Refresher Course

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Course Introduction

Welcome

You need to be aware of this training disclaimer.

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, and other interpretive materials for complete and current information.

In this course, there are some 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.
Course Introduction

Who Must Take this Course?

Welcome to the Refresher Course.

This course is a recertification requirement for the following types of assisters who previously completed federal training and certification requirements and who, after being certified, performed authorized assister functions for at least one year and were not decertified:

**Navigators** in Federally-facilitated Marketplaces

**Non-Navigator assistance** personnel in Federally-facilitated Marketplaces, **excluding** federal In-Person Assisters (IPAs)

Note: In this lesson, the terms "you" and "assister" refer to both of these types of assisters. 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 and State Partnership Marketplaces. In this course, the terms “Marketplace” or “Marketplaces,” standing alone, generally refer to FFMs.
Course Introduction

Certification and Recertification Requirements

CMS regulations require all Navigators, non-Navigator assistance personnel, and certified application counselors (CACs) in FFMs to complete the following requirements before they are certified to carry out any required or authorized functions:

- Complete training that has been approved for their assister type by the U.S. Department of Health and Human Services (HHS).
- Achieve a passing score on all approved certification examinations.
- Meet any licensing, certification, or other standards prescribed by their state, if applicable, so long as such standards do not prevent the application of the provisions of Title I of the Affordable Care Act.
- Obtain continuing education and be certified and/or recertified on at least an annual basis after successfully completing recertification training requirements for their assister type.

CACs in FFMs are certified and recertified by their CAC designated organizations (CDOs).

For more information about continuing education requirements, refer to the CMS Enrollment Assister Bulletin.
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For more information about continuing education requirements, refer to the CMS Enrollment Assister Bulletin.

Course Introduction

What Topics are Covered in the Refresher Course?

This course includes a review of important information that will help you provide consumers in FFMs with eligibility and enrollment assistance or support them with exemptions and appeals. As a returning Navigator or non-Navigator assistance personnel who previously completed training, you will also learn about operational updates in the FFMs for 2018.
To become recertified for 2018, returning Navigators and non-Navigator assistance personnel must complete the following 2018 training courses in addition to this Refresher Course:

- Privacy, Security, and Fraud Prevention Standards
- Coverage to Care Assistance
- Assister Standard Operating Procedures

You will receive a certificate confirming your recertification after you successfully complete all of the above courses and receive a passing score on all required course examinations.

For more information about topics covered in this course, you can but are not required to refer to the following 2018 training courses:

- Marketplace Basics
- Marketplace Eligibility and Application Assistance
- Comparing and Enrolling in Marketplace Plans
- Marketplace Exemptions and Appeals Assistance

**Important Reminder**

CMS Navigator grantee staff and volunteers must not hold themselves out as Federally-certified Navigators or carry out any Navigator functions (including outreach and education activities) until they have completed required training and are certified or recertified, as applicable.

Individuals must not hold themselves out as Navigators or perform Navigator functions in an FFM unless they are affiliated with a current CMS Navigator grantee and have a current certification that accurately reflects that affiliation or they are themselves certified as a current CMS Navigator grantee.
Marketplace Overview

The Health Insurance Marketplaces

Consumers who don’t have health insurance through a job, Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), or another source that provides qualifying health coverage can apply for coverage through the Health Insurance Marketplaces.

Each state has a Marketplace for individuals and families and a Small Business Health Options Program (SHOP) Marketplace for small businesses and their employees. States have the option to run their own individual and SHOP Marketplaces or to have the Federal Government run them.

This refresher course is addressed to Navigators and non-Navigator assistance personnel in states with FFMs. However, you should understand a few key differences between FFMs and other Marketplace types.

State-Operated
States that manage all Marketplace functions have a State-based Marketplace (SBM). Some states have an SBM on the Federal Platform, meaning they hold primary responsibility for managing Marketplace functions but rely on the federal HealthCare.gov platform to manage their eligibility and enrollment functions.
Federally-Operated
States that choose to have the Federal Government manage all Marketplace functions have an FFM. In some FFMs, states choose to oversee or regulate plan management functions. Some states with an individual market FFM operate their own SHOP Marketplace. Others have a Federally-facilitated SHOP Marketplace (FF-SHOP).

State Partnership Marketplaces
Some states partner and engage actively with the Federal Government to operate certain aspects of the state’s FFM. This type of FFM is called a State Partnership Marketplace (SPM). States with SPMs can be responsible for plan management functions or consumer assistance activities.

Different Types
Generally, states are the primary regulators of health insurance companies. States are responsible for enforcing statutory requirements for health insurance and provisions of the Affordable Care Act—both inside and outside of the Marketplaces.

Marketplace Overview

2018 Marketplace Information by State
You can view important characteristics about your state’s Marketplace by selecting your state in the “Marketplaces by State” map. We encourage you to write down your state’s information and keep it handy but you can view this map at any time by selecting the Resources tab in the course Menu.

**Marketplace Overview**

**How Consumers Use the Marketplaces**

Consumers can use the Marketplaces to find and apply for health coverage that fits their budgets and specific needs.

Remember, eligible consumers can enroll in qualified health plans (QHPs) during the annual Open Enrollment Period (OEP) or during a Special Enrollment Period (SEP).

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

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.

No matter how consumers apply and enroll, you can provide in-person help.

Individuals and families can find health and dental coverage through the Marketplaces for
individuals and families. They can apply online, by phone, or by mail.

Eligible small employers and their employees can find health and dental coverage through the SHOP Marketplaces. Eligible small employers may also choose to offer coverage to dependents of employees. They can apply online or by phone but the SHOP Marketplaces do not accept applications by mail.

Qualified Health Plans
Remember, all health insurance plans sold in the Marketplaces are QHPs. 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, and

- Follows established limits on cost sharing (e.g., deductibles, copayments, and out-of-pocket maximum amounts) and meets other requirements.
Although this course generally focuses on the Marketplaces for individuals and families, it is also important for you to know some basic details about SHOP Marketplaces. This will help you recall how both types of Marketplaces can function together within a state.

The Marketplaces for individuals and families and the SHOP Marketplaces perform some of the same core functions, such as making QHPs available. However, there are some key differences.

**Marketplaces for Individuals and Families**
Collect and verify eligibility information from consumers and their families. Consumers and their families may qualify for advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs) to help lower their costs. They can also be assessed or determined eligible for Medicaid and CHIP.

Verify all consumer information including immigration status.

Consumers can apply for health coverage through the Marketplaces for individuals and families during the individual market OEP. For coverage beginning on January 1, 2018, Open Enrollment starts November 1, 2017 and ends December 15, 2017.

**SHOP Marketplaces**
Collect eligibility information from small employers and their employees and former employees to whom they offer coverage.

APTC and CSRs aren't available to lower the cost of health coverage to persons enrolled through the SHOP Marketplaces.

SHOP Marketplaces do not review or verify citizenship or immigration status since employers are required to determine if their employees have legal work status.

Employers determine their own OEP for employees and others to whom they offer coverage through a SHOP Marketplace. This OEP may be different from the individual market OEP. Employers can complete an initial group enrollment through a SHOP Marketplace during any month of the calendar year.

The SHOP Marketplaces are open to eligible small employers. Generally, a small employer is one that:

- Employed 1 to 50 (100 in some states) full-time and full-time equivalent (FTE) employees, on average, on business days during the preceding calendar year, and

- Employs at least one employee on the first day of the plan year.

Participating employers determine the share of premium costs they will cover for their employees.
An employee with an offer of coverage through a SHOP Marketplace may instead choose to enroll in a QHP through a Marketplace for individuals and families if the following conditions apply:

- The employee has not enrolled in the SHOP coverage offered by his/her employer, AND
- The employer’s offer is not affordable for the employee, OR
- The employer’s offer does not meet minimum value.

Marketplaces for individuals and families, SHOP Marketplaces.
To enroll in a QHP in a Marketplace, consumers must:

- Live in the U.S. and live in a state served by the Marketplace where they are applying.
- Be U.S. citizens, U.S. nationals, or lawfully present non-citizens for the entire time they plan to have coverage.
- Not be incarcerated (unless pending the disposition of charges).

**Marketplace Overview**

**Essential Health Benefits**

Remember, the Affordable Care Act requires most types of health coverage to offer EHBs, including:

- Individual and small group market QHPs that are certified and sold in the Marketplaces.
- Non-grandfathered individual and small group market insurance plans sold outside of the Marketplaces.
- Medicaid plans provided to people newly eligible for Medicaid in states that expand the Medicaid program.

Select here if you'd like to review the 10 EHBs:

- Outpatient Care
- Emergency Services
- Hospital
- Baby Care
- Mental Health Substance Abuse
- Prescriptions
- Disability Care
- Lab Tests
- Preventive Services
- Dental and Vision for Kids
• Medicaid plans provided to people newly eligible for Medicaid in states that expand the Medicaid program.

There are 10 EHBs that all QHPs must include:

1. Ambulatory patient services (e.g., doctor and clinic visits)
2. Emergency services (e.g., ambulance, first aid, and rescue squad)
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices (e.g., therapy sessions, wheelchairs, oxygen)
8. Laboratory services
9. Preventive and wellness services and chronic disease management (e.g., blood pressure screening, immunizations)
10. Pediatric services, including dental and vision care

Key Tip: Routine adult dental coverage isn't an EHB and most QHPs don't offer it; however, consumers may be able to purchase stand-alone dental plans in the FFMs.
### Health Plan Categories

QHPs in the Marketplaces are separated into five health plan categories:

- Bronze
- Silver
- Gold
- Platinum
- Catastrophic

Health plan category metal levels are based on each plan's actuarial value (AV)—that is, the percentage of total average costs for covered benefits that a plan will cover. Health plan categories don't reflect the quality or amount of care the plans provide.

Catastrophic health plans are only available to individual market consumers under age 30 or consumers who qualify for a hardship or affordability exemption (e.g., a life situation such as a flood or natural disaster) which may prevent them from affording health insurance coverage. They protect consumers from very high medical costs by only providing coverage when a consumer needs a lot of care. Generally, Catastrophic plans...
have lower premiums than the other health plan categories but higher out-of-pocket costs. Consumers cannot use APTC and CSRs to lower the costs of a Catastrophic plan like they can with other health plan categories.

Health insurance companies that sell QHPs in an FFM must offer at least one Silver and one Gold plan; also, they must be licensed and in good standing in the state where the plans are sold. QHPs must meet nondiscrimination and network adequacy requirements and they must offer the same premiums whether they’re sold inside or outside the FFMs. QHPs may also have to meet other state-specific requirements.

