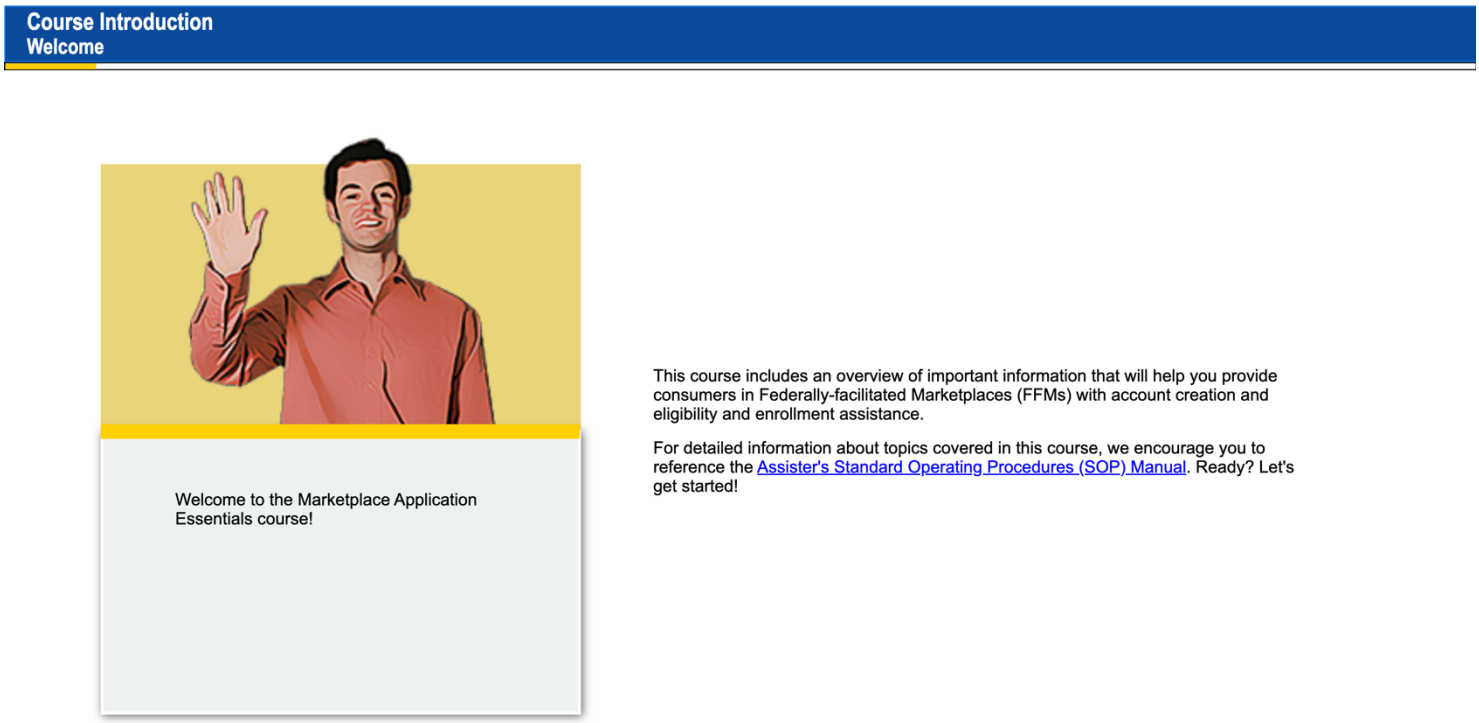
Marketplace Application Essentials

Course Introduction

Welcome

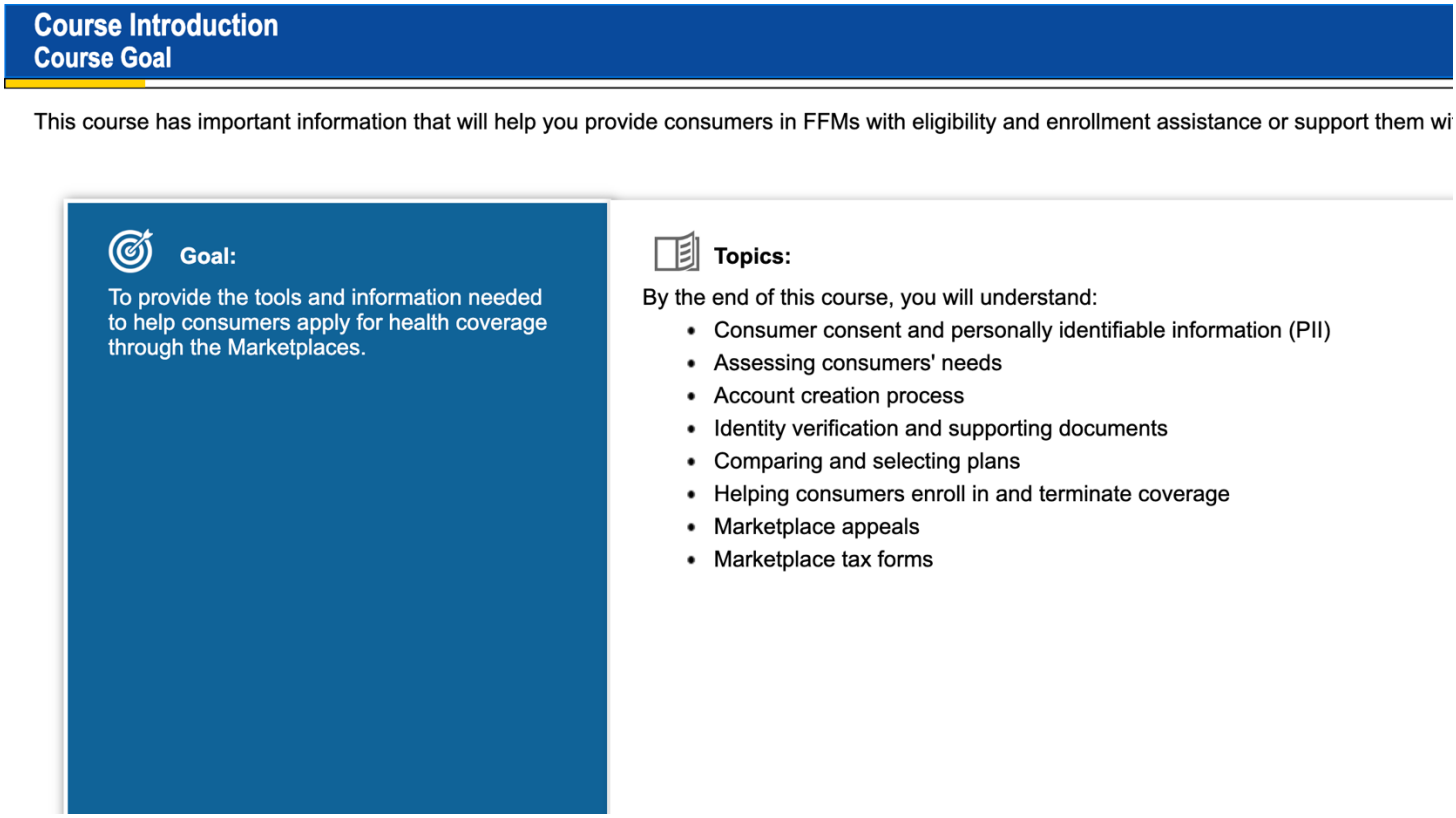


Welcome to the Marketplace Application Essentials course!

This course includes an overview of important information that will help you provide consumers in Federally-facilitated Marketplaces (FFMs) with account creation and eligibility and enrollment assistance.

For detailed information about topics covered in this course, we encourage you to reference the Assister's Standard Operating Procedures (SOP) Manual. Ready? Let's get started!

Course Goal



This course has important information that will help you provide consumers in FFMs with eligibility and enrollment assistance or support them with appeals.

Goal:

To provide the tools and information needed to help consumers apply for health coverage through the Marketplaces.

Topics:

By the end of this course, you will understand:

- Consumer consent and personally identifiable information (PII)
- Assessing consumers' needs
- Account creation process
- Identity verification and supporting documents
- Comparing and selecting plans
- Helping consumers enroll in and terminate coverage
- Marketplace appeals
- Marketplace tax forms

Preparing to Apply

Introduction

Preparing to Apply
Introduction

Before we discuss the application process for individuals and families in Federally-facilitated Marketplaces (FFMs), let's review a few things you should keep in mind when you meet with consumers.

As a Navigator or certified application counselor (CAC) in an FFM, you must:

- Assist applicants and enrollees submitting Marketplace eligibility applications in an FFM's service area.
- Explain your duties and responsibilities to each consumer you assist and let them know that you can't 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 qualified health plans (QHPs), Medicaid, and Children's Health Insurance Program coverage (CHIP).

Beginning with Navigator grants awarded in 2022, including non-competing continuation awards, Navigators are required to also provide information on and assistance with all of the following topics:

- Understanding the process of filing Marketplace eligibility appeals;
- Understanding and applying for hardship and affordability exemptions granted through the Marketplace for consumers age 30 and older seeking to enroll in a Catastrophic plan;
- Marketplace-related components of the premium tax credit reconciliation process and understanding the availability of Internal Revenue Services (IRS) resources on this process;
- Understanding basic concepts and rights related to health coverage and how to use it; and
- Referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice related to consumer questions about the Marketplace application and enrollment process and premium tax credit reconciliations.

The Centers for Medicare and Medicaid Services (CMS) will continue to provide all assisters with additional information related to these assistance activities through webinars, job aids, and other technical assistance resources.

Here is a reminder about providing appropriate services for consumers with specific needs.

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Appropriate Services

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.

Navigators must provide information and services in a manner that is accessible to persons with disabilities and persons with Limited English Proficiency (LEP). This may require 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. Additionally, this may require language assistance services, like interpreters, for individuals with LEP.

CACs in FFMs are expected to provide referrals to Navigators or the FFM Call Center if they aren’t able to assist consumers with 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.

Consumer Consent and PII

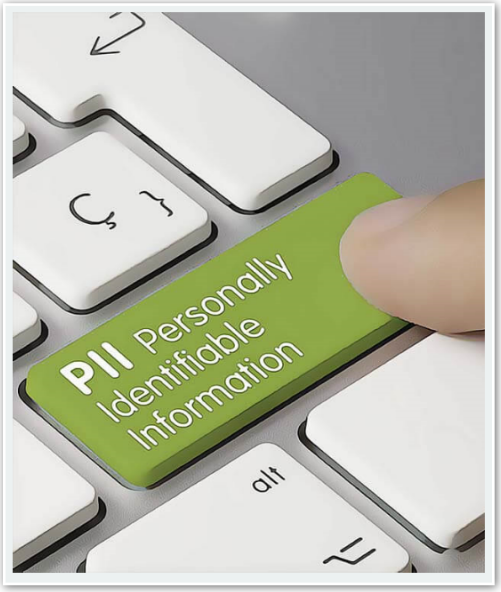
Preparing to Apply
Consumer Consent and Personally Identifiable Information (PII)

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 provide consent for you to follow up with them about applying for or enrolling in coverage as well as 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 certification requirements.



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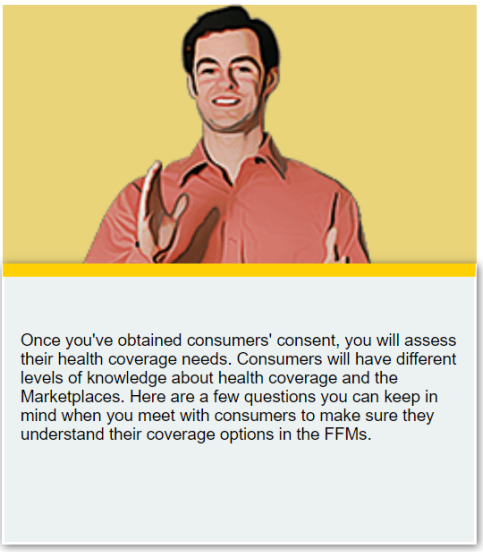
Assess Consumers' Needs

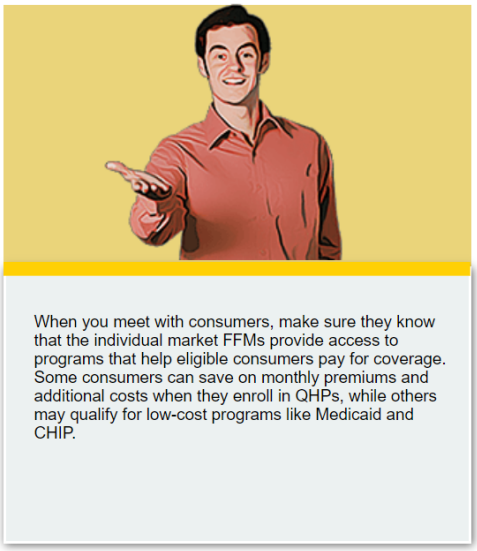
Preparing to Apply
Assess Consumers' Needs



Once you've obtained consumers' consent, you will assess their health coverage needs. Consumers will have 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 (ACA), 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.

