and cost-sharing reductions if he enrolls in a Silver plan through a Marketplace for individuals and families. CHIP is generally only available for children up to age 19.
Eligible consumers may be able to lower their costs for Marketplace plans by taking advantage of APTC and CSRs.

- Generally, consumers who receive APTC must reconcile them when they file their federal income tax returns.
When determining consumers' eligibility for the PTC and CSRs, the Marketplaces count consumers' incomes somewhat differently from public health coverage programs like Medicaid and CHIP. You're responsible for explaining how consumers' modified adjusted gross income (MAGI) is used to determine their eligibility for each of these programs under the ACA.

**Income Types**
Identify the income types included in MAGI for various programs

**Eligibility**
Explain how MAGI is used to determine eligibility for Medicaid and CHIP

**Medicaid Expansion**
Describe how some states have expanded their Medicaid programs to cover all people with household incomes below a certain level
Financial Requirement: Modified Adjusted Gross Income

For APTC, CSRs, most categories of Medicaid eligibility, and CHIP, all Marketplaces and state Medicaid and CHIP agencies determine a household's income using MAGI.

Generally, MAGI is a household's adjusted gross income (AGI) plus these, if any: untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest. Earned wages and unemployment benefits are counted in MAGI calculations while most kinds of cash assistance, including child support and Supplemental Security Income (SSI), are not.

It's important for consumers to know that state Medicaid and CHIP agencies calculate MAGI using monthly income while the Marketplaces use annual income. There are some other key differences in how state Medicaid and CHIP agencies count MAGI—select here to learn more.

Household size and composition are also important factors when calculating MAGI. For many people, the basic equation for calculating household size, or the number of individuals in a family, is:

**Tax Filers + Tax Dependents = Household Size**

For Medicaid and CHIP eligibility, consumers' household size can be based on immediate family members they live with like spouses, siblings, and children, even if those people are not in their tax household. Marketplace, Medicaid, and CHIP applications will ask for the information needed to determine household size for consumers.

Most consumers who qualify for Medicaid on a basis other than MAGI (e.g., disability or blindness) still must meet other income requirements. These consumers will likely need to complete another application or provide additional information to their state Medicaid agency.

Some Medicaid and CHIP agencies may have different policies to calculate MAGI for eligibility. You should refer consumers to their state Medicaid or CHIP agency to learn more about the policies in their state.

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**Most Categories**

MAGI is generally used to determine Medicaid and CHIP eligibility for children, pregnant individuals, parents, and other adults who may be eligible for the adult group created by the ACA.

**Adjusted Gross Income (AGI)**

Federal tax rules for determining AGI in a tax-filing household include:
• Earned income (e.g., wages, salary, or any compensation for work) minus any pretax deductions (i.e., dependent care, retirement)
• Net income from self-employment
• Taxable and non-taxable Social Security income, including Social Security Disability Insurance (SSDI) and retirement benefits but not Supplemental Security Income (SSI)
• Unemployment benefits

Investment income, including interest, dividends, and capital gains (MAGI does not consider resources such as bank accounts or stocks when determining Medicaid eligibility)

**MAGI Calculation**

MAGI for Medicaid and CHIP is based on current monthly income rather than annual income. Some states may use a MAGI-based flexibility to smooth out predictable income fluctuations to make more accurate monthly income determinations.

For MAGI calculations for Medicaid and CHIP, an amount received as a lump sum is counted as income only in the month it was received. Gambling and lottery winnings (pursuant to lotteries occurring on or after January 1, 2018) count as income in the month they were received if the amount is less than $80,000, and count as income over more than one month if greater than $80,000.

The MAGI calculation for Medicaid and CHIP does NOT include:

- Educational scholarships, awards, or fellowship grants not used for living expenses.
- Certain American Indian/Alaska Native income, like:
  - Distributions from Alaska Native Corporations and Settlement Trusts.
  - Distributions from any property held in trust, subject to federal restrictions located within the most recent boundaries of a prior federal reservation, or otherwise under the supervision of the Secretary of the Interior.
  - Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from:
    - Rights of ownership or possession in any lands; or
    - Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources.
  - Distributions resulting from real property ownership interests related to natural resources and improvements:
    - Located on or near a reservation or within the most recent boundaries of a prior federal reservation; or
    - Resulting from the exercise of federally protected rights relating to such real property ownership interests.
  - Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.
  - Student financial assistance provided under the Bureau of Indian Affairs education programs.
If consumers choose to apply for APTC and CSRs to help lower their costs using a Marketplace application, they should be aware that they must file a federal income tax return to qualify. However, consumers who apply for Medicaid or CHIP don't have to file federal income tax returns to be assessed or determined eligible. Here are a couple of quick questions for you.

Do you think consumers need to file federal income tax returns to count their household sizes accurately for Medicaid or CHIP?

No. For Medicaid and CHIP eligibility, consumers' household size can be based on immediate family members they live with like spouses, siblings, and children. Individuals who apply for Medicaid or CHIP don't need to file federal income tax returns or be claimed as dependents on someone else's federal income tax return.

Is MAGI also used to determine a consumer's eligibility for APTC and CSRs through a Marketplace?

Yes, but with some modifications as compared to Medicaid and CHIP. For example, Medicaid and CHIP generally rely on current monthly household income to determine eligibility for coverage. However, the Marketplaces rely on projected yearly household income for the year consumers are seeking coverage when they assess eligibility for APTC and CSRs. This means consumers need to estimate their income for the year and report any changes to the Marketplaces as soon as they happen.

Remember, Medicaid and CHIP MAGI calculations don't include certain American Indian/Alaska Native income.
You should always help consumers report their current and projected yearly income accurately and remind them not to misrepresent personal information when applying for coverage.

All consumers who apply for health coverage through the FFM must sign their Marketplace applications under penalty of perjury. The Federal Government can impose civil money penalties on any person who provides false information on a Marketplace application.
Medicaid Adult Expansion

The ACA aims to significantly reduce the number of uninsured consumers by providing affordable coverage options through the Marketplaces, Medicaid, and CHIP. Under the law, most states have expanded their Medicaid programs to cover adults with household incomes below a certain level. Others haven't.

Whether consumers qualify for Medicaid coverage may depend in part on whether their state has expanded its program to low-income adults.

- **In all states:** Consumers can qualify for Medicaid based on income, household size, disability, age, pregnancy status, status as a current or former foster youth, parent and caretaker status, and other factors. Eligibility rules differ among states.

- **In states that have expanded Medicaid coverage:** In addition to the above, consumers who are adults age 19 through 64, not pregnant, and not entitled to or enrolled in Medicare and have household income below 133 percent of the FPL (In practice*, below 138 percent of the FPL) can qualify for Medicaid in the adult group.

The Marketplaces help consumers receive an assessment or a determination about whether they qualify for Medicaid based on these criteria. The tablet on this page shows how much household income consumers in states that have expanded Medicaid coverage can earn and still qualify for Medicaid in the adult group. These amounts are higher for consumers in Alaska and Hawaii. FPL guidelines are updated and published yearly by HHS in January or February, and Medicaid and CHIP eligibility is based on the new guidelines once they're released.