Marketplace Overview

Knowledge Check
This type of plan is only available to individual market consumers and protects them from very high medical costs by providing coverage only when they need a lot of care.

Choose the correct answer.

- Bronze
- Platinum
- COBRA
- Catastrophic

The correct answer is D. Catastrophic health plans are only available to individual market consumers and protect them from very high medical costs by providing coverage when they require a lot of care. They generally have lower premiums than other plan categories but higher out-of-pocket costs for deductibles, copayments, and coinsurance.
• Marketplaces can be operated by a state, the Federal Government, or a combination of both.

• Individual Marketplaces collect and verify eligibility for consumers and their families.

• SHOP Marketplaces collect and verify information from small employers.

• The Affordable Care Act requires that most individual and small group health plans must cover EHBs.

Preparing to Apply

Introduction

Before we take a closer look at the application process for individuals and families in FFMs, let's review a few things you should keep in mind when you meet with consumers.

As a Navigator or non-Navigator assistance personnel in an FFM, you must:

• Provide face-to-face assistance to applicants and enrollees submitting Marketplace eligibility applications in an FFM's service area.

• Explain your duties and responsibilities to each consumer that you assist and let them know that you cannot provide tax or legal advice in your capacity as an assistant.

• Provide consumers with fair, accurate, and impartial information about the full range of health coverage options for which they're eligible.

• Clarify distinctions between health coverage options, including QHPs, Medicaid, and CHIP.

You should also help consumers enroll in the coverage they have selected or apply for any applicable exemptions and appeals.

Select here for a reminder about providing appropriate services for consumers with specific needs.
- Explain your duties and responsibilities to each consumer that you assist and let them know that you cannot provide tax or legal advice in your capacity as an assister.

- Provide consumers with fair, accurate, and impartial information about the full range of health coverage options for which they're eligible.

- Clarify distinctions between health coverage options, including QHPs, Medicaid, and CHIP.

You should also help consumers enroll in the coverage they have selected or apply for any applicable exemptions and appeals.

It's important for you to communicate with consumers in a manner that is culturally appropriate. You should show respect for consumers' cultural diversity and provide information that is relatable and easy to understand, using translated documents when needed.

You may need to provide language interpretation assistance or other accommodations for consumers with physical, developmental, and/or intellectual disabilities or for consumers with cognitive, hearing, speech, and/or vision impairments. You must provide information and services in a manner that is accessible to persons with disabilities and persons with Limited English Proficiency (LEP).

For more information, refer to the courses on Serving Vulnerable and Underserved Populations, Cultural Competence and Language Assistance, and Working with Consumers with Disabilities.
Preparing to Apply

Consumer Consent and PII

One of the first things you should do when helping consumers is obtain consent to access their personally identifiable information (PII) for purposes related to your assister functions. Remember these best practices for handling consumers’ PII:

• Always return originals and copies of all documents that contain consumers’ PII to them and only make copies for yourself or others if necessary to carry out your required duties. If consumers mistakenly or accidentally leave behind documents containing their PII at your organization’s facility or at an enrollment event, you should store them in a safe, locked location and return them to consumers as soon as possible.

• Document consumers’ preferred contact information when you obtain their consent per your organization’s standard consumer consent procedures. If consumers have provided you with consent to follow up with them about applying for or enrolling in coverage and have provided you with their preferred contact information, you may keep their names and contact information to schedule appointments or follow up with them about application or enrollment issues.

PII collected from consumers, including their names, email addresses, telephone numbers, application ID numbers, home addresses, or other notes, must be stored securely.

Remember, you must successfully complete the Privacy, Security, and Fraud Prevention Standards course in addition to this course to meet recertification requirements.
• PII collected from consumers, including their names, email addresses, telephone numbers, application ID numbers, home addresses, or other notes, must be stored securely.

Remember, you must successfully complete the Privacy, Security, and Fraud Prevention Standards course in addition to this course to meet recertification requirements.

Preparing to Apply

Assess Consumers' Needs

Once you've obtained consumers' consent, you will assess their health coverage needs. Consumers will come to you with different levels of knowledge about health coverage and the Marketplaces. Here are a few questions you can keep in mind when you meet with consumers to make sure they understand their coverage options in the FFMs.

• Do they need additional information about the Affordable Care Act, health coverage, or the FFMs?

• Do they currently have health coverage or access to coverage through their employer even if they aren't currently enrolled?

• If not, have they started the FFM eligibility application process?
• Who needs coverage—an individual, a child, a spouse, or the whole family?

• What health plan features are most important to the applicant(s)? Consumers might be most concerned about affordable premium prices, coverage of certain health care services and prescription drugs, and whether specific doctors are included in their plan's network.

Preparing to Apply

Discussing Individual Market FFMs With Consumers

When you meet with consumers, you should make sure they know that the individual market FFMs provide access to programs that help eligible consumers pay for coverage. Some consumers can save on monthly premiums and out-of-pocket costs when they enroll in QHPs while others may qualify for low cost programs such as Medicaid and CHIP.

Consumers who may be eligible for programs to help lower their QHP costs through an individual market FFM include:

• Individuals who do not have affordable health coverage through their jobs or another source.

• Individuals who are not eligible for job-based coverage through a spouse or parent.

• Self-employed consumers (and their families) whose businesses have no employees.
• Self-employed consumers (and their families) whose businesses have no employees.

Businesses with No Employees

Generally, self-employed consumers whose businesses have no employees may not purchase group coverage through a SHOP Marketplace.

Preparing to Apply

Consumers Applying for Medicaid or CHIP

Some consumers may need your help applying for Medicaid or CHIP coverage. Here are a few reminders.

Consumers can apply for Medicaid and CHIP at any time. There isn’t a limited enrollment period for either program.

You can help consumers apply for Medicaid and CHIP in three ways:

• Contact a state Medicaid or CHIP agency
• Submit an individual market FFM application online at HealthCare.gov
• Contact the FFM Call Center at 1-800-318-2595 (TTY: 1-855-889-4325) 24 hours a day, 7 days a week

All states are required to provide Medicaid coverage for certain groups of consumers in certain mandatory eligibility groups.

If you help consumers in a state that has not expanded Medicaid, they may qualify for APTCs and CSRs if they enroll in a QHP offered through a Marketplace. Otherwise, they may be eligible for a hardship exemption from the individual shared responsibility payment.

Sometimes, it’s faster and more straightforward for consumers to apply for Medicaid/CHIP coverage through their state Medicaid/CHIP agency rather than through the individual market FFMs. This is true for consumers who have a disability and individuals who are enrolled in other public benefits programs like the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF).

For an overview of specific eligibility requirements for Medicaid and CHIP (as well as coverage provided by those programs), refer to the Affordable Care Act Basics course.
• Contact the FFM Call Center at 1-800-318-2596 (TTY: 1-855-889-4325) 24 hours a day, 7 days a week

All states are required to provide Medicaid coverage for certain groups of consumers in certain mandatory eligibility groups.

If you help consumers in a state that has not expanded Medicaid, they may qualify for APTCs and CSRs if they enroll in a QHP offered through a Marketplace. Otherwise, they may be eligible for a hardship exemption from the individual shared responsibility payment.

Sometimes, it's faster and more straightforward for consumers to apply for Medicaid/CHIP coverage directly through their state Medicaid/CHIP agency rather than through the individual market FFMs. This is true for consumers who have a disability and individuals who are enrolled in other public benefits programs like the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF).

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

- Pregnant women at or below a certain household income level
- Children in households with certain income levels
- Parents/caretaker relatives at or below a certain household income level
- Consumers with disabilities
- Some low-income older adults

Some states choose to cover other groups of consumers referred to as optional eligibility groups, whom federal law doesn't require states to cover under Medicaid. Examples of optional groups include:

- Adults without dependent children
- Medically-needy consumers

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 group in your state.

For an overview of specific eligibility requirements for Medicaid and CHIP (as well as coverage provided by these programs), refer to the Affordable Care Act Basics course.
Preparing to Apply

Useful Tools to Help Consumers Get Started

Many individuals and families don’t think they can afford coverage and don’t realize financial help may be available. Before they begin a Marketplace application, the Savings Estimator Tool and Window Shopping Tool at HealthCare.gov can help them learn about the features and costs of different QHPs in their area. Let’s take a look at each one.

The Savings Estimator Tool provides consumers with a quick view of income levels that qualify for savings in 2018. Individuals may qualify at different levels. Remind consumers that they will find out exactly how much they’ll save and pay for a plan when they complete a Marketplace eligibility application.

The Window Shopping Tool lets consumers answer a few quick questions to see available health plan options in their area and provides estimated prices based on their projected income. For example, it can:

- Show consumers whether doctors, medical facilities, and prescription drugs they use are covered by available QHPs in their area.

- Estimate consumers’ total costs during a plan’s coverage year based on how much care they might use.
Preparing to Apply

Sensitivity to Consumer's Concerns

Let's go over some important reminders before we review the application process.

**Identifying Applicants**
Consumers must be U.S. citizens, U.S. nationals, or lawfully present in the U.S. to enroll in a QHP in an FFM. Consumers who aren't lawfully present can still apply for coverage for their family member(s) who are lawfully present.

Those applying for coverage for a family member who is lawfully present can do so without being asked to provide proof of their own citizenship or immigration status.

These best practices can help you talk with consumers who are immigrants and who are seeking health coverage for themselves or on behalf of someone else.

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

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

- Determine whether they have an eligible immigration status, or
- Obtain immigration documents if they don't have them readily available.

**Identify the applicant**

Be sure to correctly identify the consumer(s) who are applying for health coverage by asking them if they're seeking coverage for themselves or on behalf of someone else.

**Avoid unnecessary questions**

Avoid unnecessary questions, especially questions about the immigration status of consumers who aren't applying for health coverage and live in mixed immigration status households.

Avoid words such as "undocumented," "unauthorized," or "illegal." Instead, use words such as "eligible immigrant" and "eligible status."

**Allow the Consumer to Act on His or Her own Behalf**

Consumers should always input their own information in an online or paper application. If a consumer asks for help typing or using a computer to learn about, apply for, or enroll in coverage in an FFM, an assister may only use the keyboard or mouse to follow the consumer's specific directions with the consumer physically present (in-person).

Also remember that you cannot recommend specific health plans to consumers or make eligibility determinations for consumers.
Preparing to Apply

Knowledge Check

There are many rules you must remember when you are assisting consumers.

Which of the following statements are allowable for you when you are assisting consumers?

A. One of your roles is to help consumers enroll in healthcare coverage. You should be ready to choose a plan for them and explain what the benefits are for that plan.