Discussing Individual Market FFMs With Consumers



When you meet with consumers, 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 additional costs when they enroll in QHPs, while others may qualify for low-cost programs like Medicaid and CHIP.

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

- Individuals who don’t have affordable health coverage through their employer or another source.
- Individuals who aren’t eligible for employer-sponsored coverage through a spouse or parent.
- Self-employed consumers (and their families) whose businesses have no employees.

Affordable

For 2023, a plan is considered “affordable” if the plan’s premiums do not exceed 9.12 percent of the employee’s household income. At the time of this publication, the affordability threshold for PY2024 has not yet been released.

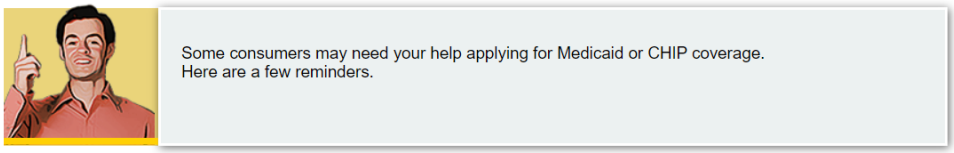
Previously, a job-based plan was considered affordable for all family members to whom an employer’s offer extends if the premium for the employee’s self-only coverage was affordable. The premium required to cover any family members was not taken into account.

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

Businesses with No Employees

Generally, self-employed consumers whose businesses have no employees may not purchase group coverage through a Small Business Health Options Program (SHOP) Marketplace.

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 a Marketplace application online at HealthCare.gov
- Contact the FFM Call Center at 1-800-318-2596 (TTY: 1-855-889-4325) 24 hours a day, seven days a week

All states are required to provide Medicaid coverage for certain groups of consumers in certain mandatory eligibility groups. Some states cover other optional eligibility groups as well.

If you help consumers in a state that hasn’t expanded Medicaid to low-income adults and they’re not otherwise eligible for Medicaid or other coverage, they may qualify for APTC and CSRs if they enroll in a QHP offered through a Marketplace. Otherwise, they may be eligible to purchase Catastrophic health coverage.

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

Refer to the Health Coverage Basics course for detailed information about Medicaid and CHIP coverage, including eligibility requirements.

Mandatory and Optional Eligibility Groups in Medicaid

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

- Pregnant individuals
- Children under age 19
- Parents and other caretaker relatives
- Supplemental Security Income (SSI) beneficiaries
- Some low-income older adults

Some states cover other groups of consumers referred to as **optional eligibility groups**, which federal law provides as options for states to cover under Medicaid. Examples of optional groups include:

- Individuals eligible for family planning services
- Age- and disability-related poverty-level group
- Medically needy individuals

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.

Note: The Consolidated Appropriations Act of 2023 makes this option for extended Medicaid coverage for postpartum individuals permanent beginning January 1, 2024.

Useful Tools to Help Consumers Get Started

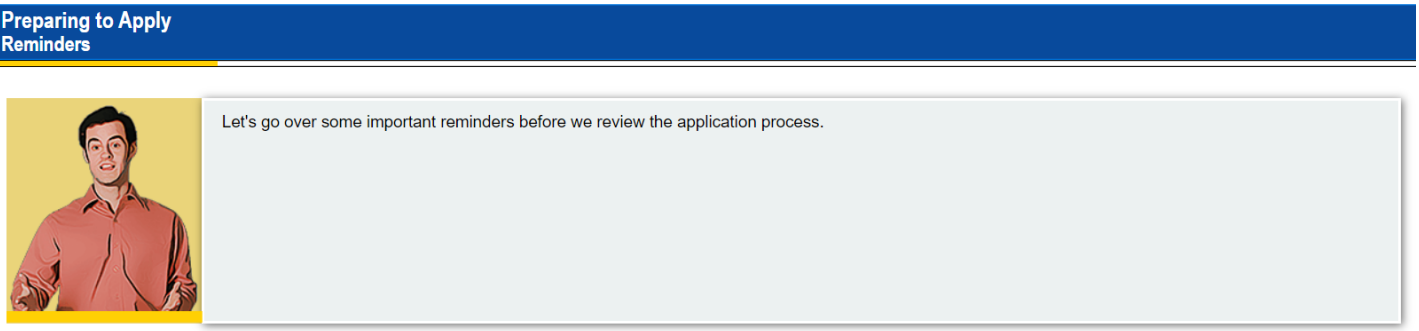
Many individuals and families don't think they can afford coverage and don't realize financial help may be available. Before they begin a Marketplace application, the Savings Estimator Tool and Window Shopping Tool at HealthCare.gov can help them learn about the features and costs of different QHPs in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

The Savings Estimator Tool helps consumers check if they may save on Marketplace premiums based on their income. 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 review available QHP 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.

Reminders



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

Eligible Citizenship and Immigration Statuses

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.

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.

Allow each consumer to act on their 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, you may only use the keyboard or mouse to follow the consumer's specific directions.

Also remember that you can’t recommend specific health plans to consumers or make eligibility determinations for consumers.

Knowledge Check

Preparing to Apply
Knowledge Check

There are many rules you must remember when you're assisting consumers. Which of the following statements is true when you're assisting consumers? Select the correct answer and then select **Check Your Answer**.

- A. One of your roles is to help consumers enroll in health coverage. You should be ready to choose a plan for them and explain the benefits that plan covers.
- B. When you assist the same consumer multiple times, you must receive new consent from that consumer each time you access their PII. The older consent the consumer provided is no longer valid.
- C. When using the Savings Estimator Tool, you will be able to tell consumers which plans are best for them. You may offer your advice on which plans they can and can't afford.
- D. When using the Window Shopping Tool, you should tell consumers that they'll be able to review QHPs available in their area and estimated prices based on their projected income.

Check Your Answer

Correct!
When using the Window Shopping Tool, consumers will be able to review QHPs available in their area and estimated prices based on their projected income. You should not tell consumers which plans are best for them or choose a plan for them, but you may offer your advice on which plans they can and can't afford. Additionally, consumer consent is valid until the specified expiration date or the consumer revokes their consent.

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Answer: When using the Window Shopping Tool, consumers will be able to review QHPs available in their area and estimated prices based on their projected income. You should not tell consumers which plans are best for them or choose a plan for them, but you may offer your advice on which plans they can and can't afford. Additionally, consumer consent is valid until the specified expiration date or the consumer revokes their consent.

Key Points

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 additional costs when they enroll in QHPs, while others may qualify for low-cost programs like 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.

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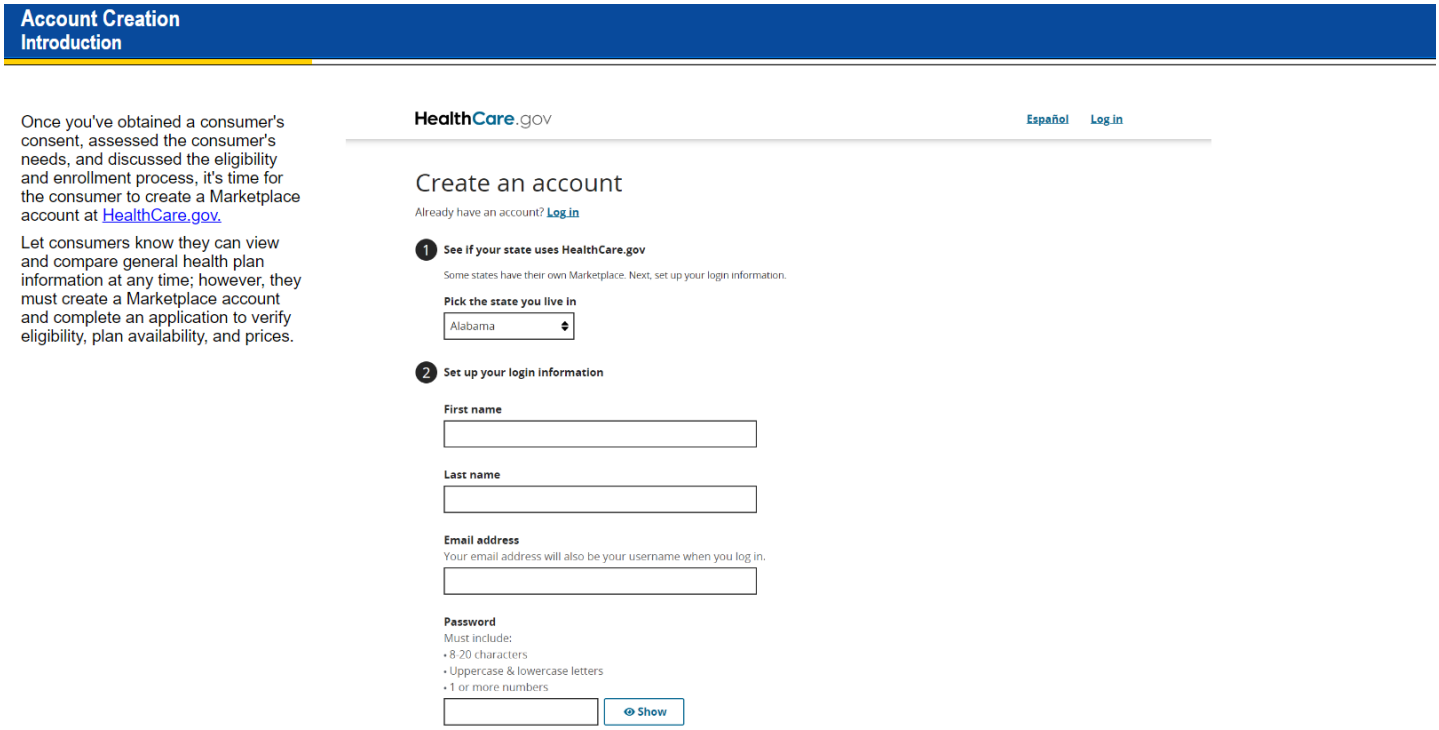
Account Creation