Be sure you know whether the state you are working in has expanded Medicaid eligibility for adults and the applicable FPL. Additional information on Medicaid expansion is provided later in the training. You can also use the "Marketplaces by State" map located in the Map tab within the Options drop-down menu to determine if your state or other states have expanded Medicaid.

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*In practice* refers to the actual implementation of Medicaid expansion rules, which may differ from the statutory requirements.
Based on HHS Poverty Guidelines for 2022

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*In Practice

The ACA's MAGI calculation is generally based on taxable income as defined in the Internal Revenue Code. For Medicaid and CHIP, the MAGI-based methodology includes a deduction equivalent to five percent of the FPL. With this five percentage point disregard, the Medicaid adult group eligibility threshold is effectively 138 percent of the FPL.
You can help consumers apply for Medicaid through the Marketplace application process. If a consumer is not eligible for Medicaid because your state hasn't expanded Medicaid to the adult group, that person might still be eligible for programs to help lower their costs through the Marketplaces.

Consumers with incomes between 100 percent and 138 percent of the FPL may be eligible for insurance affordability programs through the Marketplaces (i.e., APTC and CSRs) if:

- Their state has not yet expanded Medicaid, OR
- They have been determined ineligible for Medicaid.

In all states, lawfully present immigrants with incomes below 100 percent of the FPL can still qualify for insurance affordability programs through a Marketplace if they are ineligible for Medicaid based on their immigration status and they meet other eligibility requirements.

For the latest information on state plans for Medicaid expansion, refer to the Map tab in the course menu.
You're meeting with Easton, a 30-year-old songwriter who lives with a roommate in a Medicaid expansion state. Easton has no dependents. He makes $60,000 a year and is therefore above 400 percent of the FPL. Easton is interested in learning more about the ACA.

Which of the following are accurate statements that you should tell Easton about the law and its key provisions?

- A. The ACA created the Marketplaces, which are an easy way for Easton to shop for health coverage.
- B. Easton can apply for coverage through his state’s Marketplace to find out if he’s eligible for programs to lower the costs of his health coverage.
- C. Easton may be eligible for Medicaid if his state expanded its Medicaid program to cover low-income adults.
- D. The ACA lets Easton make apples-to-apples comparisons of QHPs.

The correct answers are A, B, and D. Based on his income alone, Easton could only be eligible for Medicaid with a household income of 138 percent of the FPL or less—that is, $18,754 for a household of one in 2022.
When assessing consumers’ eligibility for APTC, CSRs, most categories of Medicaid eligibility, and CHIP, all Marketplaces and state Medicaid and CHIP agencies determine a household’s income using MAGI.

- The Federal Government can impose civil money penalties on any person who provides false information on a Marketplace application.

- Some states have expanded their Medicaid programs to cover certain low-income adults. Others haven’t.
Remember that the ACA requires most individuals to obtain MEC. However, beginning with tax year 2019, consumers are no longer required to report on their health coverage enrollment when they file their taxes. They are also no longer required to file for an exemption if they did not have MEC for part or all of a tax year. Most Medicaid and CHIP coverage is considered MEC. Medicare Part A and Part C coverage are also considered MEC. Consumers who don’t get MEC through these programs may find that the Marketplaces are an important option for getting coverage.

To provide optimal assistance to consumers, you should understand how these programs may interact with the ACA and the Marketplaces. Let’s start by reviewing the Medicaid program.

### Benefits
State the mandatory Medicaid benefits

### Types of Consumers
Identify the types of consumers eligible for Medicaid

### Eligibility
Understand Medicaid eligibility and presumptive eligibility rules and requirements
Medicaid is a health coverage program for low-income families and individuals, including:

- Parents and children
- Pregnant individuals
- Older consumers
- People with disabilities
- Other low-income adults, depending on the state

States have a great deal of flexibility in designing and administering their programs. Each state operates its own Medicaid program within federal guidelines to:

- Set eligibility standards
- Determine the type, amount, and scope of services provided
- Establish payment rates for Medicaid services
Medicaid provides a wide range of benefits to eligible consumers. While all state Medicaid agencies are generally required to provide certain benefits to certain beneficiaries, some states may choose to provide additional benefits. You should be familiar with the benefits covered by your state's Medicaid program.

You can also review a comprehensive list of mandatory and optional benefits at Medicaid.gov.

Mandatory Medicaid benefits in all states include:

- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Early and periodic screening, diagnostic, and treatment services for children (which includes health screenings for children and treatment if medical problems are identified)
- Inpatient hospital services
- Outpatient hospital services
- Nursing facility services
- Nurse midwife services
- Certified pediatric and family nurse practitioner services
- Freestanding birth center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant individuals
- COVID-19 testing, treatment, and vaccinations

COVID-19 Testing, Treatment, and Vaccinations

Beginning March 11, 2021, most consumers enrolled in Medicaid have mandatory Medicaid coverage, without cost sharing, for a COVID-19 vaccine and its administration, testing, and treatments for COVID-19, and, for
those diagnosed with or presumed to have COVID-19, the treatment of a condition that may seriously complicate the treatment of COVID-19 during the period the person has or is presumed to have COVID-19.
You already learned that consumers must meet certain financial requirements to qualify for Medicaid. Nonfinancial requirements can also affect eligibility.

Under federal law, all states are required to cover certain groups of consumers called mandatory eligibility groups. These include:

- Pregnant individuals at or below a certain household income level
- Children and parents/caretaker relatives in households at certain income levels
- People with disabilities
- Certain low-income older adults

Some states choose to cover other groups of consumers called optional eligibility groups, which are those that federal law doesn't require states to cover under Medicaid. Common examples include:

- Medically needy consumers
- Consumers with disabilities who are employed

Medicaid coverage for optional groups varies from state to state.

It's important that you know which groups are covered by Medicaid and the household income requirements for each of them in your state.
Let's review each mandatory eligibility group in more detail. Select each to learn more.

### Low-income Pregnant Individuals

In practice, all states must cover pregnant individuals whose household income is at or below at least 138 percent of the FPL (e.g., $38,295 for a family of four or $25,268 for a family of two in 2022) and who meet all other eligibility criteria (e.g., state residency and immigration/citizenship requirements). Many states choose to set a higher household income level for pregnant individuals.

- Once Medicaid eligibility is established, pregnant individuals remain eligible on the basis of their pregnancy and during the postpartum period, which begins on the date the pregnancy terminates and ends on the last day of the month in which a 60-day period ends. Beginning April 1, 2022, the American Rescue Plan Act of 2021 (ARP) gives states a new option to extend Medicaid state plan coverage for pregnant individuals through the end of the month in which the individual's 12-month postpartum period ends. The option provides for continuous eligibility during the postpartum extension. If adopted for Medicaid, the state must also elect to apply the extended postpartum coverage to a separate CHIP in the state for low-income children who are pregnant and low-income pregnant individuals, as applicable. This option is time-limited to a five-year period beginning on April 1, 2022. Assisters should check with their state authorities to determine whether the state they operate in has exercised this option and the state timeline for implementation. Individuals may be eligible for Medicaid on another basis after their eligibility as a pregnant individual expires. State Medicaid agencies are required to consider all other bases of Medicaid eligibility before determining a beneficiary is ineligible and terminating a beneficiary's Medicaid coverage.