B. When you assist the same consumer multiple times, you must receive new consent from that consumer each time you access his or her PII and the older consent the consumer provided is no longer valid.

C. When using the Savings Estimator Tool, you will be able to tell which plans will be best for the consumers you are assisting. You may offer your advice on which plans they can and cannot afford.

D. If a consumer asks for help typing or using a computer to learn about, apply for, or enroll in coverage through an FFM, you may do so as long as you follow their specific directions while they are physically present (in person).
Preparing to Apply

Key Points

- One of the first things you should do when helping consumers is obtain consent to access their PII for purposes related to your assister functions.

- Some consumers can save on monthly premiums and out-of-pocket costs when they enroll in QHPs, while others may qualify for low-cost programs such as Medicaid and CHIP.

- Consumers must be U.S. citizens, U.S. nationals, or lawfully present in the U.S. to enroll in a QHP in an FFM. Consumers who aren’t lawfully present can still apply for coverage for their family member(s) who are lawfully present.
Account Creation and Application Completion

Overview of the Account Creation Process

Once you’ve obtained a consumer’s consent, assessed his or her needs, and discussed the eligibility and enrollment process, it’s time for the consumer to create a Marketplace account at HealthCare.gov.

You should tell consumers that they can view and compare general health plan information at any time but they must create a Marketplace account and complete an application in order to verify eligibility, plan availability, and prices.
Account Creation and Application Completion

Assist Consumers with Creating a Marketplace Account

Here’s a quick overview of how the process works.

There are five steps consumers should follow to create a Marketplace account at HealthCare.gov.

**Step 1: Enter Information**
Visit HealthCare.gov, select "Individuals and Families," and enter basic information (i.e., name and state).

**Step 2: Password Creation**
Enter a valid email address, which is also a consumer’s Marketplace account username. Then choose a password. Passwords must contain 8-20 characters, at least one number, and a mix of uppercase and lowercase letters.
How to Reset a Password
There are three steps consumers should follow to reset a password:

- Select "Forgot your password?" from the login page and enter the email address associated with the Marketplace account.

- The FFMs send a password reset email to this address. Select the link in the password reset email to verify that the email address is correct. If selecting doesn’t work, the consumer should copy and paste the link into an Internet browser.

- Follow the directions to choose a new password.

Sometimes the FFMs reset consumers' passwords due to security measures. If this happens, consumers will not be able to log in successfully until they reset their password.

If consumers need more help or want to apply by phone, they can contact the FFM Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

The FFM Call Center is open 24 hours a day, 7 days a week (except federal holidays).

Step 3: Security Questions
Choose security questions and provide responses. These questions are used for verification purposes if necessary. You should advise consumers to write these down and keep them in a secure place.

Step 4: Create Account
Select the "Create Account" option.

Step 5: Verify Identify
In the last step, consumers verify their identity by answering questions based on information the FFMs gather from trusted data sources (e.g., a consumer's credit report). This prevents other people from creating an account using their name. If a consumer's identity is not verified, he or she may receive a prompt with instructions and next steps. Additional information about Marketplace identity verification is available at https://marketplace.cms.gov/outreach-and-education/your-marketplace-application.pdf.

IMPORTANT: Don't create a second account!
Consumers should never try to create a new account if they already have one. Instead, they should call the FFM Call Center or follow the steps at https://www.healthcare.gov/tips-and-troubleshooting/logging-in/
Account Creation and Application Completion

Streamlined or Detailed Marketplace Application

After a consumer creates a Marketplace account and logs in for the first time, they must answer a few screening questions about their household to start an application. This information helps the FFMs determine whether the consumer should complete a streamlined or detailed application.

The streamlined application is generally available to new applicants with simple household situations. It allows them to navigate through fewer screens, is optimized for mobile devices, and allows for backward navigation.

Other applicants must complete a detailed eligibility application which is sometimes called the "original" or "classic" FFM eligibility application. It is generally used for re-enrollments and for new applicants with more complex household situations.

You need to be familiar with the detailed individual market FFM application to help consumers resolve more complex issues.
Helping with Identity Verification

Remember, the FFMs verify specific information about each individual applying for coverage before they can enroll or get help with lowering their costs. Identity (ID) proofing is an important part of this process.

During ID proofing, the FFMs ask questions based on consumers' personal and financial histories that only they are likely to know. You should tell consumers that this process helps prevent someone else from creating a Marketplace account and applying for health coverage in their name without their knowledge.

Consumers should select the "My Profile" button, and then select "Verify Now" to begin. When the "Verify Your Identity" screen appears, they should select the "Get Started" button. The FFMs ask for contact information and other questions about consumers to verify their identity.
Account Creation and Application Completion

Identity Verification with Experian

If the FFMs can’t verify an individual’s identity, it means they couldn’t match some or all of the information they provided with the information available in records used for this process.

Note: Experian is a contractor that helps the FFMs with ID proofing. The Experian Help Desk can’t help consumers with the same things that you and the FFM Call Center can help with. For example, the Experian Help Desk can’t help consumers supply supporting documents or resolve Marketplace account issues (e.g., account and password resets).
Single Documents to Verify Identity
When necessary, consumers can upload or mail paper copies of any of the following documents to verify their identities:

- Driver's license issued by a state or territory
- School ID card
- Voter ID card
- U.S. military draft card or draft record
- Military dependent's ID card
- ID card issued by federal, state, or local government
- U.S. passport or U.S. passport card
- Native American tribal document
- Certificate of Naturalization (Form N-550 or N-570) or Certificate of U.S. Citizenship (Form N-560 or N-561)
- Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
- Employment Authorization Document that contains a photograph (Form I-766)
- U.S. Coast Guard Merchant Mariner card
- Foreign passport or ID card issued by a foreign embassy or consulate that contains a photograph

Multiple Documents to Verify Identity
If consumers can't provide a copy of one of the documents above, they can submit copies of two of these documents:

- Birth certificate
- Social Security card
- Marriage certificate
- Divorce decree
- Employer ID card
- High school or college diploma, including high school equivalency diploma
Account Creation and Application Completion

Identity Verification Failure

An FFM will indicate if a consumer's identity has been verified successfully. If the FFM fails to identify a consumer's identity after two tries, they will see a message with instructions to call the Experian Help Desk and a reference code number to provide them.

If Experian can verify a consumer's identity over the phone, the consumer can select the "I Have Verified My Identity Over the Phone" button to complete the ID proofing process. The consumer will be directed to submit updated contact information and to upload documents that verify his or her identity by selecting the "Upload Documents" button.

Consumers have to upload documents electronically if the system is unable to verify their identity right away—even if they verify their identity over the phone with Experian. While consumers can also mail documents to the FFMs, remind them that this method takes more time to process. If a consumer's identity still isn't verified, they may need to provide additional information.

Consumers should mail copies and keep the original documents. They should include their name, date of birth, and Social Security Number with their copies and send them to the following address:

Health Insurance Marketplace
465 Industrial Blvd.
London, KY 40750-0001
Information is typically processed within 7 to 10 business days after documents are received. If a consumer's identity still isn't verified, they may need to provide additional information.

Account Creation and Application Completion

Upload Documents to Verify Identity

To upload documents online, consumers should:

- Select "Upload Documents."
- Select the type of document(s) from the drop-down list.
- Attach a copy of the document(s).

Earlier we listed single and multiple documents that can be used for ID proofing.

For example, if a consumer provides a copy of a photo ID like a driver's license, the consumer may only need to submit that one document. If a consumer submits a Social Security card or similar document that is not a photo ID, they may need to submit additional documents.

Earlier we listed single and multiple documents that can be used for ID proofing.
The application provides a list of acceptable documents (or combination of documents) that consumers can provide under different circumstances. Consumers can check the status of submitted documents in their Marketplace account profile.

Account Creation and Application Completion

Who to Include On An Application

Remember, individuals and families only need to complete one Marketplace application per tax household.

How do you know who is included in a tax household?

If two consumers file federal income taxes together using the same federal income tax return, they're considered part of the same tax household and only need to submit one Marketplace application. Both consumers should be on the application. If two or more consumers are part of separate tax households—that is, they file their taxes separately—they must complete separate Marketplace applications.

Which household members should consumers indicate on applications for coverage?
Individuals Included on Applications for Coverage
The consumer applying for coverage and, as applicable, the following individuals should be included on applications for coverage where the applicant is applying for help paying for coverage:

- Their spouse
- Applies to legally married couples, whether opposite or same-sex
- Anyone they include on their tax return as a tax dependent (such as a child), even if the tax dependents don't live with the consumer or they have their own tax filing requirement
- Their children who live with them, even if they make enough money to file a tax return themselves
- Anyone else under 21 years of age whom they take care of and who lives with them

Individuals NOT Included on Applications for Coverage
The following individuals should not be included on their applications:

- Their unmarried partner
- Their unmarried partner's children, if the children are not the applying consumer's children or tax dependents
- Their parents who live with them but file their own tax returns and aren't tax dependents of the consumer (and spouses of parents, as applicable)
- Other relatives who file their own tax returns and aren't tax dependents of the consumer (and spouse, if they have one).

Note: The Marketplace application asks applicants whether they are married. Consumers should select "No" if they are, Unmarried for tax-filing purposes, filing federal income taxes separately due to domestic violence or spousal abandonment.
Account Creation and Application Completion

Information Collected During the Application Process

Remember, consumers need to provide the following information to the FFMs when they apply:

- Contact information
- Who’s applying for coverage
- Whether they’d like to check their eligibility for APTC and CSRs or other coverage programs (e.g., Medicaid and CHIP)
- Personal information for each applicant (e.g., name, date of birth, relationship to consumers filing the application)
- Family and household structure
- Citizenship or immigration status for each applicant (but not for non-applicants)

If applying for help paying for coverage:

- Household income information
- Information regarding access to other coverage (e.g., job-based coverage)
If applying for help paying for coverage:

- Household income information
- Information regarding access to other coverage (e.g., job-based coverage)

Account Creation and Application Completion

**Knowledge Check**

Hi, I have created a Marketplace account and I am ready to begin the application process. I really want to apply for help paying for coverage.

Which of the following pieces of information will this consumer need to know to complete his Marketplace application?

A. Whom to include on the application

B. Personal information for each applicant (e.g., name, date of birth, relationship to the consumer filing the application)

C. Explanation of pre-existing conditions for all applicants

D. Income information
The correct answers are A, B, and D. This consumer should complete the application and the FFM will help determine whether he or members of his family are eligible for other programs to help lower their costs. However, he needs to know which household members he'll include on his application, personal information for each applicant, and whether each applicant can get coverage through an employer. Pre-existing conditions do not need to be explained for all applicants. All Marketplace insurance plans must cover treatment for pre-existing medical conditions.