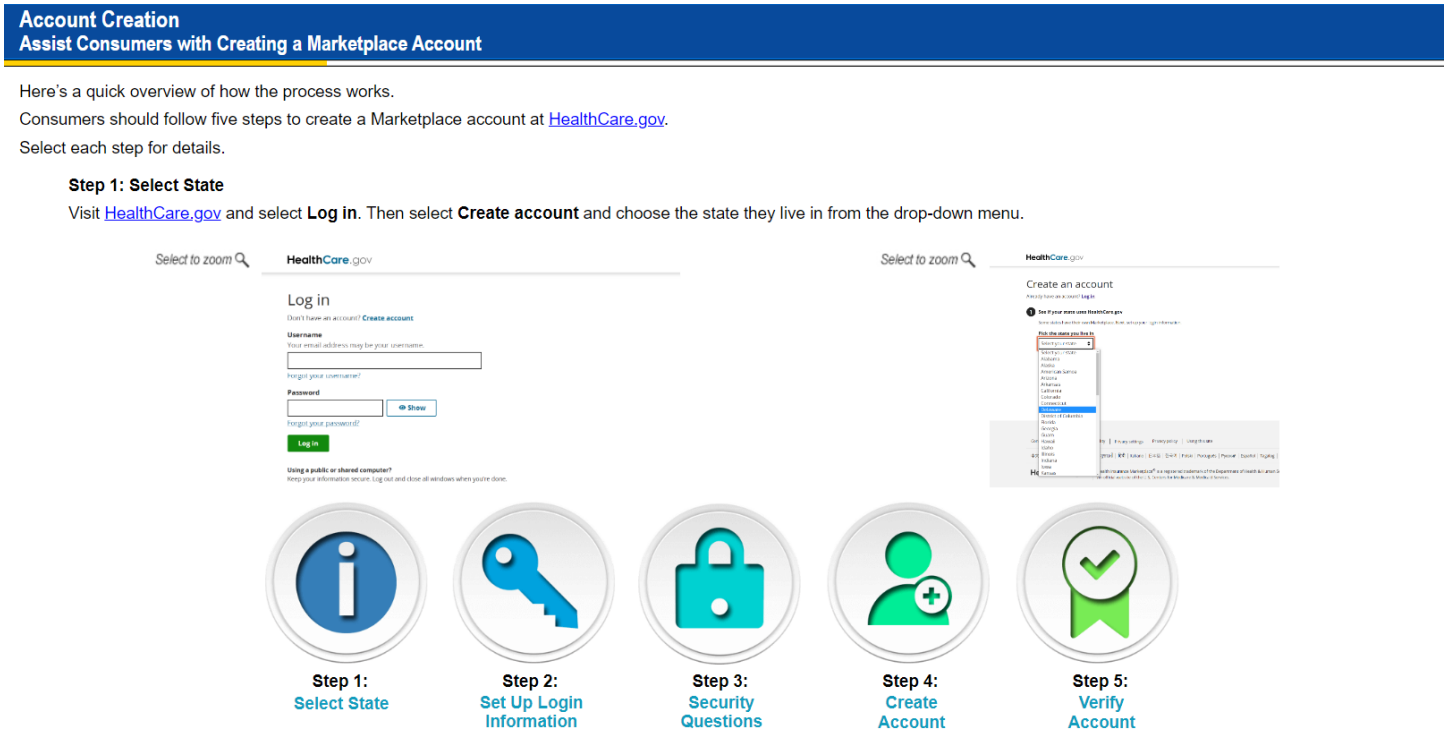
Introduction



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

Let consumers know they can view and compare general health plan information at any time; however, they must create a Marketplace account and complete an application to verify eligibility, plan availability, and prices.

Assist Consumers with Creating a Marketplace Account



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

Consumers should follow five steps to create a Marketplace account at HealthCare.gov.

Step 1: Select State

Visit HealthCare.gov and select **Log in.** Then select **Create account** and choose the state they live in from the drop-down menu.

Step 2: Set Up Login Information

Enter their name and a valid email address, which is also used as 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:

1. Select **Forgot your password?** from the login page and enter the email address associated with the Marketplace account.
2. The FFM sends 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.
3. Follow the directions to choose a new password.

Sometimes the FFMs reset consumers' passwords due to security measures. If this happens, consumers won't 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, seven days a week (except federal holidays).

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 HealthCare.gov/tips-and-troubleshooting/logging-in/.

Step 3: Security Questions

Choose security questions and provide responses. These questions are used for verification purposes if

necessary. You should advise consumers to record these and keep them in a secure place.

Step 4: Create Account

Attest to the terms and conditions, then select the **Create account** button.

Step 5: Verify Account

In the last step, the Marketplace will send a verification email to the email address the consumer provided. Consumers must verify their account by selecting the link in that email.

Helping with Identity Verification

After a consumer creates a Marketplace account and logs into HealthCare.gov for the first time, they must complete identity (ID) proofing before they can begin an application. 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. During ID proofing, the FFMs ask questions about a consumer's personal and financial history based on the consumer's Experian credit report that only the consumer is likely to know. If a consumer's identity isn't verified, they may receive a prompt with instructions and next steps. Additional information about Marketplace identity verification is available at Marketplace.cms.gov/outreach-and-education/your-marketplace-application.pdf.

Note: Experian is a contractor that helps the FFMs with ID proofing. The Experian Help Desk may be able to help consumers with issues during the ID proofing process. For example, they may be able to explain that verification was unsuccessful because a consumer used their nickname rather than their legal name. 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). Experian may be able to explain why a consumer's identity wasn't verified.

Consumers should select the **My Profile** button, and then select **Verify Now** to begin.

Verify Your Identity

When the "Verify Your Identity" screen appears, they should select the **Get Started** button.

Verification Questions

The FFMs ask for contact information and other questions about consumers to verify their identity.

Identity Verification Failure

Account Creation
Identity Verification Failure

The FFM will indicate whether a consumer's identify has been verified successfully. If the FFM can't verify certain consumers' citizenship or immigration status, it will make a second attempt using the Systematic Alien Verification Entitlement Program (SAVE) database. This process can take three to five days. If the FFM fails to identify a consumer's identity after two tries, they will receive 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 **Resubmit** button to complete the ID proofing process. If Experian can't verify a consumer's identity over the phone, the consumer will be directed to submit updated contact information and to upload documents that verify their identity by selecting the **Upload Documents** button.

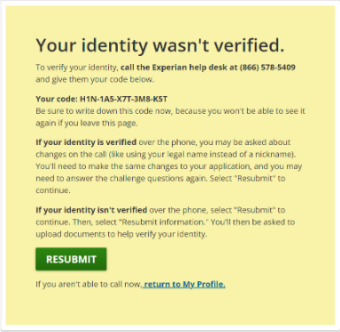
The FFM will try to verify a consumer's identity after Experian has verified it. If the FFM can't verify a consumer's identity after Experian verifies it, the consumer will have to upload documents electronically or submit them by mail. Remind consumers that sending verification documents by mail takes more time to process and that they should mail copies and keep the original documents. They should include their name, date of birth, and Social Security Number (SSN) 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 7-10 business days after documents are received. If a consumer's identity still isn't verified, they may need to provide additional information.

Health Insurance Marketplace® is a registered service mark of the Department of Health and Human Services (HHS).

Select to zoom



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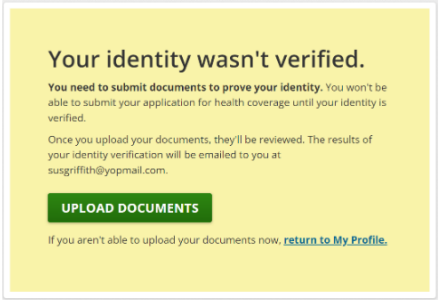

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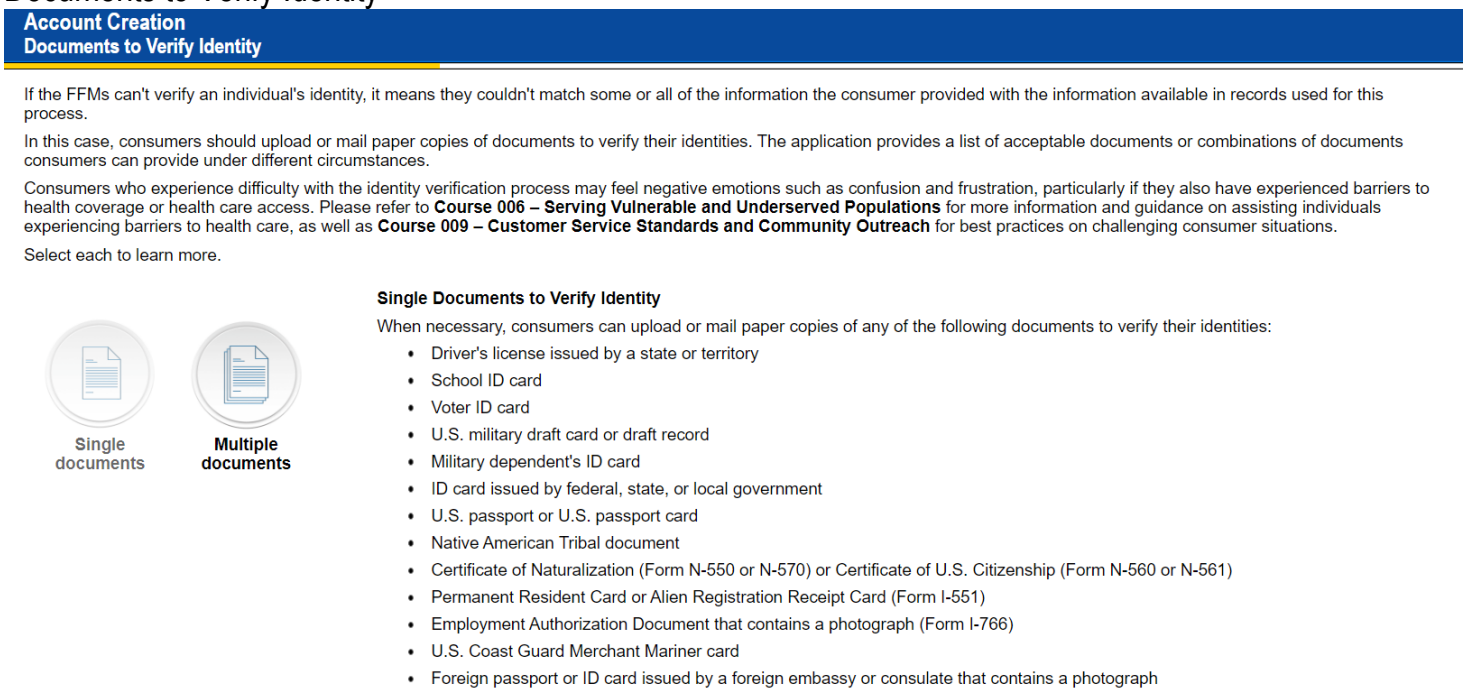
Documents to Verify Identity



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

In this case, consumers should upload or mail paper copies of documents to verify their identities. The application provides a list of acceptable documents or combinations of documents consumers can provide under different circumstances.

Consumers who experience difficulty with the identity verification process may feel negative emotions such as confusion and frustration, particularly if they also have experienced barriers to health coverage or health care access. Please refer to **Course 006 – Serving Vulnerable and Underserved Populations** for more information and guidance on assisting individuals experiencing barriers to health care, as well as **Course 009 – Customer Service Standards and Community Outreach** for best practices on challenging consumer situations.

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 single documents, they can submit copies of two of these documents:

- U.S. public birth certificate
- Social Security card
- Marriage certificate
- Divorce decree
- Employer ID card
- High school or college diploma, including high school equivalency diploma
- Property deed or title

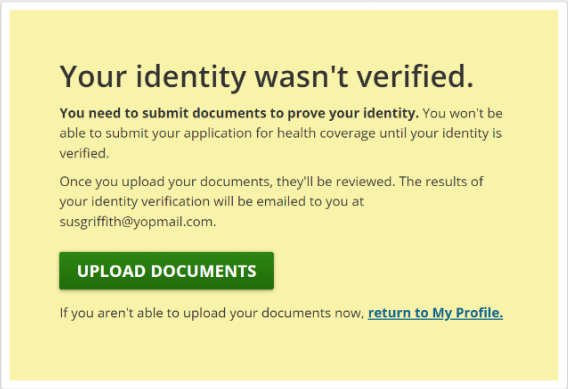
Upload Documents to Verify Identity

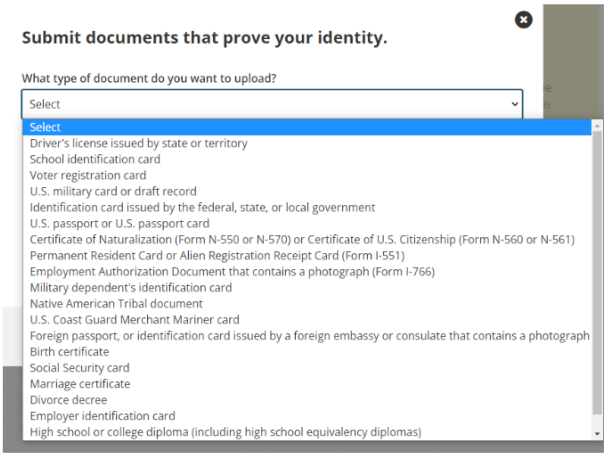
Account Creation
Upload Documents to Verify Identity

To upload documents online, consumers should:

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

Consumers can check the status of documents they've submitted in their Marketplace account profile.





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Consumers can check the status of documents they've submitted in their Marketplace account profile.

Key Points

Account Creation
Key Points

- You should know how to guide consumers through each step of creating a Marketplace account and verifying their identity.
- The FFM uses information from a consumer's Experian consumer report to verify their identity.
- Consumers may need to upload documents to verify their identity if the FFM cannot verify it using their trusted data sources.

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- Consumers may need to upload documents to verify their identity if the FFM cannot verify it using their trusted data sources.