States are also required to cover any children born to individuals who are enrolled in Medicaid or CHIP as a targeted low-income pregnant individual on the date of birth, including as a result of retroactive eligibility in Medicaid. The newborn children are then continuously eligible for Medicaid or CHIP for the first year of life. If a child cannot be determined eligible for Medicaid or CHIP based on the mother's enrollment for the birth, the parent(s) should be encouraged to submit an application for the child to the state Medicaid or CHIP agency as soon as possible. Individuals, including newborn children, can be found retroactively eligible for Medicaid for up to three months prior to application if they would have been eligible during that retroactive period.

### Children in Low-income Households

In practice, all states must cover children whose yearly family income is at or below at least 138 percent of the FPL and who meet all other eligibility criteria. All states have chosen to expand Medicaid coverage for most...
children beyond the minimum eligibility threshold. The average household income eligibility level for children is 187 percent of the FPL.

Additionally, states are required to cover:

- Children who are recipients of adoption assistance and foster care under Title IV-E of the Social Security Act.
- Former foster children (until age 26), as long as:
  - They were in the state's foster care system and enrolled in Medicaid on their 18th birthday, and
  - They aged out of the foster care system in the state while enrolled in Medicaid.

Additional help for low-income children and some pregnant women in families whose household income is too high to qualify for Medicaid may be available through CHIP.

**Low-income Parents or Caretaker Relatives**

- Low-income parents and other relatives (called "caretaker relatives") who take care of dependent children are covered by Medicaid in every state if they meet their state's income requirements and who meet all other eligibility criteria. The income thresholds for this group varies by state.
- In states with a parent/caretaker eligibility level below 138 percent of the FPL and that have expanded Medicaid to the adult group, low-income parents and caretakers whose income is too high for the parent/caretaker group may be eligible in the adult group.

More information on [Medicaid and CHIP eligibility](#).

**Elderly, Blind, or Disabled Individuals**

Medicaid is also available to aged, blind, and/or disabled individuals who:

- Receive SSI payments or are considered to be receiving such payments, OR
- Live in states that elect not to provide Medicaid to individuals receiving SSI payments but who meet eligibility rules that are more restrictive than those for SSI, OR
- Are eligible for Medicare and have limited household income and resources (also called "dual-eligible").
There are many optional eligibility groups that federal law doesn't require states to cover under Medicaid. A few examples include:

- Children at higher income levels
- "Medically needy*" consumers
- Consumers living in medical institutions (e.g., nursing facilities) if their income is up to 300 percent of the SSI federal benefit rate
- Consumers with disabilities who are employed

**Medically Needy**

"Medically needy" consumers are those whose income exceeds a state's regular Medicaid eligibility limit but who have high medical expenses (e.g., for nursing home care) that reduce their disposable income below the Medicaid eligibility limit. This process allows consumers to subtract or "spend down" their medical expenses from their income and other measurable financial resources to become eligible.

 Consumers who are enrolled in a state Medicaid spend-down program or who have an application pending for spend down may be eligible for APTC or CSRs if they apply for those programs and enroll in a QHP through their state’s Marketplace.

**SSI Federal Benefit Rate**

The SSI federal monthly benefit rate is $841 for an eligible individual, $1,261 for an eligible individual with an eligible spouse, and $421 for an essential person in 2022.
Knowledge Check

Which of the following groups of people are required by federal law to be covered by Medicaid?

Select all that apply and then select Check Your Answer:

☐ A. "Medically needy" consumers
☐ B. Pregnant individuals at or below a certain household income level
☐ C. Consumers living in nursing homes
☐ D. Children in low-income households

Correct!
Federal law requires all states to cover pregnant individuals at or below a certain household income level and children in low-income households. States have the option to cover those designated as "medically needy" and consumers living in medical institutions (if their income is up to 300 percent of the SSI federal benefit rate).

Which of the following groups of people are required by federal law to be covered by Medicaid?

A. "Medically needy" consumers
B. Pregnant individuals at or below a certain household income level
C. Consumers living in nursing homes
D. Children in low-income households

The correct answers are B and D. Federal law requires all states to cover pregnant individuals at or below a certain household income level and children in low-income households. States have the option to cover those designated as "medically needy" and consumers living in medical institutions (if their income is up to 300 percent of the SSI federal benefit rate).
Presumptive Eligibility for Medicaid

Presumptive eligibility is when the state agency determines certain "qualified entities" that provide Medicaid services may screen individuals for Medicaid eligibility and temporarily enroll those who appear to be eligible on the spot without having to wait for their application to be fully processed.

The presumptive eligibility determination is based on an individual providing information about their income and household size and, at state option, information regarding citizenship, immigration status, and residency. If the individual appears to be eligible for Medicaid based on this information, the qualified entity shall determine that individual to be "presumptively eligible" for Medicaid.

You might encounter consumers who are receiving temporary Medicaid coverage through presumptive eligibility and who have not yet completed the Medicaid application process. Let these consumers know that they won't be able to keep their Medicaid coverage for an extended period of time if they don't complete and submit a Medicaid application prior to the end of their presumptive eligibility period.

*States can authorize entities like hospitals, health clinics, or schools to temporarily enroll consumers and their families in Medicaid coverage if they appear eligible.

Not all qualified entities are authorized by the state to make presumptive eligibility determinations for all individuals. For example, some may only be authorized to make presumptive eligibility determinations for children and pregnant individuals, but not low-income parents or caretaker relatives.

Not all hospitals are qualified to make presumptive eligibility decisions.
Nonfinancial Requirements for Medicaid

If consumers belong to a mandatory or optional eligibility group in their state and meet applicable financial requirements, they must also meet certain nonfinancial verification requirements to be eligible for Medicaid. For example, these consumers may need to provide proof of the following:

- State residency
- Citizenship or immigration status
- Social Security Number (SSN)

Consumers with SSNs who apply for Medicaid coverage through a Marketplace must provide their SSN in the Marketplace application. If they don't, it will slow down the application process, and they will have to provide it later.
You have learned the mandatory benefits available under Medicaid and the eligibility groups it covers. Some covered groups, like immigrants, may only be eligible for limited Medicaid benefits. Let’s review how immigration affects Medicaid eligibility.