**Account Creation and Application Completion**

**Application Inconsistencies**

Remember, application inconsistencies called data matching issues (DMIs) may occur if an FFM's trusted data sources do not have consumers' most up-to-date information. Consumers can enroll in coverage during a temporary "inconsistency period" but they must provide documents to the FFM that support what they put on their application. If they don't, they may lose their coverage and/or any APTC or CSR amounts they were determined eligible for during the inconsistency period.
Account Creation and Application Completion

Provide Supporting Documents

If a consumer receives a notice asking for additional supporting documents to resolve an application inconsistency, the notice will indicate how long the consumer has to submit them and receive a final eligibility determination.

If a consumer fails to submit necessary documents on time, an FFM may:

- Determine the consumer ineligible for APTC and CSRs
- Terminate the consumer's enrollment

If consumers enroll and use any APTC amount during an inconsistency period, they must acknowledge that those payments are subject to reconciliation when they file taxes. You should help consumers understand this and help them gather the documents they need to resolve application inconsistencies.

For more information, refer to the Fact Sheet on Submitting Supporting Documents in the Resources section.

Note: Consumers usually have either 90 or 95 days, depending on the inconsistency type, to submit supporting documents when they encounter a DMI. For more information about how DMIs impact consumers, see the tip sheet called 5 Things Assisters Should Know about Data Matching Terminations at https://marketplace.cms.gov/technical-assistance-resources/data-matching-terminations.pdf

Account Creation and Application Completion

Best Practices for Submitting Supporting Documentation

You are responsible for helping consumers verify their information in the event of a DMI.

Uploading documents at HealthCare.gov is the fastest way to resolve a DMI. When consumers are ready, you should remind them to:

- Include the application ID number associated with the DMI on each page they submit.
- Choose the "Other" option from the drop-down list if they need to upload documents that do not fall into a specific document type category.
- Upload a file no larger than 10 MB.
If consumers have trouble uploading documents or don't have the option to upload, they can also mail paper copies; however, they cannot fax documents to an FFM. Here are some helpful tips:

- Keep the original versions of any documents and only send copies. Consumers can send documents that say "do not copy" on them. These shouldn't be treated as original documents—the FFMs just need copies to verify consumers' information.
- Include the bar code page from the initial eligibility notice the FFM mailed to them.
- Write their legal names and application ID numbers on each page that they submit if they don't have a bar code page. This makes it easier for the FFMs to match the documents to consumers' application records. Consumers can find their application ID numbers on the letters they received about their DMIs. You can also help them look up their application ID numbers for them online.

Send all documents to:
Health Insurance Marketplace
Attn: Coverage Processing
465 Industrial Blvd.
London, KY 40750-0001

Key Tip: Once consumers' documents are reviewed and processed, they are securely shredded and destroyed.

Remember
There is no need to send documents through FedEx, UPS, or United States Postal Service certified mail or to send documents with a confirmation. If consumers do use these services, the documents will still reach the processing center and will fall within the federal requirements for document retention.
Account Creation and Application Completion

**How the Marketplaces Calculate Consumers’ Income**

If consumers choose to apply for insurance affordability programs when they submit a Marketplace application, it’s important for them to provide accurate income information for each household member once their identity is verified.

Can a consumer list alimony or child support as income?

What counts as income:

- Job
- Self-employment
- Social Security benefits
- Unemployment
- Retirement
- Pension
- Capital gains
- Investment income
- Rental or royalty income
- Farming or fishing income
- Alimony received
- Other taxable income such as prizes, gambling winnings, etc.
- Taxable scholarships, awards, or fellowship grants used for education purposes (Key Tip: these amounts do count as income in the FFMs and should be entered. However, these amounts do not count as income for Medicaid and CHIP.)

What does NOT count as income:

- Child support
- Gifts
- Supplemental Security Income (SSI)
- Veterans' disability payments
- Workers' compensation
- Proceeds from loans like student, home equity, or bank loans
Account Creation and Application Completion

Modified Adjusted Gross Income and Insurance Affordability Programs

The FFMs use consumers’ modified adjusted gross income (MAGI) to determine whether they meet income requirements. MAGI is adjusted gross income (AGI) as reported on a consumer’s federal income return plus these, if any: untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest. MAGI is generally very close to consumers’ AGI. However, it does not appear as a line on federal income tax returns and does not include Supplemental Security Income (SSI).

Tax Returns
It's a good idea to advise consumers who file taxes to have their tax returns from the previous year available when they complete a Marketplace application. That's because:

- Income claimed on a federal income tax return from a previous year can help a consumer estimate his or her household’s MAGI.
- Both Marketplace applications and tax returns should have similar information about a consumer’s household size.

Key Tip: If a consumer is married and files a joint tax return with a spouse, their Marketplace application should reflect the spouse and spousal income, as applicable. Dependent(s) information may also be included on a Marketplace application if it is included on a tax return.

Remember, the Marketplaces calculate MAGI differently from state Medicaid/CHIP agencies. Refer to the Affordable Care Act Basics course for more information.
Key Tip: If a consumer is married and files a joint tax return with a spouse, their Marketplace application should reflect the spouse and spousal income, as applicable. Dependent(s) information may also be included on a Marketplace application if it is included on a tax return.

Remember, the Marketplaces calculate MAGI differently from state Medicaid/CHIP agencies. Refer to the Affordable Care Act Basics course for more information.

CMS is offering this link for informational purposes only and this fact should not be construed as an endorsement of the host organization’s programs or activities. [http://www.healthreformbeyondthebasics.org/key-facts-income-definitions-for-marketplace-and-medicaid-coverage/](http://www.healthreformbeyondthebasics.org/key-facts-income-definitions-for-marketplace-and-medicaid-coverage/)

Account Creation and Application Completion

Knowledge Check

Roberta is a divorced waitress with a seven-year-old son. She receives both alimony and child support payments from her ex-husband. Roberta comes to you for advice on what income she should include when applying for programs to help lower her costs.
Which of the following sources of income should NOT be included when estimating Roberta's income?

A. Wages
B. Tips
C. Alimony
D. Child Support

The correct answer is D. Child support should not be included in estimating household income. Wages, tips, and alimony should all be included when estimating household income.

Account Creation and Application Completion

Explaining Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions

You are responsible for explaining how APTC and CSRs work when consumers apply for coverage in an FFM. You should describe these insurance affordability programs before a consumer chooses whether to apply for them.
To be eligible for APTC, a consumer must:

- Be a U.S. citizen, national or legal resident of the U.S., and non-incarcerated.
- Have a household income between 100 percent and 400 percent of the Federal Poverty Level (FPL).
- Have no other minimum essential coverage (MEC)*, including job-based coverage that is affordable (a premium less than 9.69 percent of household income) and meets the minimum value standard.
- File a federal income tax return for the benefit year the consumer enrolled in a QHP.
- File a joint tax return, if married, unless the consumer is a victim of domestic abuse or spousal abandonment.
- Not be claimed as a dependent on another taxpayer's federal income tax return.

*MEC is coverage that meets the individual shared responsibility requirement under the Affordable Care Act. A tax penalty may be imposed for individuals that are not enrolled in coverage that meets MEC requirements. Types of coverage that meet MEC requirements include: individual Marketplace policies, certain job-based coverage, Medicare Part A or C, CHIP, Peace Corps, most Medicaid, TRICARE, Veterans Affairs (VA) health care program plans, and certain other coverage designated by the Secretary of HHS. Please note there are statutory exemptions from the requirement to obtain MEC.

Consumers who qualify for APTC may also qualify for CSRs. CSR payments are advanced directly to insurance companies for eligible consumers. To qualify for CSRs, consumers must:

- Meet the eligibility criteria for APTC.
- Enroll in a Silver plan* in a Marketplace.
- Have a household income between 100 percent and 250 percent of the FPL.

Key Tip: Use the tool available at www.healthcare.gov/see-plans to search for Silver plans available in a consumer's area.

Eligible consumers with incomes in lower FPL ranges (e.g., from 100 percent to 150 percent) generally receive more savings on out-of-pocket costs in the form of CSRs.
American Indians/Alaska Natives (AI/AN) or members of federally recognized tribes with household incomes up to 300 percent of the FPL qualify for CSRs regardless of which metal level health plan category they choose. They can also continue to receive health services from the following:

- Indian Health Service (IHS)
- Tribes and tribal organizations
- Urban Indian Health Organizations (UIHO)
- Medicare, Medicaid, and CHIP, if eligible.

Account Creation and Application Completion

Knowledge Check
Generally, to be eligible for APTC, a consumer must have a household income between ____ percent and ____ percent of the FPL.

A. 100 percent and 400 percent
B. 200 percent and 400 percent
C. 100 percent and 500 percent
D. 200 percent and 500 percent

The correct answer is A. Generally, to be eligible for APTC, a consumer must have a household income between 100 percent and 400 percent of the FPL.

Account Creation and Application Completion

Key Points
You should know how to guide consumers through each step of creating a Marketplace account, completing an application, and resolving any DMIs that may occur.

Consumers need to provide identifying information and answer questions about their citizenship or immigration status as part of the application process.

You should provide accurate information about insurance affordability programs in the FFMs and help consumers accurately report their income if they choose to apply.

Interpreting Eligibility and Enrolling in Coverage

Eligibility Results
After consumers submit a Marketplace application, the individual market FFMs verify information about each household applicant and assess or determine their eligibility for:

- An SEP (Consumers applying for an SEP must submit supporting documentation to an FFM to prove their eligibility before the FFM sends their information to a QHP issuer for processing.)
- Medicaid
- CHIP
- QHP coverage with a PTC and/or CSRs

You should be able to explain consumers' eligibility results to them and describe each program they are eligible for. Sometimes this will be a simple conversation and an applicant will quickly move to the next step of shopping for a QHP. Other times, applicants may encounter a DMI or wish to appeal a decision that an FFM made on their behalf.

For detailed information on reviewing eligibility results with consumers, refer to SOP 6 in the Assister’s SOP Manual.
Interpreting Eligibility and Enrolling in Coverage

Medicaid and the Marketplaces: Assessment Versus Determination

Remember, the individual market FFMs assess or determine consumers’ eligibility for Medicaid and CHIP. You should be able to explain how the FFM in your state determines consumers’ final eligibility for these programs.

- An FFM in a Medicaid determination state uses Medicaid rules and any applicable state-specific rules to evaluate a consumer’s MAGI and determine whether he or she is eligible for Medicaid or CHIP. In a Medicaid determination state, the FFM sends an eligibility determination notice to a consumer stating that they are eligible for Medicaid or CHIP and then transfers the consumer’s application information to the state Medicaid or CHIP agency to process the enrollment.