Application Completion

Introduction

Application Completion
Introduction

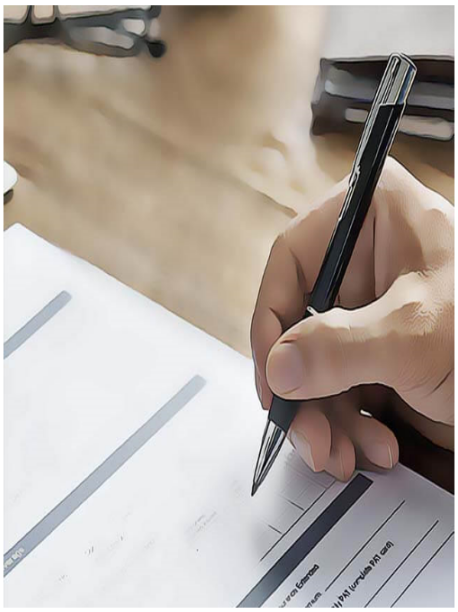
Before consumers begin a Marketplace application, you should discuss with them the information they will need to provide to the Federally-facilitated Marketplaces (FFMs) during the application process.

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 advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs) or other coverage programs (e.g., Medicaid and Children's Health Insurance Program (CHIP))
- Personal information for each applicant (e.g., name, date of birth, relationship to consumers filing the application)
- Citizenship or satisfactory immigration status for each applicant (but not for non-applicants)
- Information about life events that may qualify them for a Special Enrollment Period (SEP)

If applying for help paying for coverage:

- Tax filing information
- Household income information
- Information regarding access to other coverage (e.g., employer-sponsored coverage)



Before consumers begin a Marketplace application, you should discuss with them the information they will need to provide to the FFMs during the application process.

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)
- Citizenship or satisfactory immigration status for each applicant (but not for non-applicants)
- Information about life events that may qualify them for a Special Enrollment Period (SEP)

If applying for help paying for coverage:

- Tax filing information
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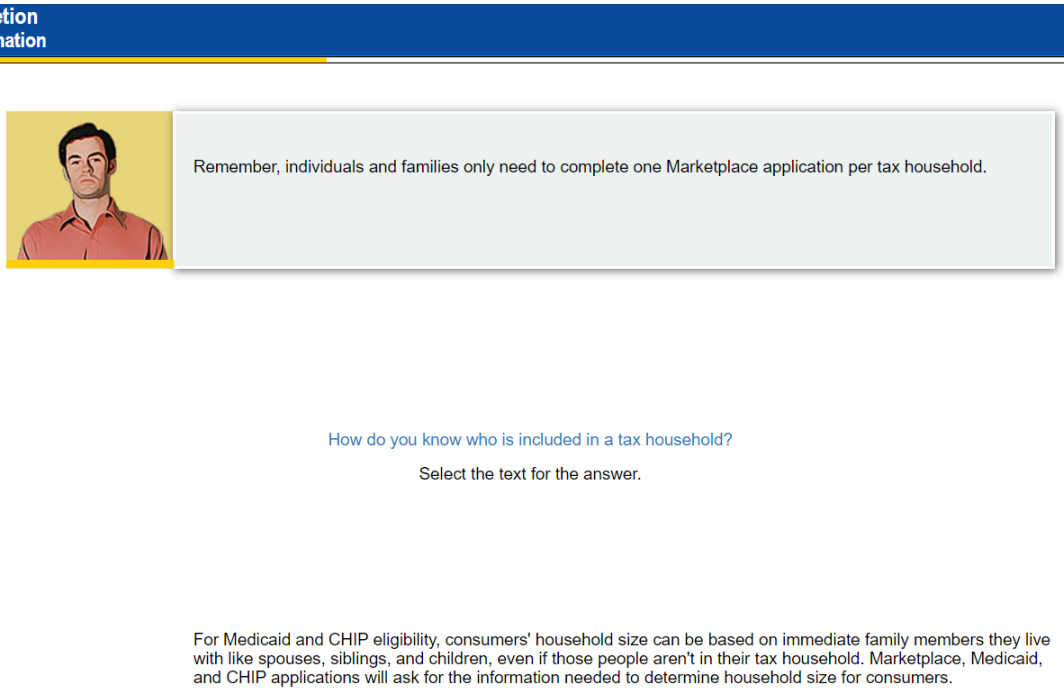
Tax Household Information



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

Tax Filers + Tax Dependents = Household Size

Generally, if consumers plan to file federal income taxes together using the same federal income tax return, they're considered part of the same tax household, and they generally should submit one Marketplace application with all applicants listed together. If consumers are part of separate tax households—that is, they will file separate federal income tax returns —they should complete separate Marketplace applications.

- If consumers are only applying for QHP coverage in an FFM (without any help paying for it), they should only include those household members who want coverage on their applications.
- If consumers choose to apply for help paying for coverage, they may need to include other household members—even if those household members don't need or want coverage. The application will ask consumers to provide information about these non-applicant household members if needed.

Individuals Included on Applications for Coverage

For adults who are applying for help paying for coverage, the Marketplace application may ask for information about the following individuals, even individuals who aren't applying for coverage themselves:

- All people who are on the same federal income tax return, including spouses and dependents
- Any spouse who lives with the consumer, even if they aren't on the same tax return
- Any children, including stepchildren, under 21 who live with them, even if they aren't on the same tax return

For children under 19 who are applying for help paying for coverage, the Marketplace application may ask for information about the following individuals, even if these individuals aren't applying for coverage themselves:

All people who are on the same federal income tax return, including parents and siblings

- Any parent, including step-parents, who lives with them, even if they're not on the same tax return
- Any siblings (including step-siblings and half-siblings) who live with them, even if they're not on the same tax return

Note: Members of the same household may need to complete separate applications if they won't file taxes together and they want to apply for help paying for coverage. For more information, refer to the *Complex Application Issues* course.

Individuals NOT Included on Applications for Coverage

The following individuals may need to submit separate applications:

- Unmarried domestic partners
- Domestic partners may have to file separate applications. Unmarried domestic partners should submit one application only if they have a child together or one partner will claim the other partner as a tax dependent. For more information, refer to the *Complex Application Issues* course.
- Family members who live together but who file separate federal income tax returns

Note: The Marketplace application asks applicants whether they're married. Consumers should select No if they are:

- Unmarried for tax-filing purposes
- Legally married but filing federal income taxes separately due to domestic violence or spousal abandonment

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

Reporting Income: MAGI

The FFMs use consumers' modified adjusted gross income (MAGI) to determine whether they meet income requirements for financial assistance for enrollment in a QHP. MAGI is:

- Adjusted gross income (AGI) as reported on a consumer's federal income tax return plus these, if applicable,
- Untaxed foreign income,
- Non-taxable Social Security benefits, and
- Tax-exempt interest.

MAGI is generally very close to consumers' AGI. However, it doesn't appear as a line on federal income tax returns and doesn't include SSI.

Remember, the Marketplaces calculate MAGI differently from state Medicaid and CHIP agencies. Refer to the *Health Coverage Basics* course for more information.

Notice

CMS is offering this link for informational purposes only and this fact shouldn't be construed as an endorsement of the host organization's programs or activities.

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Federal Income Tax Return

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

- Income reported on a federal income tax return from a previous year can help a consumer estimate their 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.

Types of Income to Report

Application Completion
Types of Income to Report

If consumers choose to apply for insurance affordability programs when they submit a Marketplace application, it's important that they provide accurate income information for each household member. This table lists types of income consumers should and shouldn't include on their application.

Report this income

Don't report this income

Taxable scholarships, awards, or fellowship grants used for education purposes count as income in the FFMs, and consumers should enter them on a Marketplace application. However, they don't count as income when determining consumers' eligibility for Medicaid and CHIP.

Note: This is not a complete list. Refer to Internal Revenue Service (IRS) Publications 17 and 525 for more details on what income is taxable and not taxable.

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

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

If consumers choose to apply for insurance affordability programs when they submit a Marketplace application, it's important that they provide accurate income information for each household member. This table lists types of income consumers should and shouldn't include on their application.

Report this income:	Don't report this income:
Wages, salaries, bonuses	Temporary Assistance for Needy Families (TANF) payments
Self-employment income	Child support payments
Tips and gratuities	SSI
All Social Security retirement and disability income	Veterans' benefits
Unemployment compensation	Workers' compensation
Rent income	Proceeds from loans
Alimony received (for divorces or separations finalized before 1/1/2019)	Child tax credit payments
	Gifts
	Alimony received (for divorces of separations finalized on or after 1/1/2019)

Taxable scholarships, awards, or fellowship grants used for education purposes count as income in the FFMs, and consumers should enter them on a Marketplace application. However, they don't count as income when determining consumers' eligibility for Medicaid and CHIP.

Note: This is not a complete list. Refer to IRS Publications 17 and 525 for more details on what income is taxable and not taxable.

Alimony received

The Tax Cuts and Jobs Act of 2017 made important changes to how consumers should treat alimony when reporting their income:

For divorces and separations finalized before January 1, 2019, alimony should be reported on the Marketplace application as income or as a deduction.

- This means that alimony payments to a former spouse will continue to be tax deductible and alimony payments received from a former spouse will continue to be reported as income.

- If a divorce or separation is modified on or after January 1, 2019, and the modification expressly provides that the alimony rule in the Tax Cuts and Jobs Act's amendment applies to this modification, then alimony shouldn’t be reported on the Marketplace application as income or a deduction.

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

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

Knowledge Check

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 information will this consumer need to know to complete their Marketplace application? Select the three correct answers and then select **Check Your Answer**.

- [x] A. Which household members are applying for coverage
- [x] 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
- [x] D. Income information

Check Your Answer

Correct!
This consumer should complete the application, and the FFM will help determine whether they or members of their family are eligible for other programs to help lower their costs. However, the consumer needs to know which household members are applying for coverage, personal information for each applicant, and whether each applicant can get coverage through an employer. You don't need to explain pre-existing conditions to applicants. All Marketplace insurance plans are prohibited from excluding coverage for treatment based on pre-existing medical conditions.

A consumer just created a Marketplace account and is ready to begin the application process. They really want to apply for help paying for coverage. What information will the consumer need to know in order to complete their Marketplace application?

Answer: This consumer should complete the application, and the FFM will help determine whether they or members of their family are eligible for other programs to help lower their costs. However, the consumer needs to know which household members are applying for coverage, personal information for each applicant, and whether each applicant can get coverage through an employer. You don’t need to explain pre-existing conditions to applicants. All Marketplace insurance plans are prohibited from excluding coverage for treatment based on pre-existing medical conditions.

Knowledge Check

Application Completion
Knowledge Check

Roberta is a divorced waitress with a seven-year-old son. She separated from her ex-husband in 2017 and receives alimony and child support payments from him. 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 Roberta **NOT** include when estimating her income? Select the correct answer and then select **Check Your Answer**.

- A. Wages
- B. Tips
- C. Alimony
- D. Child Support (selected)

Check Your Answer

Correct!
Roberta shouldn't include child support when estimating her household income. However, she should include wages, tips, and alimony.
Note: If Roberta's separation from her ex-husband was finalized on or after January 1, 2019, then she **shouldn't include child support and alimony** when estimating her household income.

Roberta is a divorced waitress with a seven-year-old son. She separated from her ex-husband in 2017 and receives alimony and child support payments from him. Roberta comes to you for advice on what income she should include when applying for programs to help lower her costs. What source of income should Roberta **NOT** include when estimating her income?

Answer: Roberta shouldn’t include child support when estimating her household income. However, she should include wages, tips, and alimony. Note: If Roberta's separation from her ex-husband was finalized on or after January 1, 2019, then she **shouldn’t include child support and alimony** when estimating her household income.