Generally, immigrants must be qualified noncitizens and, for those who are subject to the five-year waiting period, must have had a qualified immigration status for five years, if applicable, to be eligible for full Medicaid benefits. However, there are two noteworthy exceptions:

- All states are required to provide limited Medicaid coverage necessary for treatment of an emergency medical condition to noncitizens who qualify under the state plan but are not U.S. citizens or do not have satisfactory immigration status — including the cost of labor and delivery. Therefore, certain immigrants who aren’t eligible for full Medicaid benefits or a QHP through a Marketplace may be able to get limited Medicaid coverage for treatment of an emergency medical condition even if they do not have a satisfactory immigration status.
- Many states choose to cover lawfully residing immigrant children under age 21 and pregnant individuals, including qualified noncitizens during the five-year waiting period, if they meet all other eligibility requirements in the state. This is commonly known as the "CHIPRA 214 option."

Qualified Noncitizens

Qualified noncitizens are immigrants who have one of the following immigration status classifications, like:

- Lawful permanent residents (LPRs/Green Card holders)
- Asylees
- Refugees
- Cuban/Haitian entrants
- U.S. parolees whose parole is expected to last at least one year
- Conditional entrants granted entry to the U.S. before 1980
- Battered non-citizens, spouses, children, or parents
- Victims of trafficking and their spouses, children, siblings, or parents— including individuals with a pending application for a Victim of Trafficking visa
• Individuals who are granted Withholding of Deportation
• Member of a Federally recognized Indian tribe or American Indian born in Canada
• Citizens of the Marshall Islands, Micronesia, and Palau who are living in one of the U.S. states or territories (referred to as Compact of Free Association or COFA migrants)

Emergency Medical Condition

An emergency medical condition is a condition that presents acute symptoms of sufficient severity, like severe pain, that, without immediate medical attention, could reasonably be expected to result in the following:

• Placing the consumer's health in serious jeopardy
• Causing serious impairment to bodily functions
• Causing serious dysfunction of any bodily organ or part

Under emergency Medicaid, a heart attack, labor, and delivery are all examples of emergency medical conditions. States have some flexibility to define what conditions would be included under the definition of an emergency medical condition, in accordance with section 1903(v)(2) and (v)(3) of the Act.
As an assister, you might help consumers who qualify for limited Medicaid benefits that are not considered MEC. You can help these consumers submit a Marketplace application. Individuals and families may also be eligible for insurance affordability programs (i.e., APTC or CSRs).

Limited Medicaid benefit programs that don't count as MEC generally include*:

- Medicaid providing only family planning services
- Medicaid providing only tuberculosis-related services
- Medicaid providing only coverage limited to treatment of emergency medical conditions
- Some types of pregnancy-related Medicaid coverage
- Some types of medically needy coverage
- Some Section 1115 Medicaid demonstration projects

*These programs currently aren't classified as meeting MEC standards. However, to the extent that certain programs within these categories provide comprehensive coverage, the Department of the Treasury and/or HHS may recognize these programs as MEC.
Medicaid is a comprehensive health coverage program for low-income parents and children, pregnant individuals, older consumers, consumers with disabilities, and certain other adults (depending on the state).

- All state Medicaid agencies are generally required to provide certain benefits to certain Medicaid beneficiaries while some states choose to provide additional benefits.

- You can help consumers who receive limited Medicaid benefits submit a Marketplace application. Individuals and families may also be eligible for insurance affordability programs (i.e., APTC or CSRs).
Many household members of consumers you assist will also qualify for CHIP, another public health coverage program. You should be familiar with CHIP and the eligibility requirements in your state.

**Who is Covered**
State who is covered by the CHIP program

**Benefits**
Describe the benefits of CHIP

**Eligibility**
Identify CHIP eligibility and presumptive eligibility requirements
As is the case for Medicaid, states must follow federal guidelines and have flexibility to develop some aspects of their own CHIP programs (e.g., when setting eligibility standards).

Chip Basics

CHIP is a health coverage program for:

- Uninsured children up to age 19 whose family income is too high for them to qualify for Medicaid
- Low-income pregnant individuals and/or newborns in some states who do not qualify for Medicaid
At this point, you might be wondering what types of benefits are covered for children enrolled in CHIP. Since CHIP varies by state, the exact benefits a particular state covers may differ from other states. However, all states currently provide comprehensive coverage including:

- Routine checkups
- Immunizations
- Doctor visits
- Prescriptions
- Dental and vision care
- Inpatient and outpatient hospital care
- Laboratory and X-ray services
- Emergency services
- COVID-19 testing, treatment, and vaccinations

These benefits are similar to Medicaid services offered to consumers.

Some states charge small premiums and/or copayments for CHIP coverage. Families with children enrolled in CHIP aren't required to pay more than five percent of their yearly income for CHIP coverage – including out-of-pocket costs – but most programs charge premiums that are far lower. Cost sharing (e.g., deductibles, copayments, and coinsurance) isn't allowed for certain preventive services like well-baby or well-child visits.

**COVID-19 Testing, Treatment, and Vaccinations**

Beginning March 11, 2021, CHIP enrollees (qualified low-income children and pregnant individuals) have mandatory coverage, without deductibles, coinsurance, or other cost sharing, of COVID-19 vaccines and their administration, COVID-19 testing and treatment, and, in the case of a consumer diagnosed with or presumed to have COVID-19, the treatment of a condition that may seriously complicate the treatment of COVID-19 during the period the person has or is presumed to have COVID-19.
CHIP provides low-cost health coverage to uninsured children up to age 19 in families whose income is too high for them to qualify for Medicaid. Some states require that children be uninsured for up to 90 days before they can enroll in CHIP. Remember, MAGI is used to calculate consumers' financial eligibility for CHIP. Each state has its own rules about who qualifies for CHIP:

- Most states cover children in families with incomes up to at least 200 percent of the FPL.
- Nearly half of these states offer coverage to children whose household income is at or above 250 percent of the FPL.
- Other states allow children with higher income levels to pay higher premiums and buy into CHIP.
- Remember, states also have the option to provide CHIP coverage to some low-income pregnant individuals. In some states, CHIP provides coverage to individuals for the duration of their pregnancy. Under the American Rescue Plan Act of 2021, states have the option to extend Medicaid and CHIP coverage to 12 months postpartum. States can opt to do this beginning April 1, 2022. If a state elects to extend the postpartum coverage under Medicaid, they must extend such coverage under CHIP as well. Assistors can visit their state's Medicaid or CHIP website for information.

In 2022, for states other than Alaska and Hawaii, 200 percent of the FPL is equal to a yearly income of $55,500 for a family of four and $36,620 for a family of two; 250 percent of the FPL is equal to a yearly income of $69,375 for a family of four and $45,775 for a family of two.

Infants born to pregnant individuals enrolled in Medicaid or CHIP are automatically eligible for Medicaid or CHIP up to one year of age. In addition, new mothers who lose access to healthcare services provided through unborn child CHIP coverage following the birth of their child may qualify for an SEP 60 days before or after their loss of coverage under the ACA, if they are otherwise eligible to enroll in a QHP through a Marketplace. The ACA also gives states the option to extend CHIP eligibility to the children of state employees who were previously excluded from CHIP coverage.