- An FFM in a Medicaid assessment state transfers an individual’s information to the state’s Medicaid or CHIP agency for a final determination if the FFM believes he or she may be eligible. In a Medicaid assessment state, the FFM makes an initial decision that a consumer is potentially eligible for Medicaid or CHIP based on their household’s MAGI and other eligibility criteria. When this happens, the FFM transfers the consumer’s application to the state Medicaid or CHIP agency for a final eligibility determination. The agency then sends a notice to the consumer with a final eligibility determination or requests additional information if necessary.
If consumers are assessed or determined eligible for Medicaid or CHIP by an FFM, it transfers their information to the appropriate state Medicaid or CHIP agency to process their enrollment.

Even if consumers are not assessed or determined eligible for Medicaid or CHIP based on MAGI, they may request a full determination from their state agency based on non-MAGI eligibility criteria (e.g., a disability).

Consumers may contact their state Medicaid or CHIP agency directly for more information or to appeal a determination.

Remember, you can use the "Marketplaces by State" map located in the Resources tab of the course Menu to determine if your state or other states make an assessment or determination for Medicaid and CHIP eligibility.

Key Tip: If an individual is assessed or determined ineligible for Medicaid and CHIP, an eligibility determination notice will state whether that individual can enroll in a QHP and receive APTC/CSRs.

Interpreting Eligibility and Enrolling in Coverage

Medicaid Expansion

Remember, some states have expanded their Medicaid programs to cover all adults with household incomes below a certain level. Others haven’t.

- In all states: Consumers can qualify for Medicaid based on income, household size, disability, family status, and other factors. Eligibility rules differ between states.

- In states that have expanded Medicaid coverage: Consumers can qualify based on their income alone. If consumers' household income is below 133 percent of the FPL, they qualify under the Affordable Care Act. In practice, however, consumers whose household income is below 138 percent of the FPL qualify for Medicaid. A few states use a different income limit.

Be sure you know whether the state you are working in has expanded Medicaid eligibility for adults and the applicable FPL.

For the latest FPL information and guidelines, visit aspe.hhs.gov/poverty-guidelines.

The Affordable Care Act's MAGI calculation is based on AGI as defined in the Internal Revenue Code. However, the Affordable Care Act's regulations add a five percent point
deduction from the FPL—one of several ways in which the AGI is "modified." With this five percent disregard, the Medicaid eligibility threshold is effectively 138 percent of the FPL.

Interpreting Eligibility and Enrolling in Coverage

CHIP Eligibility and the FFMs

If a child is eligible for both QHP coverage and CHIP coverage, remind consumers that CHIP qualifies as MEC. Children who are eligible for CHIP are not eligible for APTC or CSRs in a Marketplace; however, they may still enroll in a QHP without APTC and CSR.
Interpreting Eligibility and Enrolling in Coverage

**Advance Payments of the Premium Tax Credit**

You should be prepared to explain consumers' options if their eligibility determinations show that they qualify for a PTC and/or CSRs.

Eligible individuals and families can use all, some, or none of the PTC amount they qualify for in advance to lower their monthly premiums when they enroll in a QHP. You should help consumers make informed decisions about the amount of PTC they want to use in advance. Eligible consumers can:

- Distribute the amount equally for each month during the year as APTC.
- Receive a smaller amount of APTC during the year.
- Use none.

Explain to consumers that the amount of APTC they use could affect the amount of taxes they owe the Internal Revenue Service (IRS) or the amount they get back when they file federal income tax returns for the year.
APTC Reconciliation

You should always make sure consumers understand the importance of reporting changes in household income and other eligibility factors during the year. When consumers file federal income tax returns, they will need to use Form 8962 to figure out the amount of PTC they were eligible for during the year and reconcile that amount with any APTC they received. You'll learn more about APTC reconciliation in the Assister Standard Operating Procedures course.

Interpreting Eligibility and Enrolling in Coverage

Helping Consumers Compare and Select Plans

After you help consumers who qualify for a PTC set the APTC amount they'd like to use, they'll set their health insurance preferences, compare plans, and choose a QHP that meets their needs.

The "Enroll To-Do List" in a Marketplace application includes seven steps:

1. Help eligible consumers choose how much PTC to apply to their monthly premiums in advance.
2. Report tobacco use.
3. See if QHPs cover consumers' doctors, hospitals, and prescription drugs.
4. Get an estimate of consumers' total yearly costs.
5. Consumers choose a QHP.
6. If desired, consumers compare and select dental coverage.
7. Review and confirm health and dental coverage choices before consumers sign the application.

Interpreting Eligibility and Enrolling in Coverage

Helping Consumers Compare and Select Plans

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- See if QHPs cover consumers' doctors, hospitals, and prescription drugs.
• Get an estimate of consumers’ total yearly costs.
• Consumers choose a QHP.
• If desired, consumers compare and select dental coverage.
• Review and confirm health and dental coverage choices before consumers sign the application.

Interpreting Eligibility and Enrolling in Coverage

Plan Comparison

When you help consumers compare QHPs, remember to show them all of the QHP options they’re eligible for. You should never provide recommendations about which plan or plans consumers should select.
Consumers can filter QHPs based on factors such as:

- Premium price range
- Yearly deductible
- Health plan type (e.g., Health Maintenance Organization (HMO), Preferred-Provider Organization (PPO))
- Marketplace health plan category (i.e., Bronze, Silver, Gold, Platinum, or Catastrophic)
- Dental coverage
- Estimated yearly costs
- Health Savings Account (HSA) eligible plans

Key Tip: remember, QHP premium amounts shown in Plan Compare will be discounted by the APTC amount an eligible consumer selects. Remind consumers that they can change this amount later if desired.
Interpreting Eligibility and Enrolling in Coverage

**Side-by-side Comparison Tool**

Consumers can use the side-by-side comparison tool to explore different QHP features and see how plans differ in categories like costs for medical care, prescription drug coverage, and in-network providers. Consumers can also use the tool to check for medical management programs that may be important to them (e.g., pain management, diabetes care, and psychiatric care for depression).

Consumers can refer to a QHP’s Summary of Benefits and Coverage (SBC) for more detailed information. You'll learn more about SBCs in the Coverage to Care Assistance course.

**QHP Dental Coverage Reminder**
Remember, pediatric dental care for consumers under age 19 is an EHB. The FFMs must offer pediatric dental care either as part of QHP coverage or through stand-alone dental plans; however, parents are not required to buy dental insurance for their children. When stand-alone dental plans are offered in an FFM, other health plans offered through that FFM don't have to include pediatric dental benefits.

Some states may require QHPs to include dental coverage for adults as well. However, routine adult dental coverage isn't an EHB and most QHPs in the FFMs don't offer it. Some FFMs sell stand-alone dental plans for adults.
Interpreting Eligibility and Enrolling in Coverage

Helping Consumers Enroll

In most cases, the earliest date consumers’ coverage can start – that is, their “effective date of coverage”—depends on when consumers select a plan:

- Consumers who enroll between the first and the 15th day of the month will generally begin coverage on the first day of the following month.

- Consumers who enroll between the 16th and the last day of the month will generally begin coverage on the first day of the second following month.

Remember to tell consumers that their effective date of coverage is not the first date on which they actually use the coverage to get care.

Key Tip: The individual market OEP for 2018 coverage begins on November 1, 2017 and ends December 15, 2017. Consumers must enroll and pay their first month's premium by the deadline noted by the issuer in the enrollment materials. If there are questions about the deadline for payment, the consumer should call his or her issuer directly.
Interpreting Eligibility and Enrolling in Coverage

Redetermination, Re-enrollment, and Changes in Circumstances

Consumers who are already enrolled in a QHP through an FFM generally don’t need to complete a new application for the following coverage year. Remember to tell consumers they are required to report changes that affect eligibility for enrollment and for any APTC or CSRs they are receiving within 30 days of the change. Even if consumers believe they have no changes to report, it’s strongly recommended that they contact the FFM to make sure their eligibility information is up to date.

Asking consumers the following questions will help you understand how to assist them:

- Do you currently have a Marketplace plan?
- Do you use it?
- What was your experience like?
- What questions do you have about using your current plan?
- Was the plan sufficient for your needs? Why or why not?
Before each OEP, the FFMs send each consumer a notice summarizing eligibility for the coming year (unless they have terminated their coverage and the FFM has a cancellation request on file)

There are four variations of this eligibility notice:

- Standard eligibility notice
- Income-based outreach notice
- Did-not-reconcile notice
- Special notice

The eligibility notice will also state:

- If the consumer's plan will be available for the next plan year.
- Any changes to the plan.
- If the plan won't be available, what plan the consumer will be enrolled in for the next plan year.

You should advise consumers to review the notice and contact the FFM if anything is incorrect. If the FFM found that a consumer's household income has changed, the notice will advise the consumer to report the change and obtain updated eligibility results. This is very important for consumers who receive financial assistance. If their household income exceeds 500 percent of the FPL, the FFM will discontinue their eligibility for APTC and CSRs at the end of the coverage year and re-enroll them in a QHP without financial assistance.

Consumers who meet any of the following criteria must also contact the FFM to obtain updated eligibility results:

- No updated tax return information is provided by the IRS in response to the Marketplace’s request;

- The most recent Marketplace eligibility results for the current plan year reflect household income in excess of 350 percent of the FPL; or

- The IRS provides updated household income information from tax data that, when evaluated together with the family size used for the enrollee's most recent eligibility results for the current plan year, reflects:

- Household income in excess of 350 percent of the FPL

- An increase or decrease in household income of greater than 50 percent when compared to the household income from the most recent FFM eligibility results
• Household income under 100 percent of the FPL; or

• Household income that meets other criteria established by the FFM.

Consumers who are enrolled in a QHP will also get a notice from their insurance company indicating whether their current plan has changed or can be renewed for the following coverage year.

Consumers' eligibility and enrollment may also be affected by changes in circumstance (e.g., a move or a new job). Consumers should report changes to the FFMs within 30 days of the change occurring.

Before Open Enrollment, the FFMs will request updated tax return information from the IRS for all consumers who have agreed to allow the Marketplaces to recheck their information. If these consumers are currently enrolled in QHPs, the FFMs will determine if they are eligible to receive APTC/CSRs. Any changes in coverage or eligibility as a result of the redetermination process will be effective on January 1 of the following coverage year.