Key Points

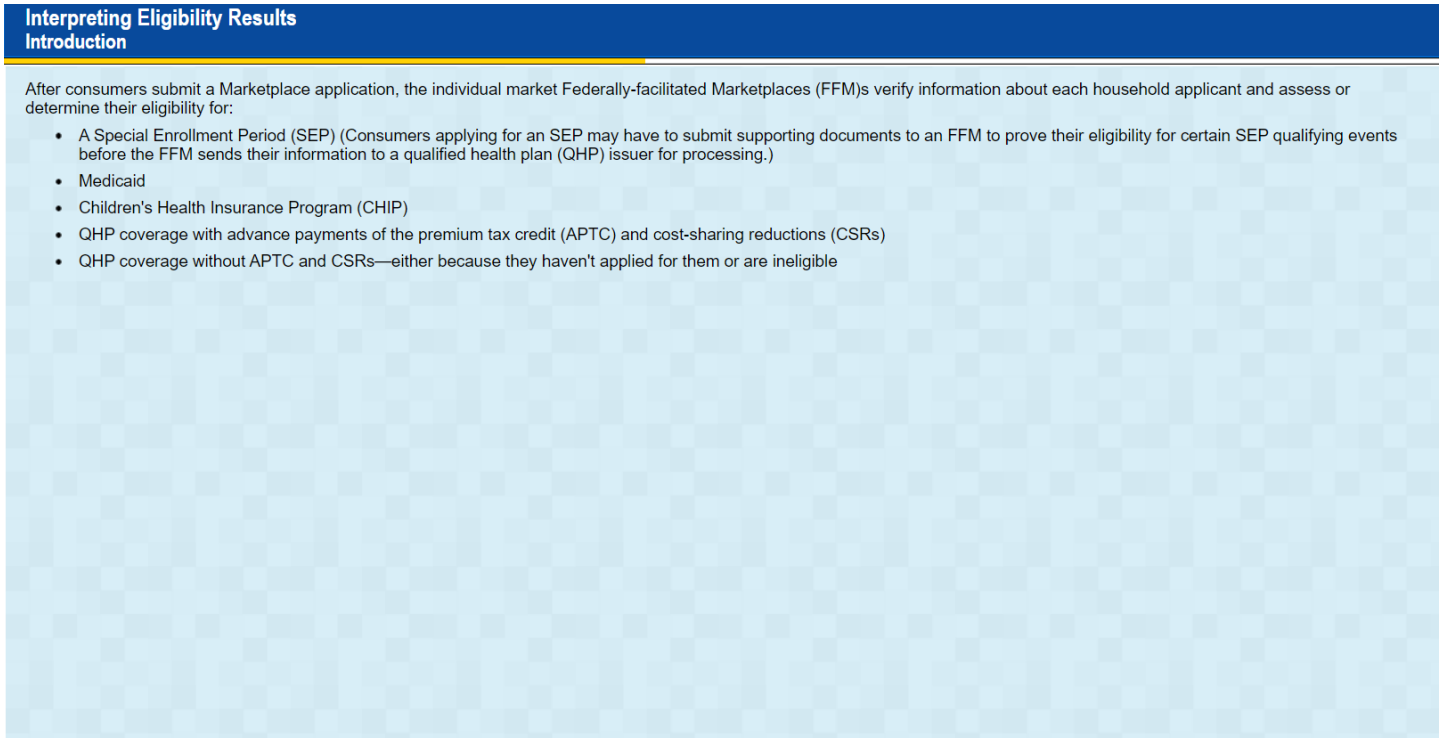
Application Completion
Key Points

- You should know how to guide consumers through each step of completing a Marketplace application.
- 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 for them.

- You should know how to guide consumers through each step of completing a Marketplace application.
- 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 for them.

Interpreting Eligibility Results

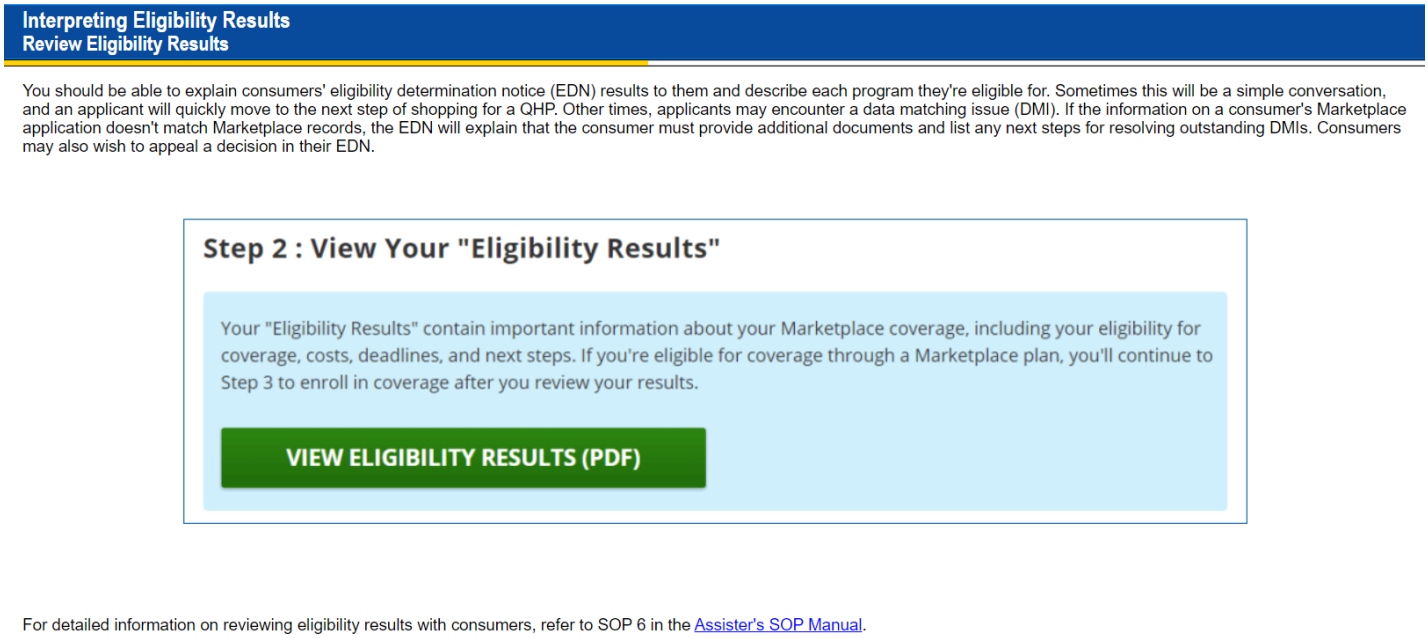
Introduction



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 may have to submit supporting documents to an FFM to prove their eligibility for certain SEP qualifying events before the FFM sends their information to a QHP issuer for processing.)
- Medicaid
- CHIP
- QHP coverage with APTC and CSRs
- QHP coverage without APTC and CSRs—either because they haven't applied for them or are ineligible

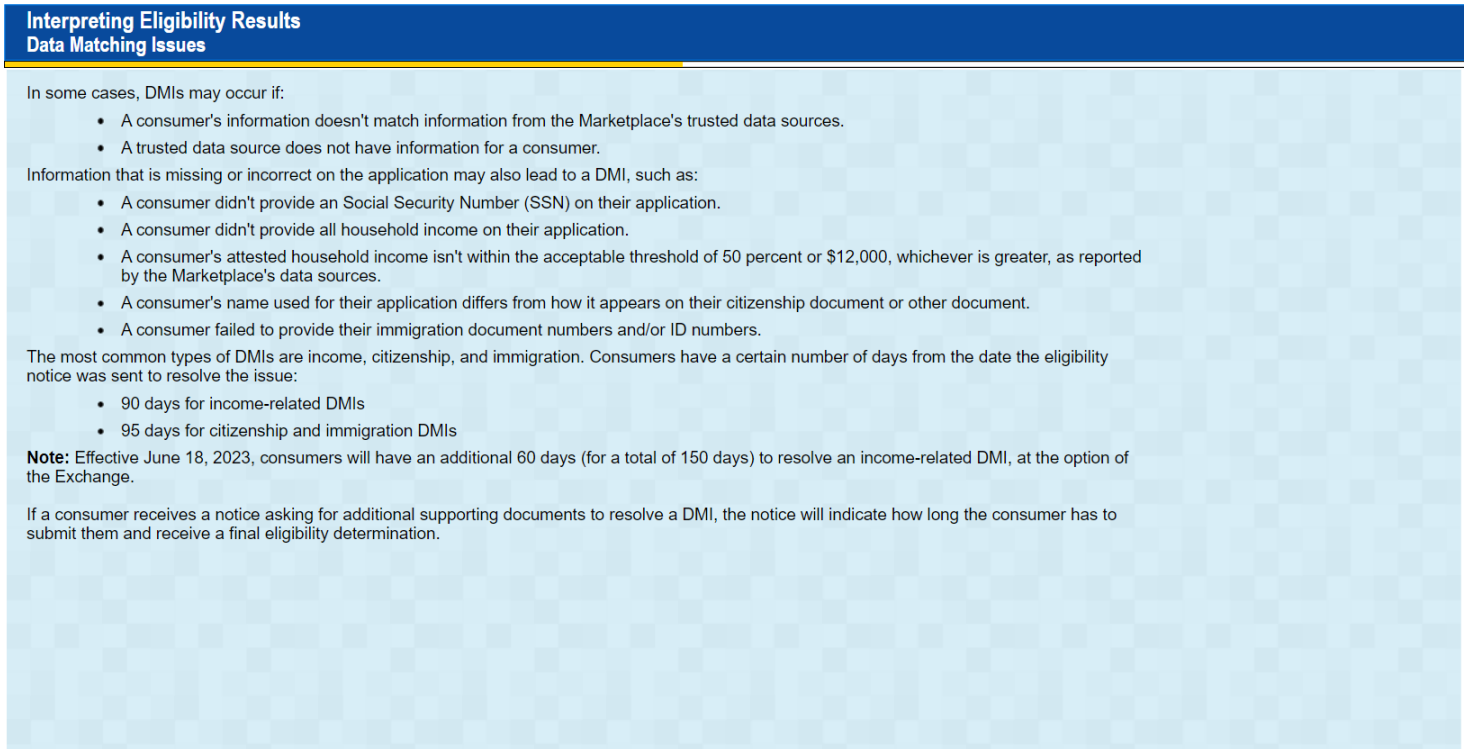
Review Eligibility Results



You should be able to explain consumers' eligibility determination notice (EDN) results to them and describe each program they're 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 data matching issue (DMI). If the information on a consumer's Marketplace application doesn't match Marketplace records, the EDN will explain that the consumer must provide additional documents and list any next steps for resolving outstanding DMIs. Consumers may also wish to appeal a decision in their EDN.

For detailed information on reviewing eligibility results with consumers, refer to SOP 6 in the Assister's SOP Manual.

Data Matching Issues



In some cases, DMIs may occur if:

- A consumer’s information doesn’t match information from the Marketplace’s trusted data sources.
- A trusted data source does not have information for a consumer.

Information that is missing or incorrect on the application may also lead to a DMI, such as:

- A consumer didn’t provide an SSN on their application.
- A consumer didn’t provide all household income on their application.
- A consumer’s attested household income isn’t within the acceptable threshold of 50 percent or $12,000, whichever is greater, as reported by the Marketplace’s data sources.
- A consumer’s name used for their application differs from how it appears on their citizenship document or other document.
- A consumer failed to provide their immigration document numbers and/or ID numbers.

The most common types of DMIs are income, citizenship, and immigration. Consumers have a certain number of days from the date the eligibility notice was sent to resolve the issue:

- 90 days for income-related DMIs
- 95 days for citizenship and immigration DMIs

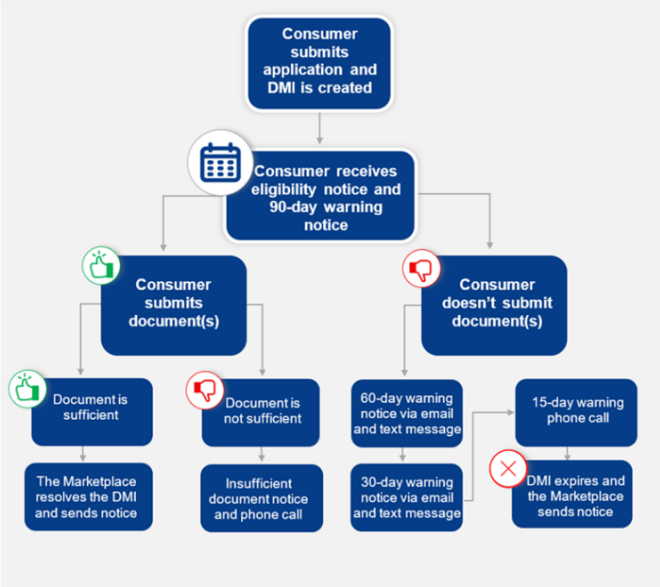
Note: Effective June 18 2023, consumers will have an additional 60 days (for a total of 150 days) to resolve an income-related DMI, at the option of the Exchange.