In 2022, for states other than Alaska and Hawaii, 200 percent of the FPL is equal to a yearly income of $55,500 for a family of four and $36,620 for a family of two; 250 percent of the FPL is equal to a yearly income of $69,375 for a family of four and $45,775 for a family of two.
Just like for Medicaid, states can authorize "qualified entities" – including health care providers, schools, Head Start programs, and other community-based organizations – to screen for CHIP eligibility and immediately enroll children who appear to be eligible on a temporary basis. Presumptive eligibility allows children to get access to CHIP services without having to wait for their application to be fully processed.

If individuals are enrolled temporarily under presumptive eligibility, they and their families must complete the application process prior to the end of the presumptive eligibility period to keep their coverage.

It's important to know if the state you are working in has presumptive eligibility. If so, resources may be available to help consumers complete the application process. More information on which states provide presumptive eligibility.
Medicaid and CHIP are also similar in terms of eligibility and immigration status. Generally, immigrants must be qualified noncitizens and for those who are subject to the five-year waiting period must have had that status for five years, if applicable, to be eligible for CHIP. However, some states provide additional benefits for immigrant children and/or pregnant individuals. In these states, all lawfully residing immigrant children and/or pregnant individuals are eligible for CHIP, including qualified noncitizens during the five-year waiting period, if they meet other eligibility requirements in the state. This is commonly known as the CHIPRA 214 option.

Eligibility for CHIP is based on a child's immigration status and not on the citizenship or immigration status of the child's parents. Parents may also have the option to enroll their child(ren) in a separate child-only plan through a Marketplace if otherwise eligible.

**Qualified Noncitizens**

Qualified noncitizens are immigrants who have one of the following immigration status classifications, like:

- Lawful permanent residents (LPRs/Green Card holders)
- Asylees
- Refugees
- Cuban/Haitian entrants
- U.S. parolees whose parole is expected to last at least one year
- Conditional entrants granted entry to the U.S. before 1980
- Battered non-citizens, spouses, children, or parents
- Victims of trafficking and their spouses, children, siblings, or parents—including individuals with a pending application for a Victim of Trafficking visa
- Individuals who are granted Withholding of Deportation
- Member of a Federally recognized Indian tribe or American Indian born in Canada
CHIP coverage varies by state, so the exact benefits that a particular state covers in CHIP may also differ from other states. However, all states provide comprehensive coverage, including which of the following?

Select all that apply and then select Check Your Answer.

- A. Immunizations
- B. Prescriptions
- C. Orthodontic care
- D. Laboratory and X-ray services

Correct!
CHIP benefits for all states include immunizations, prescriptions, and laboratory and X-ray services.

CHIP coverage varies by state, so the exact benefits that a particular state covers in CHIP may also differ from other states. However, all states provide comprehensive coverage, including which of the following?

A. Immunizations
B. Prescriptions
C. Orthodontic care
D. Laboratory and X-ray services

The correct answers are A, B, and D. CHIP benefits for all states include immunizations, prescriptions, and laboratory and X-ray services.
### Key Points

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- CHIP covers uninsured children up to age 19 in low-income families with incomes too high for them to qualify for Medicaid.
- Although covered CHIP benefits vary by state, all states must provide comprehensive coverage that includes immunizations, doctor visits, and prescription drugs.
- Eligibility for CHIP is based on a child's U.S. citizenship or immigration status and state residency — not on the U.S. citizenship or immigration status of the child's parents.
Now that we've reviewed the most common types of coverage you'll help consumers get, let's make sure you know how to help older consumers or certain other consumers who might have Medicare or become eligible for Medicare soon.

**Eligibility**
State the eligibility requirements for Medicare

**Enrollment**
Describe Medicare enrollment scenarios

**Benefits**
State the benefits available from Medicare

**Medicare & the Marketplaces**
Describe the relationship between Medicare and the Marketplaces
Medicare is a health coverage program made up of different parts and benefits. You should bring up Medicare in discussions with consumers who:

- Are age 65 or over,
- Have end-stage renal disease (ESRD), or
- Have a disability, regardless of age.

You should have a general idea of how both Medicare and Marketplace coverage work for these consumers so you can provide them with fair, accurate, and impartial information about their health coverage options.
Medicare isn't part of the Marketplaces. However, consumers who have Medicare Part A or Part C have qualifying health coverage called MEC.

You should tell consumers who have Medicare coverage that the Marketplaces won’t affect their Medicare choices or benefits. As long as consumers get original Medicare Part A (with or without Part B) or a Part C Medicare Advantage plan (e.g., an HMO or PPO), they won't have to make any changes.

The eligibility requirements for Medicare are complex. Generally, it's a good idea to refer consumers to their State Health Insurance Assistance Program (SHIP) if they have specific questions about Medicare.
Referring Consumers to Other Organizations for Help with Medicare

Remember that Navigators and CACs in FFMs must provide information in a fair, accurate, and impartial manner. All assisters must provide information that assists consumers with submitting Marketplace eligibility applications, clarifies distinctions among health coverage options including QHPs, and helps consumers make informed decisions during the health coverage selection process. Navigators in FFMs must acknowledge other health programs – including Medicare – when providing this information. Sometimes it might be helpful to refer consumers to other organizations when they need assistance that falls outside the scope of your authorized assister functions related to the FFMs.

It is a best practice to refer consumers who may be eligible for Medicare to their SHIP or other resources in their area for in-depth information. Remember to follow CMS guidance when working with (or referring consumers to) organizations that are not other FFM assister organizations or HHS entities.

Select the resource to learn more about how SHIP can help consumers who may be eligible for Medicare:

State Health Insurance Assistance Program (SHIP)

A program in every state that offers one-on-one Medicare counseling and assistance to consumers and their families. Consumers with questions about Medicare can be referred to their local SHIP at Shiptacenter.org.

Remember that Navigators and CACs in FFMs must provide information in a fair, accurate, and impartial manner. All assisters must provide information that assists consumers with submitting Marketplace eligibility applications, clarifies distinctions among health coverage options including QHPs, and helps consumers make informed decisions during the health coverage selection process. Navigators in FFMs must acknowledge other health programs – including Medicare – when providing this information. Sometimes it might be helpful to refer consumers to other organizations when they need assistance that falls outside the scope of your authorized assister functions related to the FFMs.

It is a best practice to refer consumers who may be eligible for Medicare to their SHIP or other resources in their area for in-depth information. Remember to follow CMS guidance when working with (or referring consumers to) organizations that are not other FFM assister organizations or HHS entities.

State Health Insurance Assistance Program (SHIP)

A program in every state that offers one-on-one Medicare counseling and assistance to consumers and their families. Consumers with questions about Medicare can be referred to their local SHIP at Shiptacenter.org.
Medicare Benefits: Different Parts

The different parts of Medicare help cover specific services. Refer to the graphic to learn more about each part.

As an assister, it's a good idea for you to be familiar with the coverage options available to consumers who are eligible for Medicare. Let's review the different parts of Medicare and how they might affect consumers who come to you for more information about the Marketplaces.

Note: In certain situations, consumers may have Medicare and also enroll in Marketplace coverage. You will learn about some of these situations in this module.