If consumers requested help paying for health coverage on their Marketplace application but didn't agree to allow the FFM to recheck their federal tax data on an annual basis, they will receive a notice asking them to contact the FFM to get updated eligibility results. If they don't do this by December 15 of the current coverage year, the enrollees' APTC and CSRs will end on December 31. The FFM will still renew consumers' QHP coverage for the following year if the coverage is available unless the FFM determines the consumer is no longer eligible to purchase a QHP.
Interpreting Eligibility and Enrolling in Coverage

Changes in Circumstances and Special Enrollment Periods

Some changes in circumstances are "qualifying life events," meaning consumers are eligible for an SEP to enroll in or change QHPs. SEPs typically last 60 days and can take place outside of the individual market OEP.

Examples of qualifying events include exceptional circumstances, enrollment errors, or other defects in the eligibility and enrollment process. Remember, consumers do NOT qualify for an SEP if their coverage is terminated because they didn't pay their premiums.

If consumers don't qualify for an SEP and the annual OEP for the year has already passed, they must wait for the next OEP to enroll in or change QHPs.

Effective dates of coverage for SEPs generally follow the same timeline as effective dates for the initial OEP. There are a few exceptions:

- In the case of marriage, coverage becomes effective on the first day of the month following plan selection.
- In the case of gaining or becoming a dependent through marriage, birth, adoption, placement for adoption, placement in foster care or due to a child support or other court order, coverage is effective on the date of the event. If they prefer, consumers have the option to call the FFM Call Center to request that coverage instead take effect on the first day of the month following the event or based on normal coverage effective dates.
- Consumers can apply for Medicaid and CHIP at any time and aren't confined to OEPs or SEPs.
instead take effect on the first day of the month following the event or based on normal coverage effective dates.

- Consumers can apply for Medicaid and CHIP at any time and aren't confined to OEPs or SEPs.

**Interpreting Eligibility and Enrolling in Coverage**

**Loss of Job-based Coverage and COBRA Eligibility**

When consumers lose job-based insurance, they may be offered COBRA continuation coverage by their former employer. If consumers decide not to take COBRA coverage, they can generally choose to enroll in a QHP in an FFM instead. Remember, losing job-based coverage qualifies consumers for a 60-day SEP and they may be eligible for APTC and CSRs that wouldn't otherwise be available to them if they enrolled in COBRA continuation coverage.

Consumers who leave a job and are eligible for COBRA continuation coverage must also be given an election period of at least 60 days to choose whether or not to elect continuation coverage (starting on the later of the date they are furnished the election notice or the date they would lose coverage).

For more information about COBRA coverage and the FFMs, visit healthcare.gov/unemployed/cobra-coverage/.
Interpreting Eligibility and Enrolling in Coverage

Termination of Coverage

Consumers can generally terminate their coverage at any time if they provide their insurance company with a 14-day advance notice. They don't need to wait for an individual market OEP or qualify for an SEP. Keep in mind that terminating coverage will end consumers' health AND dental plans.

Consumers can terminate coverage in an FFM by logging into their Marketplace account and selecting "End (Terminate) All Coverage" on the "My Plans and Programs" page.
Interpreting Eligibility and Enrolling in Coverage

Assisting Consumers Who Want to Switch to a Different QHP

Consumers can also switch from one QHP to another during an OEP or an SEP. After terminating their current QHP, consumers can re-enroll into a different plan by logging into their Marketplace account and selecting the "Change Plan" button on the "My Plans and Programs" page. Consumers can then select and confirm a new health plan and dental plan, if desired.

Beginning in 2017, keep in mind that consumers with certain types of SEPs may be limited to QHPs within the same health plan category as their current QHP while consumers with other types of SEPs can select a new QHP under any health plan category.
Interpreting Eligibility and Enrolling in Coverage

Low Income Consumers Who Don’t Qualify for Public Coverage and Can’t Afford QHP Coverage in an FFM

The Coverage Gap
In states that have not expanded Medicaid, many adults with incomes below 100 percent of the FPL fall into what is known as a coverage gap. Their incomes are too high to receive 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 that may fall into the coverage gap include jobless parents, working parents, and non-disabled, non-elderly childless adults.

Coverage Exemptions
Consumers in a coverage gap may be eligible to receive an exemption for the period they are without coverage or did not meet the requirement to have MEC. Generally, you can assist consumers in a coverage gap with the process of applying for exemptions that are granted through the FFMs. You might also find it helpful to refer them to other resources. Remember, you can show consumers where to access tax forms but you cannot help them fill out tax forms in your role as an assister.
Interpreting Eligibility and Enrolling in Coverage

Options for Consumers that Fall into a Coverage Gap

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/lower-costs/low-cost-community-care/.

- Purchase Catastrophic health coverage. Remember, Catastrophic health plans are available through the FFMs for consumers under 30 years old and consumers who are granted a hardship exemption. For more information, visit: HealthCare.gov/choose-a-plan/catastrophic-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.

You should always follow CMS guidance when working with or referring consumers to organizations that are not other FFMs assisted organizations or HHS entities.
with or referring consumers to organizations that are not other FFM assister organizations or HHS entities.

Interpreting Eligibility and Enrolling in Coverage

Knowledge Check

The earliest date a consumer's coverage will start depends on when they enroll and whether they have paid their first month's premium by the due date noted in the enrollment materials. This is called the __________.

A. Effective date of coverage
B. Initial date of coverage
C. Inceptive date of coverage
D. Onset coverage date

The correct answer is A. The earliest date a consumer's coverage will start depends on when they enroll and whether they have paid their first month's premium by the due date noted in the enrollment materials. This is called the effective date of coverage.
Interpreting Eligibility and Enrolling in Coverage

Key Points

- Eligible consumers can set the amount of PTC they would like to use in advance to lower their premium costs when they apply for or renew QHP coverage in an FFM. Consumers must reconcile the difference between any APTC applied during the year and the actual PTC amount they qualified for based on their final income and household size.

- When helping consumers with plan comparison, show them all of the QHP options they're eligible for and never provide recommendations about which plan or plans they should select.

- Some changes in circumstances are considered "qualifying life events" and may allow consumers to enroll in or change QHPs during an SEP.

- The earliest date a consumer’s coverage will start depends on when they enroll and whether they have paid their first month's premium by the due date noted in the enrollment materials. This is called the effective date of coverage.
Exemptions and Appeals Assistance

Introduction

As you know, the Affordable Care Act requires individuals to have MEC, obtain an exemption, or pay a fee. Let’s review important policies and procedures that are in place in all states for which the FFMs are performing exemption determinations and eligibility appeals. As of the date this training was uploaded to the Marketplace Learning Management System, the FFMs are making exemption determinations in all states except Connecticut.

What counts as MEC?

- Any QHP sold in a Marketplace
- Individual health plans sold outside the Marketplaces if they meet QHP standards
- Any "grandfathered" individual insurance plan you've had since March 23, 2010 or earlier
- Any job-based plan, including retiree plans and COBRA coverage
- Medicare Part A or Part C (but Part B coverage by itself doesn't qualify)
• Most Medicaid coverage except for limited coverage plans

• CHIP

• Coverage under a parent's plan

• Most student health plans (check with your school to see if the plan counts as qualifying health coverage)

• Health coverage for Peace Corps volunteers

• Certain types of veterans' health coverage through the Department of Veterans Affairs

• 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 your high-risk pool plan to see if it counts as qualifying health coverage)

What does not count as MEC?
Some products that help pay for medical services don't qualify. If you have only this kind of product, you may have to pay the fee.

Examples include:

• 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
Exemptions and Appeals Assistance

Minimum Essential Coverage and the Individual Shared Responsibility Payment

Remember, consumers may have to pay a fee called the individual shared responsibility payment for each month each household member did not have MEC or an exemption when they file federal income tax returns. The fee for consumers who fail to maintain MEC increases every year. It is calculated in two different ways:

1. As a percentage of consumers’ household income, or
2. A per person amount.

Consumers must pay whichever amount is higher when filing their federal tax return for the year they didn't have coverage.

For 2016 and beyond:

Percentage amount: 2.5% of household income

Note: Only count the amount of income that's above the yearly tax filing threshold ($10,300 for individuals, $20,600 for couples filing jointly in 2015, the most recent year available).

The maximum fee is equal to the total yearly premium for the national average price of a Bronze plan sold through the Marketplaces.

Per person amount: $95 per adult in household who doesn’t have health coverage and $347.50 per child under 18 in household who doesn’t have health coverage.

The maximum fee for year 2017 is $2,086.

Some consumers only have MEC for a portion of a year. The fee for not having MEC will be one-twelfth of the annual amount for each full month the consumer and each of their household members didn't have MEC. The fee is calculated on a monthly basis and the monthly amounts are added up to determine the total annual payment. It is also important to note that consumers are considered to have MEC for an entire calendar month as long as they have MEC for at least one day during that month.
The maximum fee is equal to the total yearly premium for the national average price of a Bronze plan sold through the Marketplaces.

Per person amount: $695 per adult in household who doesn't have health coverage and $347.50 per child under 18 in household who doesn’t have health coverage.

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Exemptions and Appeals Assistance

Introduction to Exemptions

The Affordable Care Act includes different categories of exemptions from the individual shared responsibility payment. Consumers may apply for more than one type of exemption; however, they only need to receive one exemption for any one period of time to avoid paying a fee for that period.

Consumers whose household incomes are low enough that they are not required to file taxes are automatically exempt and do not need to apply for an exemption.

Exemptions and Appeals Assistance

Introduction to Exemptions

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Consumers whose household incomes are low enough that they are not required to file taxes are automatically exempt and do not need to apply for an exemption.
Sometimes consumers below the tax filing threshold choose to file a tax return to receive a refund; if they do, they can still claim an exemption.

Exemptions and Appeals Assistance

Health Coverage Exemptions Tool

The Health Coverage Exemptions Tool helps consumers learn whether they may qualify for an exemption and how to apply.

Consumers can provide information about existing health coverage, income, tax filing status, and more to determine which exemptions they may be eligible for. Selecting "Next Steps" within the tool allows consumers to view instructions on how to apply for the appropriate exemption.

For example, the tool asks if a consumer experienced various hardship situations: Remind consumers that this tool is not an exemption application; they must apply for exemptions through the Marketplaces or claim exemptions through the IRS when filing their federal income tax returns depending on the specific exemption requested. There are various reasons why consumers can be exempt from the fee for failing to maintain MEC. Let's review these different categories of exemptions using the whiteboard.

Refer to the Types of Coverage Exemptions of the Form 8965 Instructions in the Resources tab for a complete listing of every exemption from the individual shared responsibility payment.
**Short Coverage Gap**
This exemption applies to each consumer in a household who fails to maintain MEC for a period less than three consecutive months. Consumers are considered covered for any month they had MEC for even one day. Consumers who have two or more coverage gaps during the year can claim this exemption only for the months of their first coverage gap. **Consumers claim this exemption when filing their federal income tax returns.** You can find instructions here.