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

Consumer Outreach to Resolve a DMI

Interpreting Eligibility Results
Consumer Outreach to Resolve a DMI

Consumers with DMIs will receive 90-, 60-, and 30- day warning notices as well as a phone call and email to ask for documents if the DMI has not been resolved, based on communication preferences.



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Submitting Documents to Resolve a DMI

Interpreting Eligibility Results
Submitting Documents to Resolve a DMI

You're responsible for helping consumers submit documents to verify their information to resolve a DMI.
Select the folder to open a PDF with best practices for submitting supporting documents to an FFM.

You're responsible for helping consumers submit documents to verify their information to resolve a DMI.

Visit the When the Marketplace Needs More Information homepage for best practices for submitting supporting documents to an FFM.

Enrolling in Health Coverage with a DMI

Consumers who encounter a DMI can enroll in coverage during a temporary "inconsistency period;" however, they must provide documents to the FFM that support what they put on their application. If they don't, they may lose their coverage as well as any APTC and CSR amounts they were determined eligible for during the inconsistency period.

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 DMIs.

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 through the Marketplace.

For more information about how DMIs affect consumers, refer to the tip sheet 5 Things Assisters Should Know about Data Matching Terminations at HHS.gov/guidance/document/job-aid-5-things-assisters-should-know-about-data-matching-terminations.

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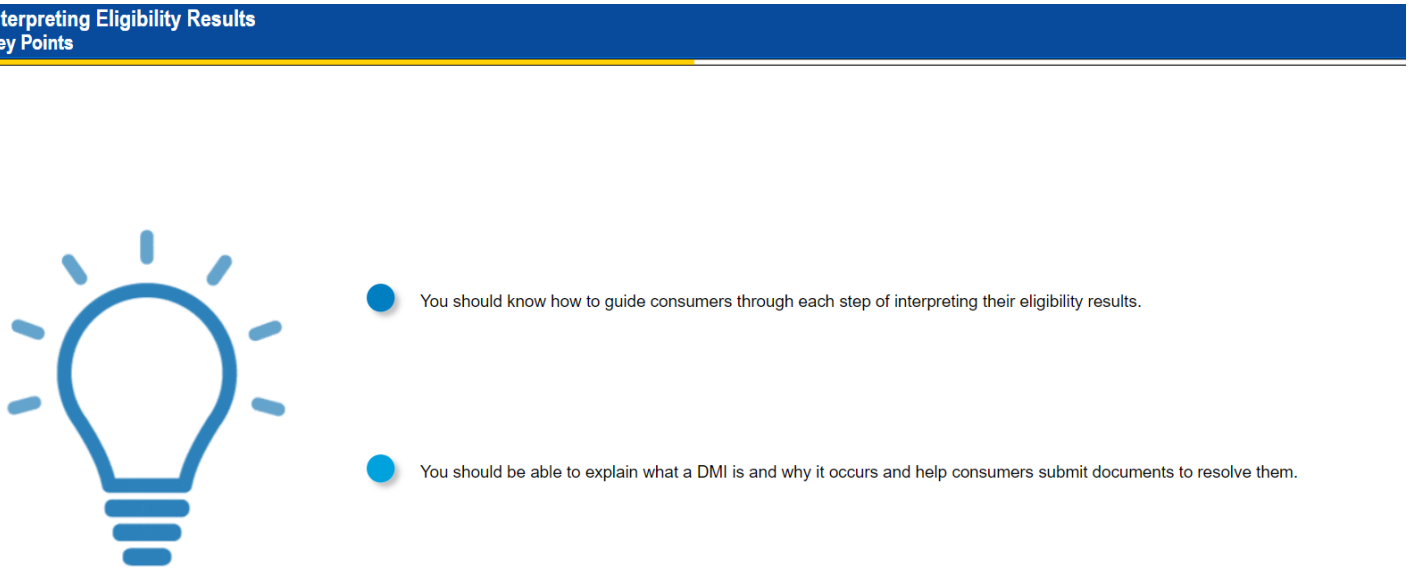
Key Points



- You should know how to guide consumers through each step of interpreting their eligibility results.
- You should be able to explain what a DMI is and why it occurs and help consumers submit documents to resolve them.

Helping Consumers Enroll in Coverage

Introduction

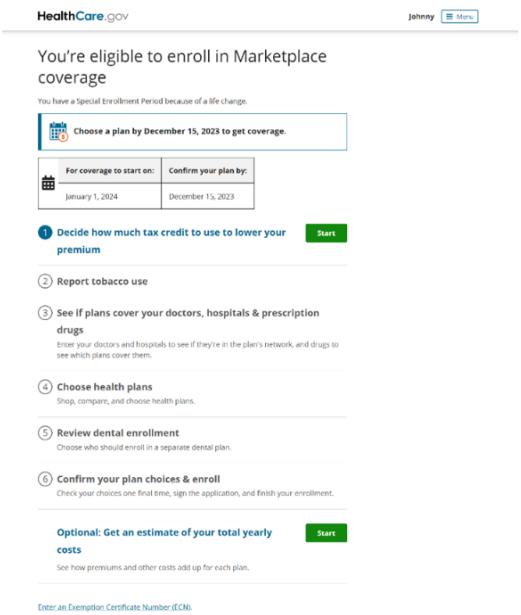
After you help consumers review their eligibility results and resolve any DMIs, if applicable, you'll help consumers who qualify for a premium tax credit set the APTC amount they'd like to use, then help consumers set their health insurance preferences, compare plans, and choose a QHP that meets their needs.

The “Enroll To-do List”

Helping Consumers Enroll in Coverage
The "Enroll To-do List"

The "Enroll To-Do List" in a Marketplace application includes six steps consumers should complete:

1. Choose how much premium tax credit to apply to their monthly premiums in advance.
2. Report tobacco use.
3. Determine if QHPs cover their doctors, hospitals, and prescription drugs.
4. Choose a QHP.
5. If desired, compare and select dental coverage.
6. Review and confirm health and dental coverage choices before signing the application.



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4. Choose a QHP.
5. If desired, compare and select dental coverage.
6. Review and confirm health and dental coverage choices before signing the application.

Choosing How Much APTC to Apply

You should be prepared to explain consumers' options if their eligibility determinations show that they qualify for APTC and cost-sharing reductions (CSRs). Eligible individuals and families can use all, some, or none of the premium tax credit amount they qualify for in advance to lower their monthly premiums when they enroll in a QHP.

Explain to consumers that the amount of APTC they apply to their monthly premiums could affect the amount of taxes they owe to the Internal Revenue Service (IRS) or the refund amount they get back when they file federal income tax returns for the year. Consumers who anticipate changes throughout the year, like an increase in household income, may want to reduce the amount of APTC they apply to their monthly premium.

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Plan Comparison

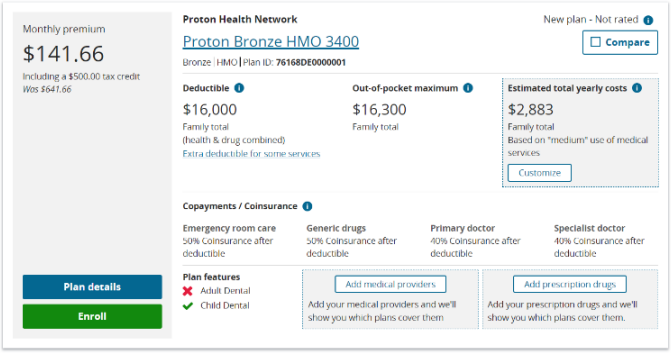
Helping Consumers Enroll in Coverage
Plan Comparison

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 like:

- 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 are discounted by the APTC amount an eligible consumer selects. Remind consumers that they can change this amount later if desired.



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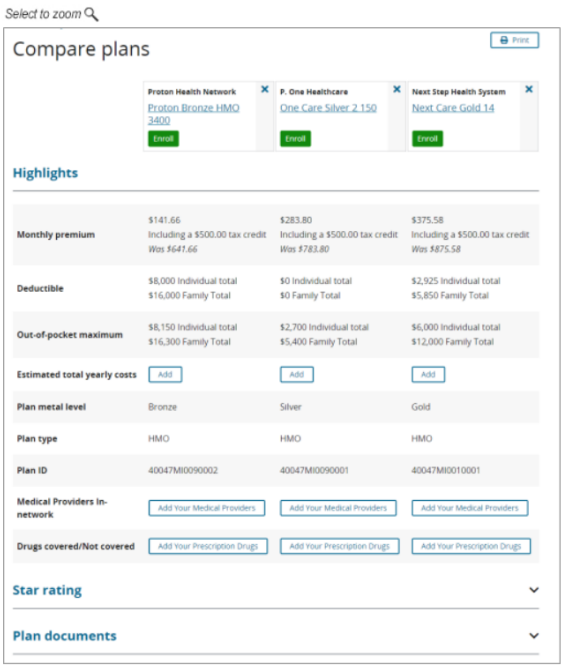
Key Tip: Remember, QHP premium amounts shown in Plan Compare are discounted by the APTC amount an eligible consumer selects. Remind consumers that they can change this amount later if desired.

Side-by-side Comparison Tool

Helping Consumers Enroll in Coverage
Side-by-side Comparison Tool

Consumers can use the side-by-side comparison tool to explore different QHP features and compare 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 are 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 can learn more about the SBC in the *Coverage to Care Assistance* course.



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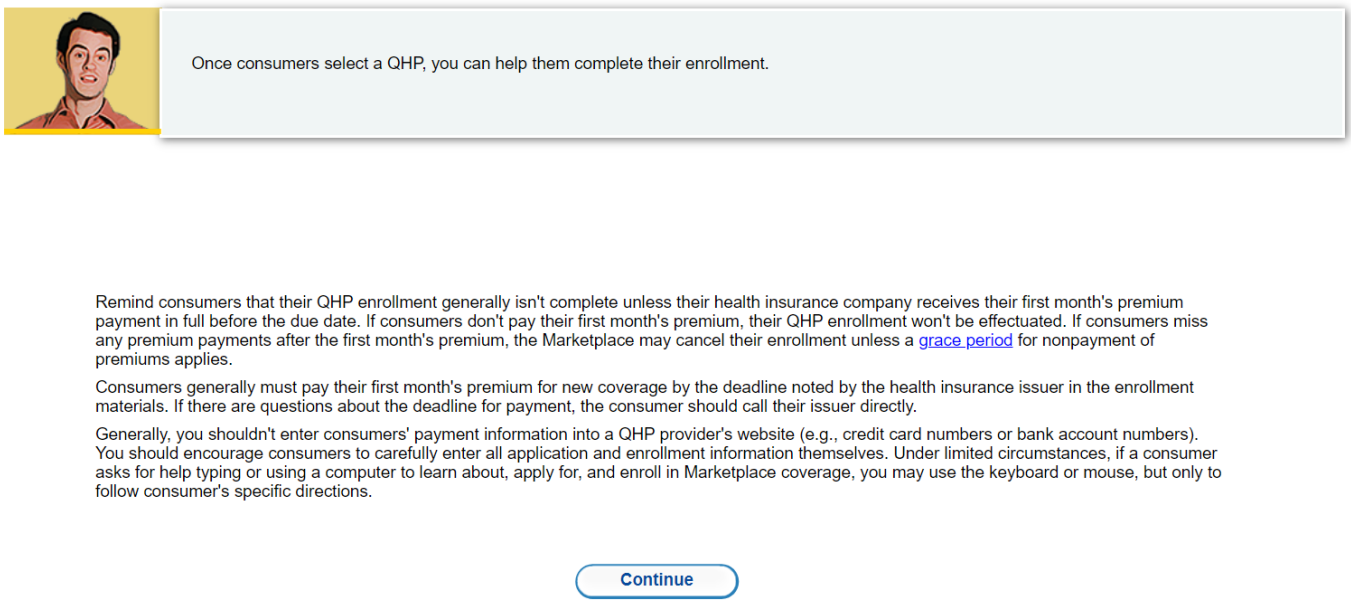
Helping Consumers Enroll



Once consumers select a QHP, you can help them complete their enrollment.