Medicare Part A (Hospital Insurance)
Part A covers inpatient hospital stays, care in skilled nursing facilities, hospice care, and some home health care. Most Medicare beneficiaries have Part A without a premium, but others may have to pay a premium for Part A.

Medicare Part B (Medical Insurance)
Part B covers certain doctors' services, outpatient care, home health care, durable medical equipment and supplies, preventive services, and other services. There's generally a premium for Part B.

Medicare Part C (Medicare Advantage Plans)
Medicare Advantage plans are a type of Medicare health plan offered by private health insurance companies that contract with Medicare to provide Part A and Part B benefits for their enrollees. Most Medicare Advantage plans also offer prescription drug coverage (Part D), and some offer additional benefits that Parts A, B, and D don't cover. Consumers with a Medicare Advantage plan pay a Part B premium and usually pay an additional monthly premium amount for other benefits that the plan covers.

Medicare Part D (Prescription Drug Coverage)
Part D covers prescription drugs. Health insurance companies approved by Medicare offer Part D coverage. Medicare Advantage plans may also offer prescription drug coverage that follows the same rules as Medicare prescription drug plans. There's generally a premium for Part D.

Visit Medicare.gov for more information about Medicare benefits and enrollment processes.
Now that we’ve reviewed the different parts of Medicare, let’s discuss eligibility for Part A. In general, consumers who paid Social Security and Medicare taxes for at least 10 years (or at least 40 quarters) are entitled to premium-free Part A Medicare. Those already receiving Social Security benefits are automatically enrolled in premium-free Part A (when they become entitled), but others have to apply for premium-free Part A.

Consumers who have Medicare generally can’t enroll in QHPs through a Marketplace. It is against the law for a private insurer to sell a Marketplace plan to a consumer when the insurer knows the consumer has Medicare coverage. This is generally true even if a consumer has only Part A or only Part B coverage.

Additionally, if a consumer has been determined eligible for or is enrolled in Medicare that counts as MEC (i.e., Part A or Part C), the consumer is not eligible to receive financial assistance — that is, APTC or CSRs — to help pay for a Marketplace plan.

Now that we’ve reviewed the different parts of Medicare, let’s discuss eligibility for Part A. In general, consumers who paid Social Security and Medicare taxes for at least 10 years (or at least 40 quarters) are entitled to premium-free Part A Medicare. Those already receiving Social Security benefits are automatically enrolled in premium-free Part A (when they become entitled), but others have to apply for premium-free Part A.

Consumers who have Medicare generally can’t enroll in QHPs through a Marketplace. It is against the law for a private insurer to sell a Marketplace plan to a consumer when the insurer knows the consumer has Medicare coverage. This is generally true even if a consumer has only Part A or only Part B coverage.

Additionally, if a consumer has been determined eligible for or is enrolled in Medicare that counts as MEC (i.e., Part A or Part C), the consumer is not eligible to receive financial assistance — that is, APTC or CSRs — to help pay for a Marketplace plan.
In general, consumers ages 65 and older who are not entitled to premium-free Medicare Part A (because they haven’t earned enough quarters of coverage) may choose to purchase Part A coverage by filing an application at a Social Security office. Because these consumers will need to pay monthly premiums, this type of Medicare coverage is called **Medicare Premium Part A (Premium Part A)**.

Older consumers who want to get Premium Part A can apply for coverage only during a prescribed enrollment period and must also enroll in (or already be enrolled in) Medicare Part B. To purchase Premium Part A, consumers must also live in the U.S. AND be U.S. citizens or lawful permanent residents of the U.S. for at least five consecutive years.

You can help consumers find more information about Medicare benefits at Medicare.gov. Remember, consumers can also search for their local SHIP for detailed information about Medicare at Shiptacenter.org.

Consumers who don’t have Medicare coverage may choose to enroll in Marketplace coverage rather than purchase Part A and/or Part B coverage as long as they are eligible. Financial assistance for Marketplace coverage might not be available.
It's important that consumers close to age 65 who are applying for coverage through a Marketplace know about the benefits of enrolling in Medicare as soon as they become eligible.

Consumers who don't sign up for Medicare during their Initial Enrollment Period (IEP) and do not have job-based coverage based on current employment, including coverage through a SHOP Marketplace, may have to pay higher premiums when they sign up for Medicare later.

Here is some information you should tell these consumers depending on their circumstances.

If consumers... Are receiving Social Security retirement or Social Security disability benefits,

Then consumers... Will be automatically enrolled in Part A and Part B once they are eligible. The consumer will receive information about Medicare in the mail a few months before they're automatically enrolled in Part A and Part B.

And... They should consider signing up for Part D during their Initial Enrollment Period (IEP) so they will have prescription drug coverage on their first day of eligibility and so they don't have to pay a late enrollment penalty that may apply if they enroll later.

If consumers... Are newly eligible for Medicare and don't get Social Security benefits yet,

Then consumers... Have job-based coverage based on current employment, including coverage through a SHOP Marketplace,

And... For someone turning 65 years old, the IEP includes the three months before, the month of, and the three months after a consumer turns 65. If consumers don't sign up for Medicare during their IEP and don't have job-based coverage (including coverage through a SHOP Marketplace), they may have to pay a late enrollment penalty or wait for a General Enrollment Period to enroll in Part B coverage.

If consumers... Have job-based coverage based on current employment, including coverage through a SHOP Marketplace,

Then consumers... Should consider signing up for premium-free Part A (if eligible) when their IEP begins and consider whether they can delay enrollment in Part B until the job-based coverage or the current employment ends, whichever occurs first, and at which time they may be able to apply during a Special Enrollment Period
based on their job-based coverage or current employment ending.

If consumers...Are eligible for programs to lower their QHP costs through a Marketplace (i.e., APTC and CSRs),

Then consumers...Will lose eligibility for APTC and CSRs through a Marketplace when they become eligible for Medicare premium-free Part A based on their age or when their Medicare Part A (premium free or with a premium) coverage starts, regardless of the basis for their eligibility for Part A. Note: Consumers who are enrolled in a Marketplace plan first and then become eligible for Medicare can stay enrolled in the Marketplace plan but will no longer qualify for APTC or CSRs once Medicare begins.

If consumers... Want help to pay for some of their health care costs that their original Medicare plan doesn't cover,

Then consumers... Should consider purchasing a Medicare Supplement Insurance (Medigap) policy or whether to enroll in a Medicare Advantage plan.

And...For consumers enrolled in original Medicare (Part A and Part B) and a Medigap policy, Medicare and Medigap will each pay its share of covered health care costs. Generally, when a consumer buys a Medigap policy, they must have Part A and Part B.

Note: Part C (called Medicare Advantage or MA) is not a type of Medigap policy. Consumers cannot enroll in a Medigap policy if they are enrolled in an MA plan because Medigap only helps consumers with costs that original Medicare (Part A and Part B) doesn't cover. MA Plans are a type of Medicare health plan offered by private health insurance companies that contract with Medicare to provide Part A and Part B benefits for their enrollees. Most MA Plans also offer prescription drug coverage (Part D) for enrollees, and some MA plans may offer other supplemental benefits. For more information, visit Medicare.gov.
Some consumers you help may have Marketplace coverage and then become automatically enrolled in Medicare later. Let’s take a closer look at what these consumers need to know.