**Marketplace Affordability**
Marketplace coverage is considered unaffordable if the lowest cost Bronze plan available to a consumer through a Marketplace for the 2018 benefit year is more than 8.13 percent of household income.

- The total cost to a consumer must be more than 8.13 percent, including any premium tax credit the consumer would qualify for if they enrolled in that plan.
- If a consumer qualifies for this exemption, the exemption may apply to everybody on their tax return who doesn't have coverage for the 2018 benefit year.

Consumers may apply for this exemption to the FFMs or the IRS when filing their taxes if the exemption is needed for future months through the end of the tax year (based on projected income) or through the IRS when filing their taxes for prior months or the entire tax year (based on actual income).

Note: Consumers who qualify for an affordability exemption based on projected income may be eligible to purchase Catastrophic coverage. You can find affordability exemption application information here.

**Job-based Affordability**
Job-based health insurance is considered unaffordable in different ways depending on how the coverage is offered:

- For an employee: If the annual premium for the lowest cost self-only plan (a plan that covers only the employee and not members of the employee’s family) is more than 8.13 percent of household income.
- For the employee’s family: If the annual premium for the lowest cost family plan is more than 8.13 percent of household income.

If a consumer can claim this exemption, it may apply to everybody on the consumer’s tax return who doesn’t have coverage in 2018. This will depend on the cost of the coverage and who it’s offered to.
Note: It's possible that an employee won't be eligible for the exemption because the self-only plan available to them is affordable. But other members of the household could be eligible for the exemption if family coverage offered to them is unaffordable. Consumers may apply for this exemption through an FFM if it is needed for future months (based on projected income) or through the IRS when filing their taxes for prior months or the entire tax year (based on actual income). You can find job-based Marketplace exemption application information here.

**Consumers Whose Income Is Too Low to File Taxes**
This exemption applies to consumers who don't file tax returns because their household incomes are below the tax filing threshold. Consumers who don't file federal income tax returns are automatically exempt. However, the only way for consumers to know if they will qualify for this exemption is to file a federal income tax return. If a consumer qualifies, their family members who did not have health coverage will also likely qualify for this exemption. You can find instructions here.

**Consumers who are members of:**

- A federally recognized Indian tribe or are Indians eligible for services through the Indian Health Service, tribes or tribal organizations, or urban Indian organizations

- A recognized health care sharing ministry; or

- A recognized religious sect with religious objections to insurance, including Social Security and Medicare.

This exemption applies to each consumer in a household.

Consumers who can obtain exemptions because they are members of (1) a federally recognized Indian tribe or are Indians eligible for services through the Indian Health Service, tribes or tribal organizations, or urban Indian organizations or (2) a recognized health care sharing ministry may receive exemptions only from the IRS when filing their annual federal income tax returns.

Consumers must apply for an exemption through the FFMs if they are a member of a recognized religious sect with religious objections to insurance, including Social Security and Medicare. You can find more information here.

Consumers who are U.S. citizens or residents living abroad or consumers who aren't lawfully present in the U.S.
This exemption is available for U.S. citizens who lived outside the U.S. for 330 days in the past 12 months or were bona fide residents of a foreign country for a full tax year, resident aliens meeting certain requirements, and "Dreamers." Consumers may apply for this exemption through the IRS when filing their federal income tax returns. You can find instructions here.
Hardship
This exemption applies to consumers facing life situations that keep them from obtaining health insurance such as homelessness, receiving a utility shut-off notice, fire, flood or other disaster, bankruptcy, being a victim of domestic violence, death of a family member, or not being eligible for Medicaid because their state did not expand Medicaid. To claim most hardship exemptions, consumers must fill out a paper application and mail it to the FFMs. Instructions are here.

To claim the non-Medicaid expansion exemption, consumers must apply through the IRS when filing their federal income taxes. Instructions are here.

Incarceration
This exemption is for consumers who were in prison, jail, or a similar institution or correctional facility during 2017. Incarceration doesn't include probation, parole, home confinement, or being held but not convicted of a crime. Consumers can apply for this exemption to the IRS when filing their tax return for any month they were incarcerated for at least one day. Instructions are here.

Exemptions and Appeals Assistance
IRS.gov and HealthCare.gov Resources

Exemptions and Appeals Assistance
IRS.gov and HealthCare.gov Resources
Consumers can download the latest Form 8965, *Health Coverage Exemptions*, and instructions for completing it at IRS.gov. Consumers can claim most exemptions that are claimed when filing a federal income tax return by using Form 8965. Remember, you should not provide tax advice in your role as an assister; therefore, you should not help consumers fill out IRS Form 8965.

In addition to helping consumers find out if they qualify for an exemption, the interactive Health Coverage Tax Tool at HealthCare.gov provides the price of the lowest cost Bronze plan in consumers' area and other information they need to fill out IRS Form 8965.

Exemptions and Appeals Assistance

**Applying for Exemptions Granted by the Marketplaces**

You should help consumers identify and complete the appropriate exemption application if they wish to apply for an exemption granted by the Marketplaces. Select each step to review the process.

**Step 1: Personal Information**

The application asks the consumer to fill out his or her personal information, including name, address, phone number, and whether the consumer wants to get information by email. If the consumer has a preferred spoken or written language other than English, they should fill that part in as well.
**Step 2: Household Information**
This section asks the consumer which household members will be included on the application. Consumers should provide demographic information for each household member. Even if the consumer doesn't have all the required documents, you can encourage them to start filling out the exemption application and identifying the documents they will need to gather and submit with the application.

**Step 3: Documents for Proof of Income**
Documents needed for different exemption applications: To claim an affordability exemption, "proof of income" documents are needed such as a recent pay stub and/or a letter from the consumer's employer verifying his or her income.

**Step 4: Read and Sign the Application**
Remind the consumer to sign the application and confirm that all the information provided is accurate.

**Step 5: Submit Application**
Mail the completed application with supporting documents. Remember, the Marketplaces don't accept online or telephone exemption applications at this time. All exemption applications must be mailed with copies of consumers’ supporting documentation to the Marketplaces to the following address:

Health Insurance Marketplace: Exemption Processing
465 Industrial Blvd.
London, KY 40741
Exemptions and Appeals Assistance

Obtaining an Exemption Certificate Number from a Marketplace

When consumers submit an exemption application to a Marketplace, the Marketplace reviews it and determines their eligibility. Response times can vary depending on:

- How complicated a request is
- How complete an application is, and
- Whether a consumer needs to submit more supporting documents after he or she applies.

Consumers who are granted an exemption by an FFM will be assigned a six or seven digit exemption certificate number (ECN) via a notice in their Marketplace account at HealthCare.gov, through their email, or by mail. Consumers can find their ECN in the "Eligibility Results" column of an exemption notice and must provide it on Form 8965 when filing federal income tax returns. ECNs tell the IRS that a consumer has received an exemption from a Marketplace. An ECN is also needed if a consumer age 30 or above decides to enroll in Catastrophic coverage.

Additional information:
If multiple household members qualify for exemptions granted by a Marketplace, each consumer in the household will receive a separate ECN.

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Exemptions and Appeals Assistance

Providing ECNs During the Federal Income Tax Filing Process

Consumers can apply for an exemption through the IRS or report an approved exemption granted by a Marketplace using Form 8965. Only one Form 8965 should be filed for each tax household. If a consumer or another household member will be claimed as a dependent by another taxpayer, that household member does not need to file Form 8965 and does not have to pay the fee for not having MEC.

Consumers may need to claim all members of their tax households on their exemption applications for their households to be considered for an exemption. If consumers receive an exemption from a Marketplace, they will need to enter their ECN(s) in the appropriate section of Form 8965.

Remind consumers to keep their ECNs and approval notices in a safe place. Consumers should also keep a copy of their submitted exemption applications and supporting documents in case follow-up is needed. If consumers claim an exemption through the IRS via the tax filing process instead of applying through a Marketplace, remember that they will not receive an ECN and do not need one.

Consumers may need to claim all members of their tax households on their exemption applications for their households to be considered for an exemption. If consumers receive an exemption from a Marketplace, they will need to enter their ECN(s) in the appropriate section of Form 8965.

Remind consumers to keep their ECNs and approval notices in a safe place. Consumers should also keep a copy of their submitted exemption applications and supporting documents in case follow-up is needed. If consumers claim an exemption through the IRS via the tax filing process instead of applying through a Marketplace, remember that they will not receive an ECN and do not need one.
Tips for helping consumers apply for exemptions:

- Be familiar with the different exemption types so you can help consumers determine which exemptions best fit their situation. If consumers choose the wrong exemption type or submit the wrong exemption application, they'll have to submit a new application.

- Confirm that consumers who seek exemptions on behalf of other people are designated authorized representatives or are otherwise qualified to seek exemptions on behalf of others.

- Help consumers determine who is in their tax household. Consumers can use one application per exemption for multiple members of their tax household.

- Remind consumers to complete all of the questions on the application for every adult in the tax household and any dependent child who also needs the exemption. If consumers skip questions, the Marketplaces will contact them for the missing information. This will slow the exemption application process down.

- Encourage consumers to submit all supporting documents requested on the application.

- Remind consumers that missing information may delay processing since applications can't be processed until documentation is received.

- Remind consumers that they shouldn't send original documents to the Marketplaces (other than the application itself).

- Advise consumers to keep copies of their exemption application, the original documents submitted with them, proof of mailing, and their exemption certificates (if an exemption was granted).

- Make sure that any hard copies of consumers' records are returned. If consumers leave their information with you by accident, take immediate measures to return the information and be sure to follow your organization's procedures.
Exemptions and Appeals Assistance

Catastrophic Coverage

Remember, consumers can purchase a Catastrophic health plan if they:

- Are under 30 years of age
- Receive a cancellation notice from their insurance company and believe other plans are unaffordable
- Are granted a hardship or affordability exemption

Consumers who enroll in a Catastrophic plan aren’t eligible for PTCs.

To enroll in a Catastrophic plan, consumers should log into their Marketplace account and select “Exemption” to the left of the “Application Status” section. Here, they’ll be prompted to enter the ECN for each person in their household who qualifies for an exemption. Then, they can proceed with their application and enroll in a Catastrophic health plan.