Remind consumers that their QHP enrollment generally isn't complete unless their health insurance company receives their first month's premium payment in full before the due date. If consumers don’t pay their first month’s premium, their QHP enrollment won’t be effectuated. If consumers miss any premium payments after the first month’s premium, the Marketplace may cancel their enrollment unless a grace period for nonpayment of premiums applies.

Consumers generally must pay their first month's premium for new coverage by the deadline noted by the health insurance issuer in the enrollment materials. If there are questions about the deadline for payment, the consumer should call their issuer directly.

Generally, you shouldn’t enter consumers' payment information into a QHP provider's website (e.g., credit card numbers or bank account numbers). You should encourage consumers to carefully enter all application and enrollment information themselves. Under limited circumstances, if a consumer asks for help typing or using a computer to learn about, apply for, and enroll in Marketplace coverage, you may use the keyboard or mouse, but only to follow consumer's specific directions.

Effective Date of Coverage

In most cases, the earliest date consumers' coverage can start – that is, their "effective date of coverage"—is:

- For the Open Enrollment Period (OEP) for 2024 coverage, January 1 (for consumers who enroll between November 1, 2023, and December 15, 2023) or February 1 (if they enroll between December 16, 2023, and January 15, 2024); or
- For SEPs, the first day of the month following plan selection, unless a special effective date applies. Remember to tell consumers that their effective date of coverage is based on when they choose a plan and the type of SEP they qualify for, not the first date on which they actually use the coverage to get care.

Grace Period

There's a three-month grace period for consumers who are receiving APTC when they fail to pay their premiums (after their first month’s premium) by the due date noted in the issuer's enrollment materials. A QHP must continue to pay claims during the first month of the grace period; however, it may delay payments for any claims made in the second and third months until consumers pay any overdue premiums. If consumers still haven't paid their premiums in full after the third month, their QHP is terminated retroactively to the end of the first month of the grace period. This means the consumer may have to pay any claims made on their behalf during the second and third months of the grace period.

Redetermination, Re-enrollment, and Changes in Circumstances

Helping Consumers Enroll in Coverage
Redetermination, Re-enrollment, and Changes in Circumstances

Consumers who are already enrolled in a QHP through a Federally-facilitated Marketplace (FFM) generally don't need to complete a new application for the following coverage year. Remember to tell consumers they're required to report changes that affect their eligibility for a QHP, as well as any APTC or CSRs they receive, 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.

Select each number to learn more.

1 2 3 4 5

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're required to report changes that affect their eligibility for a QHP, as well as any APTC or CSRs they receive, 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 FFM sends a notice to all current enrollees to encourage them to return to update their application during Open Enrollment, called the Marketplace Open Enrollment Notice (MOEN). This notice also informs certain enrollees when they're at risk of losing financial assistance if they don't update their information.

Current enrollees will also receive a notice from their issuer which states whether the enrollee's plan will be available for the next plan year and any changes to the plan. If there's no plan available from the same issuer, the FFM will match the enrollee to a plan offered by a different issuer and send a notice to the enrollee that this will be their coverage for the next plan year if they don't return to the Marketplace to actively choose one.

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 a consumer's household is no longer eligible for financial assistance, 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.

Changes in circumstance may also affect consumers' eligibility and enrollment (e.g., a move or a change in access to employer-sponsored health coverage). Consumers should report changes to the FFMs within 30 days of the change occurring.

Before Open Enrollment the FFMs 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 whether they’re eligible to receive APTC and CSRs. Any changes in coverage or eligibility as a result of the redetermination process are 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 without APTC and CSRs for the following year if the coverage is available, unless the FFM determines they’re no longer eligible to purchase a QHP.

Special Enrollment Periods

Helping Consumers Enroll in Coverage
Special Enrollment Periods

Some changes in circumstances are "qualifying life events," meaning consumers are eligible for an SEP to newly enroll in or change QHPs outside of the annual OEP as well as during Open Enrollment for an earlier coverage start date. A qualifying life event can occur at any time during the year. Consumers who are enrolled in Marketplace coverage must report changes to eligibility information as soon as possible, generally within 30 days of the change. If consumers qualify for an SEP, they generally have 60 days from the date of their qualifying event to newly select or change their Marketplace coverage. When consumers report changes on a Marketplace application, the Marketplace redetermines consumers' eligibility and notifies them of:

- Any changes in eligibility for Marketplace coverage or help paying for coverage.
- Whether they are eligible for an SEP.
- Whether they are eligible for coverage through Medicaid or Children's Health Insurance Program (CHIP).
- When their coverage will start.
- Their next steps.

SEPs typically last 60 days and can provide an opportunity for consumers to enroll in coverage outside of the individual market OEP. ***Note:** Effective January 1, 2024 (or earlier, if elected by a Marketplace), Marketplaces must provide consumers 90 days after they lose Medicaid or CHIP coverage that counts as minimum essential coverage (MEC) to enroll in a Marketplace plan using an SEP. State Exchanges may allow more time, up to the number of days provided for the applicable Medicaid or CHIP reconsideration period.

Select each term below to learn more about SEPs.

Qualifying Life Events
SEP Eligibility Verification
Plan Category Limitations
Prior Coverage Requirements
Coverage Effective Dates
New SEPs

If consumers don't qualify for an SEP and the annual OEP for the current coverage year has already passed, they must wait for the next OEP to enroll in or change QHPs. Remember, consumers do NOT qualify for an SEP if their coverage is terminated because they didn't pay their premiums.

- For more information on SEPs, review the SEP Overview for Assisters and visit HealthCare.gov/coverage-outside-open-enrollment/special-enrollment-period.
- For more information on how to help consumers report changes to a Marketplace application, refer to SOP 13 – Update a Federally-facilitated Marketplace Account.

Some changes in circumstances are "qualifying life events," meaning consumers are eligible for an SEP to newly enroll in or change QHPs outside of the annual OEP as well as during Open Enrollment for an earlier coverage start date. A qualifying life event can occur at any time during the year. Consumers who are enrolled in Marketplace coverage must report changes to eligibility information as soon as possible, generally within 30 days of the change. If consumers qualify for an SEP, they generally have 60 days from the date of their qualifying event to newly select or change their Marketplace coverage. When consumers report changes on a Marketplace application, the Marketplace redetermines consumers’ eligibility and notifies them of:

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Learn more about SEPs.

Qualifying Life Events

Consumers may visit HealthCare.gov/screener and answer a few questions to find out if they may qualify for an SEP to enroll in or change plans. There are six categories of SEP qualifying events:

- Loss of qualifying health coverage
- Change in household size
- Change in primary place of living
- Change in eligibility for Marketplace coverage or help paying for coverage
- Enrollment or plan error
- Other qualifying changes

For a full list of qualifying events, visit HealthCare.gov/coverage-outside-open-enrollment/special-enrollment-period.

SEP Eligibility Verification

- Consumers who are newly enrolling in Marketplace coverage during an SEP due to loss of qualifying coverage may be required, at the discretion of the Exchanges using the Federal platform, to verify their eligibility by submitting supporting documents showing their loss of coverage.
- Consumers generally have 60 days before or 60 days after the date of their coverage loss to enroll, change plans, or add new dependents to their current plan. The submission of required documents to verify their SEP eligibility also takes place during the 60-day window.
- Once their eligibility is verified, the FFM can transfer their information to an issuer if they selected a QHP.
- For all other SEP types, consumers don't need to submit documents before they can start using their new coverage.

For more information on SEP eligibility verification and to find a list of documents consumers can provide to verify their SEP eligibility, visit HealthCare.gov/coverage-outside-open-enrollment/confirm-special-enrollment-period.

Plan Category Limitations

- Existing Marketplace enrollees and their dependents generally will only be able to choose a plan from their current plan category or must wait until the next OEP to change to a plan in a different category.
- Some circumstances allow existing enrollees and their dependents to change to a different plan category. For example, enrollees who become newly eligible for CSRs and aren't already enrolled in a Silver plan can change to a Silver plan so they can use their CSRs.
- Consumers newly enrolling in Marketplace coverage aren't limited in the plans they can choose to enroll in.

For more information on plan category limitations, visit HealthCare.gov/coverage-outside-open-enrollment/changing-plans.

Prior Coverage Requirements

Some SEPs are available to anyone who's eligible for coverage and experienced a qualifying life event.

Some SEPs are only for:

- Consumers who had prior coverage for one or more days in the 60 days preceding their SEP qualifying life event (e.g., marriage, change in primary place of living).
- Consumers who already have Marketplace coverage (e.g., change in household income or eligibility for help paying for coverage).

Prior coverage requirements do not apply to members of a federally recognized Tribe or Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders.

The Marketplace will provide details and instructions on whether and how consumers need to prove prior coverage in their eligibility notice.

Coverage Effective Dates

- The effective date of coverage for most SEPs is the first day of the month following plan selection (for consumers who will lose coverage in the future, Marketplace coverage starts the first day of the month following their last day of prior coverage).
- For some SEPs, including but not limited to gaining or becoming a dependent through birth, adoption, placement for adoption, placement in foster care, or due to a child support or other court order, coverage is effective retroactive to the date of the qualifying event, such as the date of birth. 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 date of plan selection.
- The Department of Health and Human Services (HHS) 2024 Notice of Benefit and Payment Parameters final rule includes a provision that, for consumers who qualify for the loss of qualifying coverage SEP and who select a plan between 60 days before the loss of coverage and the last day of the month preceding

the loss of coverage, a Marketplace has the option to provide a coverage effective date of the first of the month in which the loss of coverage occurs, instead of the first of the month after the loss of coverage occurs, as is currently required. We will notify assisters when this is available in the FFM, likely in 2024.

Policy Updates

- Due to the end of the Medicaid/CHIP continuous enrollment period ("unwinding")a temporary Unwinding SEP is available to consumers who lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024. Consumers can access this SEP by submitting a new application or updating an existing application between March 31, 2023 and July 31, 2024 and attesting to a last date of Medicaid or CHIP coverage within the same time period. Consumers will have 60 days from the date they submit their application to select a Marketplace plan with coverage that starts the first day of the month after they select a plan.
- Beginning Plan Year (PY) 2023, for consumers who qualify for the loss of qualifying coverage SEP and who select a plan within the 60 days prior to losing coverage, their coverage effective date is the first day of the month after loss of coverage or, at the option of the Exchange, if a plan is chosen before the last day of the month preceding the loss of coverage, the first of the month in which the loss of coverage occurs.
- The SEP available to consumers who have an estimated annual household income at or below 150 percent of the federal poverty level (FPL) in their state and are APTC-eligible allowing them to enroll in Marketplace coverage or change their Marketplace coverage once per month, if they so choose, continues to be available under the Inflation Reduction Act of 2022.
- Consumers who are enrolled in employer-sponsored coverage (ESC) may qualify for an SEP if they are determined newly eligible for APTC because their ESC no longer offers affordable coverage, and they drop their employer coverage. This applies to consumers whose coverage is no longer affordable due to the change in IRS rules that went into effect on January 1, 2023 ("the family glitch"). Consumers can access this SEP by attesting "Yes" to the application question that asks about losing qualifying health coverage and providing the date they can end their employer coverage or the date they lost it in the past.

If consumers don't qualify for an SEP and the annual OEP for the current coverage year has already passed, they must wait for the next OEP to enroll in or change QHPs. Remember, consumers do NOT qualify for an SEP if their coverage is terminated because they didn't pay their premiums.

- For more information on SEPs, review the SEP Overview for Assisters and visit HealthCare.gov/coverage-outside-open-enrollment/special-enrollment-period.
- For more information on how to help consumers report changes to a Marketplace application, refer to SOP 13 – Update a Federally-facilitated Marketplace Account.

Loss of Employer-sponsored Coverage and COBRA Eligibility

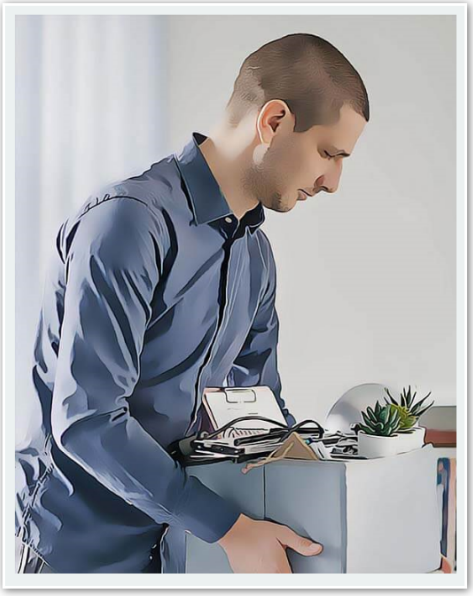
Helping Consumers Enroll in Coverage
Loss of Employer-sponsored Coverage and COBRA Eligibility

When consumers lose ESC, their former employer may offer Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage. Consumers who leave a job and are eligible for COBRA continuation coverage must be given an election period of at least 60 days to choose whether or not to elect COBRA continuation coverage (starting on the date they're furnished the election notice or the date they would lose coverage, whichever is later).