Automatically Enrolled in Medicare

- Generally, consumers are automatically enrolled in Part A and Part B without an application if they are getting Social Security or Railroad Retirement Board benefits at the time they meet the entitlement or eligibility requirements for Medicare.
- Additionally, consumers who are receiving Social Security disability benefits are also automatically enrolled in Medicare Parts A and B in the 25th month of their disability payments.
- Coverage begins the first day of the month they turn 65, but the coverage start date may vary if a consumer is enrolled in disability benefits.

Automatically Enrolled in Medicare and Have Marketplace Coverage

If consumers are automatically enrolled in Medicare, it’s important for you to talk to them about when they might be automatically enrolled and how to terminate their Marketplace coverage in a way that avoids both gaps in coverage and dual coverage. Marketplace coverage doesn’t automatically end when a consumer is enrolled in Medicare.

If consumers are not automatically enrolled in Medicare, they might come to you for help when deciding between Marketplace coverage and Medicare. Remember, both Part A and Medicare Advantage count as MEC just like Marketplace plans do. However, you should inform these consumers of the consequences of delaying Medicare enrollment—that is, they may have to pay higher premiums if they don’t sign up during their IEP. It’s also important for these consumers to know that they are not eligible to receive financial assistance from a Marketplace to help lower the costs of coverage (i.e., APTC and CSRs) if they are also eligible for Medicare that counts as MEC.

Remember, some of the Medicare eligibility scenarios you encounter may be complex. It is a best practice to refer these consumers to their SHIP or another organization for more detailed information about Medicare.
Help With Medicare Costs

What could you tell consumers who have or are entitled to Medicare Part A since they aren’t eligible for APTC and/or CSRs through a Marketplace?

Consumers with Medicare Part A might also be eligible for help with paying Medicare costs under these other programs:

- Extra Help with Medicare prescription drug costs (low-income subsidy)
- Medicare Savings Programs (MSPs) for help with Medicare Part A and Part B costs, which include:
  - Qualified Medicare Beneficiary (QMB) program, which helps pay for Part A premiums, Part B premiums, and deductibles, coinsurance, and copayments for services and items that Medicare covers
  - Specified Low-income Medicare Beneficiary (SLMB) program, which helps pay for Part B premiums only
  - Qualifying Individual (QI) program, which helps pay for Part B premiums only
  - Qualified Disabled and Working Individuals (QDWI) program, which helps pay for Part A premiums

More information on eligibility and coverage is available in the Resources section.

What could you tell consumers who have or are entitled to Medicare Part A since they aren’t eligible for APTC and/or CSRs through a Marketplace?

Consumers with Medicare Part A might also be eligible for help with paying Medicare costs under these other programs:

- Extra Help with Medicare prescription drug costs (low-income subsidy)
- Medicare Savings Programs (MSPs) for help with Medicare Part A and Part B costs, which include:
  - Qualified Medicare Beneficiary (QMB) program, which helps pay for Part A premiums, Part B premiums, and deductibles, coinsurance, and copayments for services and items that Medicare covers
  - Specified Low-income Medicare Beneficiary (SLMB) program, which helps pay for Part B premiums only
  - Qualifying Individual (QI) program, which helps pay for Part B premiums only
  - Qualified Disabled and Working Individuals (QDWI) program, which helps pay for Part A premiums

More information on eligibility and coverage is available in the Resources section.
It's time for a knowledge check to review how you might assist an older consumer. Eduardo, who is 71 years old, comes to your office for more information about his health coverage options. He's currently enrolled in Medicare premium-free Part A and Medicare Part B. He wants to know more about other options that might be available to help lower his costs.

Which of the following discussions would be appropriate to have with Eduardo?

Select all that apply and then select Check Your Answer.

- A. Tell him you can't help him and that he should contact his local State Health Insurance Assistance Program to find out if he qualifies for state-based financial assistance to lower his Medicare costs.
- B. Tell him that he can keep his current Medicare premium-free Part A and Medicare Part B and apply for coverage through a Marketplace to help him with Medicare premium costs.
- C. Tell him that he can keep his current Medicare premium-free Part A and Medicare Part B and apply for a Medicare Savings Program (MSP) to see if he's eligible to get help paying for his Medicare costs.
- D. Tell him that because he's enrolled in Medicare premium-free Part A and Medicare Part B, insurers currently cannot sell him a QHP through the Marketplace if they know it will duplicate his Medicare benefits. Additionally, since Medicare premium-free Part A qualifies as minimum essential coverage, being eligible for it makes him ineligible for advance payments of the premium tax credits and cost-sharing reductions. Lastly, he can't drop his Medicare without also dropping his Social Security or Railroad Retirement Board benefits, and he'll also have to pay back all retirement benefits he's received and all costs paid by Medicare for his health care claims. Therefore, it's advisable to remain enrolled in Medicare premium-free Part A rather than drop it to enroll in Marketplace coverage.

The correct answers are C and D. You should tell Eduardo about Medicare Savings Programs, which will help him lower his Medicare costs if he is eligible. Since Eduardo is currently enrolled in Medicare, he cannot enroll in a QHP through the Marketplace because insurers cannot sell Medicare enrollees a QHP. Additionally, since Medicare premium-free Part A is considered minimum essential coverage, being eligible for it makes him ineligible for advance payments of the premium tax credits and cost-sharing reductions. Lastly, he can't drop his Medicare without also dropping his Social Security or Railroad Retirement Board benefits, and he'll also have to pay back all retirement benefits he's received and all costs paid by Medicare for his health care claims. Therefore, it's advisable to remain enrolled in Medicare premium-free Part A rather than drop it to enroll in Marketplace coverage.
Knowledge Check

Here is the last Medicare knowledge check.

Which of the following is usually the best option for older consumers enrolled in a QHP through a Marketplace for individuals and families if they are about to become entitled to premium-free Medicare Part A?

Select the correct answer and then select Check Your Answer.

- A. Apply for Medicare immediately or as soon as their Initial Enrollment Period begins.
- B. Stay enrolled in their current QHP.
- C. Wait until after they become eligible for Medicare to decide whether to apply for Medicare.
- D. Switch to another QHP with health coverage options similar to what Medicare provides.

Correct!
If consumers are about to become eligible for Medicare, their best option is usually to enroll in Medicare immediately or as soon as their Initial Enrollment Period begins. They may experience increased costs, fees, and gaps in coverage if they don't sign up for Medicare when they first become eligible.

Here is the last Medicare knowledge check.

Which of the following is usually the best option for older consumers enrolled in a QHP through a Marketplace for individuals and families if they are about to become entitled to premium-free Medicare Part A?