If an ECN is not entered, available Catastrophic health plans will not appear in the Plan Compare Tool unless a consumer is under the age of 30. Select here for more information about applying for Catastrophic health plans.
Exemptions and Appeals Assistance

Assisting Consumers with Eligibility Appeals

If consumers don't agree with a decision made by a Marketplace, they may be able to file an appeal. All eligibility determination notices, regardless of whether consumers are determined eligible or ineligible for a particular program, will tell consumers how they can appeal a decision if they're dissatisfied with the outcome.

Consumers have 90 days from the date they receive their eligibility determination notice to start an appeal. Consumers can also request an appeal if they didn't receive their eligibility determination notice in a timely manner.

Consumers can appeal the following kinds of Marketplace decisions, whether in connection with an initial eligibility determination or a redetermination:

- Eligibility to enroll in a QHP in a Marketplace
- Denial of an SEP
- Denial of PTC or CSR
- Level of PTC and CSR
- Eligibility for Medicaid or CHIP
- An exemption from the MEC requirement
- Eligibility to enroll in a Catastrophic health plan
- Length of time to provide a notice of eligibility determination
- An exemption from the MEC requirement
- Eligibility to enroll in a Catastrophic health plan
- Length of time to provide a notice of eligibility determination

Exemptions and Appeals Assistance

Filing an Appeal

Consumers can file appeals in three ways. Their eligibility determination notices will explain the process for how to file an appeal. Generally, consumers can appeal their eligibility results by:

Writing a letter to:
Health Insurance Marketplace
Attn: Appeals
465 Industrial Blvd.
London, KY 40750-0061

Mailing an appeal request form using the proper form for their states. All of the appeal request forms can be found at HealthCare.gov

Faxing their appeal request to a secure fax line: 1-877-369-0129
Consumers must submit specific information to complete an appeal request. At a minimum, they should provide their first and last name, address, and the reason for their appeal. Depending on the state where consumers live and their eligibility results, they may be able to submit an appeal through a Marketplace or to their state Medicaid or CHIP agency.

Exemptions and Appeals Assistance

After Filing an Appeal

After consumers file an appeal, they will receive a letter that:
- States their appeal request was received
- Provides a description of the appeals process
- Includes instructions for submitting additional material for consideration

After you file an appeal

- Decisions you can appeal
- Your eligibility notice
- How to appeal your Marketplace eligibility
- Appeal forms
- After you file an appeal
- Expedited appeals
- Getting help filling an appeal
- Decisions employers can appeal
- How to appeal a SHOP Marketplace decision

If your appeal request has been "accepted" or is pending:
- If the letter says your request is pending, cut out the letter:
  - Provides a description
  - Includes instructions

If your appeal request is "denied" or "out of scope":
If the letter says your appeal is denied, cut out the letter:
  - You must follow the notification
  - Learn what to do if...

How your appeal will be handled:
- In general, the Marketplace
Exemptions and Appeals Assistance

Appeals Process Summary

Here is a summary of the process for resolving eligibility appeals in a Marketplace.

- A consumer disagrees with an eligibility determination.
- The complete appeal request is submitted.
- An informal resolution is attempted.
  - If the consumer accepts, the appeal is closed and the decision is communicated through a notice.
  - If the consumer doesn't accept, a formal hearing is scheduled and then conducted.
- After the hearing, the appeal is closed and the decision is communicated to the consumer through a notice.
• If the consumer is still dissatisfied, the consumer can seek review in court to the extent it's available by law.

If it turns out an initial eligibility determination was wrong and a consumer didn't enroll in a QHP, they will qualify for an SEP to enroll in coverage through a Marketplace.

If an initial eligibility determination was correct, a consumer cannot enroll in or change QHPs through a Marketplace if the original enrollment period in which they applied has ended.

It's important to remind consumers that an appeal decision may result in a change in eligibility for other members of their household as well as for themselves.

Exemptions and Appeals Assistance

Legal Advice and Appeals

Beginning with FFM Navigator grants awarded in 2018, Navigators must help consumers understand the process of filing Marketplace eligibility appeals. Until FFM Navigator grants are awarded in 2018, Navigators are permitted but not required to provide appeals assistance.

Remember that, in your role as an assister, you should not provide legal advice regarding appeals or any other matter. For example, the Marketplace appeal request form has an option for an expedited appeal. While a Navigator may help consumers understand the difference between an appeal and an expedited appeal, the Navigator should not help a consumer decide which one is best suited to their circumstances. Consumers can decide to file requests for expedited (faster) appeals if the time needed for the standard appeal process would jeopardize their lives, health, or their ability to achieve, maintain, or regain maximum function.

CMS interprets Navigators' assistance with Marketplace eligibility appeals to include, where relevant to consumers' needs, providing information about free or low-cost legal help in the consumer's area, including local legal aid or legal services organizations and other state offices to help with the Marketplace eligibility appeals process. As long as they have sufficient knowledge to make these types of referrals, CACs and non-Navigator assistance personnel in FFIs may but are not required to provide them. You can tell consumers that they can have a friend, lawyer, or someone else help them with their appeal but that you cannot provide legal advice within your capacity as an assister. You can also refer consumers to free and low-cost legal services providers in your community such as legal aid organizations funded by the Legal Services Corporation, state Consumer Assistance Programs (CAPs), Health Insurance Ombudsmen, or other state agencies. When making such referrals, you should be sure to follow...
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Exemptions and Appeals Assistance

Knowledge Check

The individual shared responsibility payment does have a limit. In 2017, the fee is $___ per adult or ___ percent of household income, whichever is greater.

A. $250 or 6.95 percent
B. $695 or 2.5 percent
C. $950 or 7.5 percent
D. $750 or 9.5 percent

The correct answer is B. The individual shared responsibility payment does have a limit. In 2017, the fee is $695 per adult or 2.5 percent of household income, whichever is greater.
Exemptions and Appeals Assistance

**Key Points**

- The individual shared responsibility payment does have a limit. In 2017, the fee is $695 per adult or 2.5 percent of consumers' household income, whichever is greater.

- In situations where multiple household members qualify for exemptions, each consumer in the household will receive a separate ECN.

- If consumers don't agree with a decision made by a Marketplace, they may be able to file an appeal.

- When you're assisting consumers, you should never provide tax or legal advice regarding exemptions, appeals, or any other matter.
Great job! You have completed the Refresher Course!

Now that you've completed this course, you must also complete the following 2018 training courses and achieve a passing score on all applicable course exams to become recertified:

- Privacy, Security, and Fraud Prevention Standards
- Coverage to Care Assistance
- Assister Standard Operating Procedures

For more information about continuing education requirements, refer to the CMS Enrollment Assister Bulletin.

Select Exit to leave the course and take the Refresher Course exam. Good luck!
Resources

Resources Page for Assisters
https://www.medicare.gov:

Information regarding joining a Medicare health plan or drug plan.
https://www.medicare.gov/sign-up-change-plans/when-can-i-join-a-health-or-drug-plan/when-can-i-join-a-health-or-drug-plan.html

SHOP Marketplace Overview
A summary of the Small Business Health Options Marketplace Program.
https://www.healthcare.gov/small-businesses/provide-shop-coverage/shop-marketplace-overview/

The SOP Manual serves as your primary guide to helping consumers with activities within the individual market Federal-facilitated Marketplaces (FFMs, such as enrolling in health coverage).

Tips to get started in the Health Insurance Marketplace
Four tips to get started with enrolling into a Marketplace plan.

Incarceration
Information regarding incarceration and the Marketplace.
https://www.healthcare.gov/incarcerated-people/

Savings Estimator Tool
Provides consumers with a quick view of income levels that qualify for savings in 2018.
https://www.healthcare.gov/lower-costs

Identity Proofing in the Marketplace
A description of the identity proofing process that occurs before completing a Marketplace application.

Logging Into Your Account
Tips on troubleshooting login issues for healthcare.gov accounts.
https://www.healthcare.gov/tips-and-troubleshooting/logging-in/

TRICARE and the Affordable Care Act
A summary of how TRICARE coverage is regarded under the Affordable Care Act regulations.
https://tricare.mil/About/MEC.aspx
5 Things Assisters Should Know about Data Matching Terminations
Information about how data matching issues impact consumers.

Income Definitions for Marketplace and Medicaid Coverage
Information regarding how Modified Adjusted Gross Income (MAGI) is calculated for the Marketplace and Medicaid.

Medicaid and CHIP: Fast Facts for Assisters
Summary of important facts regarding Medicaid and CHIP eligibility.

Federal Poverty Level (FPL) Guidelines
Up-to-date information regarding the Federal Poverty Guidelines (FPL) for families and individuals.
https://aspe.hhs.gov/poverty-guidelines

COBRA coverage and the Marketplace
A description of COBRA health coverage and how it relates to the Marketplace.
https://healthcare.gov/unemployed/cobra-coverage/

Tips on Providing Referrals to Consumers

How to find low-cost health care in your community
Use the following tool to find a community health center near the consumer.
https://www.healthcare.gov/community-health-centers/

Catastrophic Plans
A definition of Catastrophic health plans and their role in the Marketplace.
https://HealthCare.gov/choose-a-plan/catastrophic-plans/

Pharmaceutical Assistance Programs
A tool to see if a pharmaceutical company offers an assistance program for the drugs they manufacture.
https://Medicare.gov/Pharmaceutical-Assistance-Program

If you have job-based insurance
An explanation of how job-based insurance affects Marketplace coverage.
https://www.healthcare.gov/have-job-based-coverage/

Health coverage for retirees
An explanation of the different choices retirees have for health coverage.
https://www.healthcare.gov/retirees/
If you already have Medicare coverage
Information regarding consumers who already have Medicare coverage and how this affects their eligibility for Marketplace coverage.
https://www.healthcare.gov/medicare/

How to get or stay on a parent’s plan
An explanation of the Affordable Care Act regulations regarding consumers staying on their parent’s health coverage plans.

Student health plans & other options
An explanation of the Affordable Care Act regulations regarding different health coverage options for students.
https://www.healthcare.gov/young-adults/college-students/

The VA and the Affordable Care Act
A summary of how VA coverage is regarded under the Affordable Care Act regulations.
https://www.va.gov/health/aca/EnrolledVeterans.asp

Refugee Medical Assistance
A description of refugee medical assistance programs.
https://www.acf.hhs.gov/orr/programs/cma/about

Health Coverage Tax Tool
Use this tool to help you figure out your premium tax credit or claim an "affordability" exemption. This tool can tell you your second lowest cost Silver plan of your lowest cost Bronze plan.
https://www.healthcare.gov/tax-tool/

Exemptions from the requirement to have health insurance
A description of the different types of exemptions available under the Affordable Care Act and how to apply for them.
https://www.healthcare.gov/health-coverage-exemptions/exemptions-from-the-fee/