A. Apply for Medicare immediately or as soon as their Initial Enrollment Period begins.

B. Stay enrolled in their current QHP.

C. Wait until after they become eligible for Medicare to decide whether to apply for Medicare.

D. Switch to another QHP with health coverage options similar to what Medicare provides.

The correct answer is A. If consumers are about to become eligible for Medicare, their best option is usually to enroll in Medicare immediately or as soon as their Initial Enrollment Period begins. They may experience increased costs, fees, and gaps in coverage if they don't sign up for Medicare when they first become eligible.
Generally, consumers must be U.S. citizens or lawful permanent residents and live in the U.S. continuously for the past five years preceding the month in which they submit an application for Medicare Part B. Medicare claims under Part A or Part B will not be paid for consumers who are not lawfully present in the U.S., even if they earned enough quarters of coverage to qualify.

You can learn more about Medicare eligibility for immigrants in the course on Serving Vulnerable and Underserved Populations in this training.

Consumers who are not U.S. citizens can contact the Social Security Administration for more information about Medicare eligibility requirements.
Consumers who already have Medicare Part A and/or Part B generally can't enroll in QHPs through a Marketplace because it's against the law for a private insurer to sell a Marketplace plan to someone who has Medicare coverage when the insurer knows the plan will provide duplicate benefits.

- If consumers are enrolled in QHPs and get financial assistance through a Marketplace, they'll lose their eligibility for Marketplace-based financial assistance when their Medicare Part A coverage begins or when they become eligible for premium-free Part A due to age or disability, ESRD or ALS diagnoses. However, consumers with premium-free Part A typically pay less for health coverage than they would for Marketplace coverage.

- Consumers who don't have Medicare coverage and who are not eligible for premium-free Part A may be able to enroll in a QHP through a Marketplace and may be eligible for APTC and CSRs.

- Consumers who have Part B only or Premium Part A and Part B may be eligible to enroll in a QHP through a Marketplace, but an insurer that knows its plan will duplicate a consumer's Medicare coverage can only sell them a QHP after they voluntarily end all their Medicare coverage.

- Additional programs for lowering consumers' costs may be available through Medicare.

Consumers who already have Medicare Part A and/or Part B generally can't enroll in QHPs through a Marketplace because it's against the law for a private insurer to sell a Marketplace plan to someone who has Medicare coverage when the insurer knows the plan will provide duplicate benefits.

- If consumers are enrolled in QHPs and get financial assistance through a Marketplace, they'll lose their eligibility for Marketplace-based financial assistance when their Medicare Part A coverage begins or when they become eligible for premium-free Part A due to age or disability, ESRD or ALS diagnoses. However, consumers with premium-free Part A typically pay less for health coverage than they would for Marketplace coverage.

- Consumers who don't have Medicare coverage and who are not eligible for premium-free Part A may be able to enroll in a QHP through a Marketplace and may be eligible for APTC and CSRs.

- Consumers who have Part B only or Premium Part A and Part B may be eligible to enroll in a QHP through a Marketplace, but an insurer that knows its plan will duplicate a consumer's Medicare coverage can only sell them a QHP after they voluntarily end all their Medicare coverage.

- Additional programs for lowering consumers' costs may be available through Medicare.
At this point, you might be wondering how you can help consumers who do not qualify for Medicaid, CHIP, Medicare, or programs to help lower their costs through a Marketplace or if other private health coverage is unaffordable for them.

**Coverage Gap**
Define the coverage gap

**Coverage Exemptions**
Help consumers who fall in the coverage gap obtain Marketplace exemptions

**Consumer Options**
State options available to consumers in a coverage gap
What is a coverage gap?
In states that have not expanded Medicaid to low-income adults, many adults with incomes below 100 percent of the FPL fall into a coverage gap. Their incomes are too high to get Medicaid or other public health coverage under their state's current rules and are too low to qualify for help paying for coverage in a Marketplace. Some consumers who may fall into the coverage gap include jobless parents, working parents, and non-disabled, non-elderly childless adults.
It might also be helpful to refer consumers who fall into a coverage gap to other programs or organizations. Here are some options you should discuss with them:

- **Obtain health care services at federally qualified community health centers (FQHCs).** These centers provide services on a sliding scale depending on a consumer's income. Use the following tool to find a community health center near the consumer: [HealthCare.gov/community-health-centers/](http://HealthCare.gov/community-health-centers/).

- **Purchase Catastrophic health coverage.** Catastrophic plans are available through the Marketplaces for consumers under 30 years old and consumers who are 30 years old or older and are granted a hardship or affordability exemption. Catastrophic plans usually have lower monthly premiums than comprehensive plans but cover consumers only if they need a lot of care. They protect consumers from worst-case scenarios like serious accidents or illnesses. For more information, visit: [HealthCare.gov/choose-a-plan/catastrophic-health-plans/](http://HealthCare.gov/choose-a-plan/catastrophic-health-plans/).

- **See what pharmaceutical assistance programs may be available.** Some pharmaceutical companies offer assistance programs for the drugs they manufacture. You can help consumers see if assistance is available for the medications they take by visiting: [Medicare.gov/Pharmaceutical-Assistance-Program](http://Medicare.gov/Pharmaceutical-Assistance-Program).

- **Obtain a short-term plan.** Consumers may enroll in short-term, limited-duration insurance policies designed for people who experience a temporary gap in health coverage.

You should always follow [CMS guidance](https://www.cms.gov/) when working with or referring consumers to organizations that are not other FFM assister organizations or HHS entities.
Some consumers may fall into a coverage gap.

- Consumers in a coverage gap who wish to purchase Catastrophic health coverage and are age 30 and above must continue to apply for, obtain, and report an affordability or hardship exemption through the Marketplace.

- You can refer consumers in a coverage gap to other sources for care, including FQHCs, Catastrophic health plans, pharmaceutical assistance programs, and short-term, limited-duration insurance policies.
Congratulations! You have learned about the key features of the ACA, including provisions that can help eligible consumers lower their health coverage costs. You also read about the responsibilities that all consumers must meet to obtain health coverage.

You’ve successfully completed this course.

Select the link to take the Affordable Care Act Basics exam. Good luck!
Affordable Care Act Basics Resources

HealthCare.gov/immigration-status-and-the-marketplace

Incarcerated Consumers: Explanation of incarceration status in relation to eligibility for coverage through a Marketplace.
HealthCare.gov/incarcerated-people

Medicaid Expansion: Official resource at HealthCare.gov that provides information for consumers who live in states that did not expand Medicaid.
HealthCare.gov/medicaid-chip/medicaid-expansion-and-you

More Information about the ACA: The text of the Affordable Care Act can be accessed through this link at HealthCare.gov.
HealthCare.gov/where-can-i-read-the-affordable-care-act

aspe.hhs.gov/poverty-guidelines

Medicaid and CHIP Eligibility Levels by State: A CMS chart of Medicaid and CHIP eligibility levels for selected MAGI groups in each state.
Medicaid.gov/medicaid/program-information/medicaid-and-chip-eligibility-levels/index.html

Medicaid and CHIP Fast Facts for Assisters: A fact sheet for helping low-income individuals, families, or children who are uninsured or who are seeking information about health coverage options.