- Consumers eligible to enroll in COBRA can generally choose to enroll in a QHP through an FFM instead. Remember, consumers who lose ESC qualify for a 60-day SEP and may be eligible for APTC and CSRs that wouldn't be available to them if they enrolled in COBRA continuation coverage.
- Consumers may also be eligible for a 60-day SEP to enroll in a QHP through an FFM if their former employer ceases all employer contributions for COBRA continuation coverage.
- Consumers who choose to end their COBRA early will have to wait until the next OEP, their COBRA runs out, or qualify for another SEP to enroll in Marketplace coverage.
- Consumers who lose ESC may also be eligible for Medicaid/CHIP.
- COBRA continuation coverage is typically more expensive than when the consumer was employed, and may increase up to 102% of the cost of the premium. Employers aren't required to pay any portion of the premiums.

Typically, consumers have until the later of 60 days after losing eligibility for their employer's group health coverage, or 60 days after receiving their COBRA election notice, to elect COBRA continuation coverage. Due to the COVID-19 National Emergency, these deadlines were temporarily extended. Instead of employees being required to elect COBRA within 60 days of losing group health coverage or 60 days after receiving their COBRA election notice, whichever is later, plans are required to "disregard" the period between March 1, 2020, and July 10, 2023. Therefore, employees who experienced a COBRA qualifying event between March 1, 2020, and July 10, 2023, have until one year from their original COBRA election deadline, or 60 days after July 10, 2023 (September 8, 2023), whichever was earlier, to elect COBRA continuation coverage.

For more information about COBRA continuation coverage and the FFMs, visit HealthCare.gov/unemployed/cobra-coverage.



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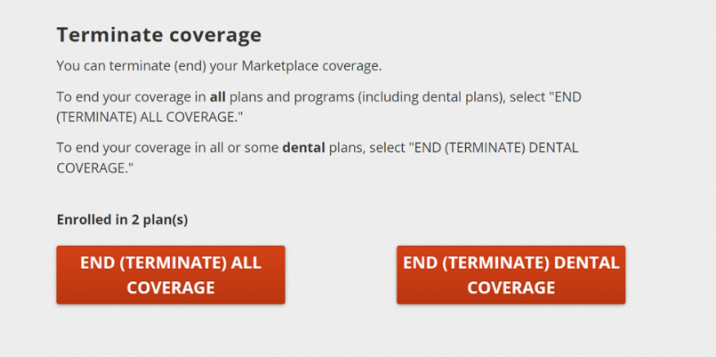
For more information about COBRA continuation coverage and the FFMs, visit HealthCare.gov/unemployed/cobra-coverage.

Termination of Coverage

Helping Consumers Enroll in Coverage
Termination of Coverage

Consumers who wish to end coverage through an FFM can generally terminate it at any time. They don't need to wait for an individual market OEP or qualify for an SEP. Enrollee-initiated terminations are effective on the date an enrollee requests to terminate coverage or on another prospective date the enrollee selects.

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. Consumers will receive a termination notice from their health plan issuer. Consumers enrolled in a stand-alone dental plan (SADP) can terminate this coverage while remaining enrolled in their Marketplace health plan.



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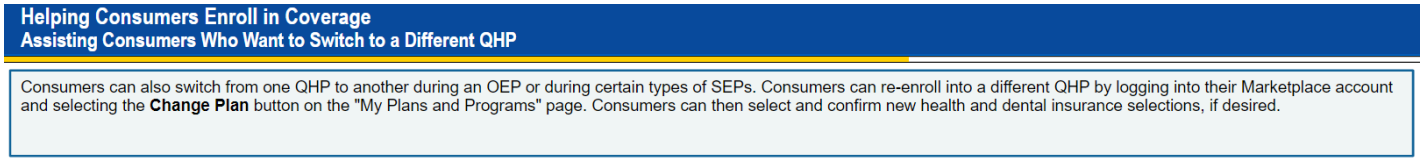
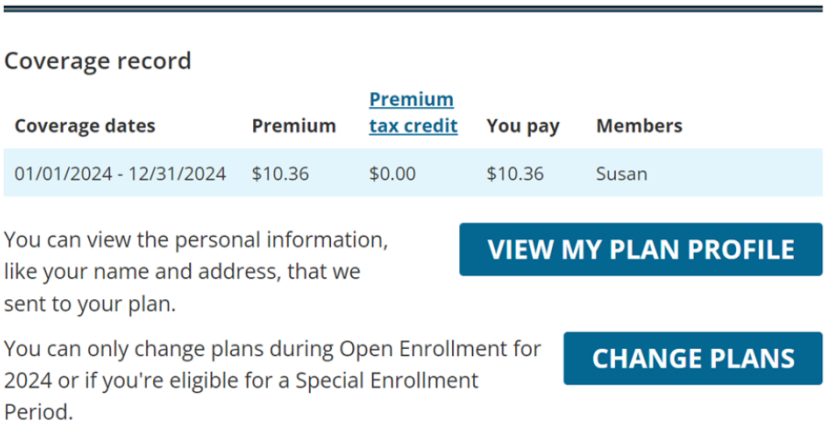
Assisting Consumers Who Want to Switch to a Different QHP





Consumers can also switch from one QHP to another during an OEP or during certain types of SEPs. Consumers can re-enroll into a different QHP 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 new health and dental insurance selections, if desired.

Key Points

Helping Consumers Enroll in Coverage
Key Points

- Eligible consumers can set the amount of premium tax credit 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 they received during the year and the actual premium tax credit amount they qualified for based on their final income and household size.
- When helping consumers with plan comparison, show them all 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.

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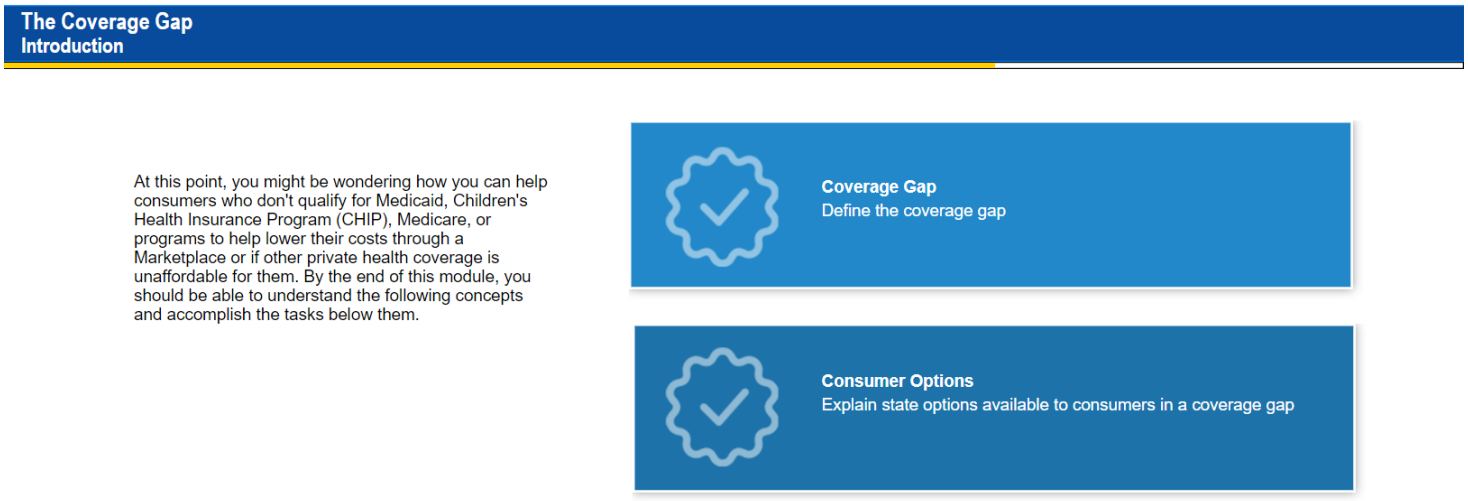
The Coverage Gap

Introduction



At this point, you might be wondering how you can help consumers who don’t qualify for Medicaid, CHIP, Medicare, or programs to help lower their costs through a Marketplace or if other private health coverage is unaffordable for them. By the end of this module, you should be able to understand the following concepts and accomplish the tasks below them.

Coverage Gap

Define the coverage gap

Consumer Options

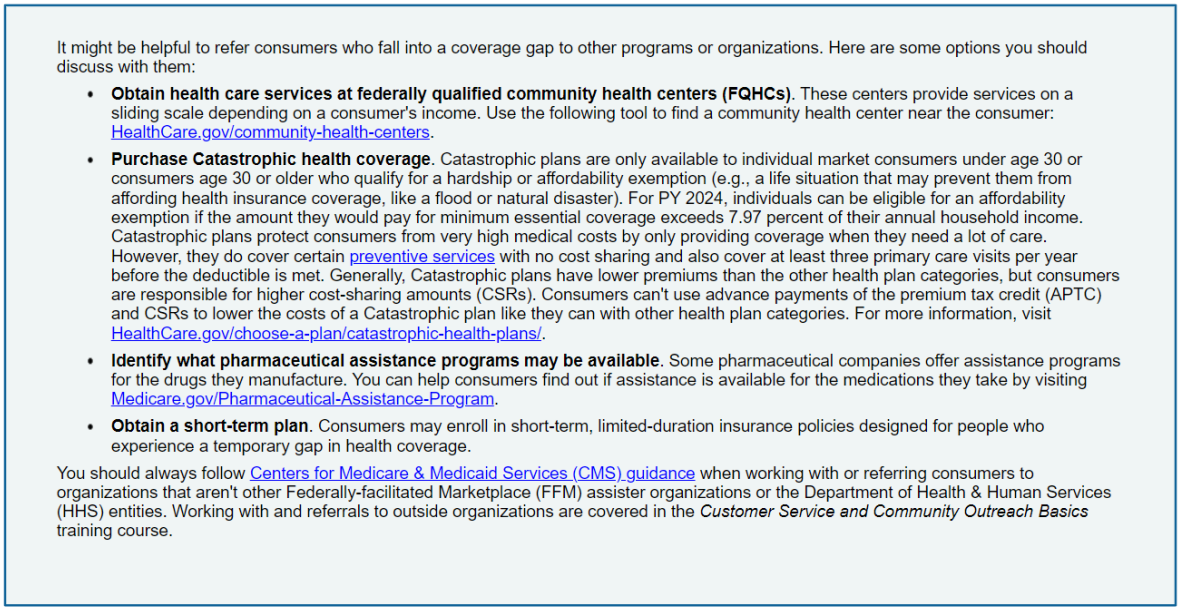
Explain state options available to consumers in a coverage gap

What is a Coverage Gap?

The Coverage Gap
What is a Coverage Gap?

In states that haven’t expanded Medicaid to low-income adults, many adults with incomes below 100 percent of the FPL fall into a coverage gap. Their incomes are too high to get Medicaid or other public health coverage under their state's current rules and are too low to qualify for help paying for coverage in a Marketplace. Some consumers who may fall into the coverage gap include jobless parents, working parents, and non-disabled, non-elderly childless adults.

Options for Consumers Who Fall into a Coverage Gap



It might be helpful to refer consumers who fall into a coverage gap to other programs or organizations. Here are some options you should discuss with them:

- **Obtain health care services at federally qualified community health centers (FQHCs)**. These centers provide services on a sliding scale depending on a consumer's income. Use the following tool to find a community health center near the consumer: HealthCare.gov/community-health-centers.
- **Purchase Catastrophic health coverage**. Catastrophic plans are only available to individual market consumers under age 30 or consumers age 30 or older who qualify for a hardship or affordability exemption (e.g., a life situation that may prevent them from affording health insurance coverage, like a flood or natural disaster). For PY 2024, individuals can be eligible for an affordability exemption if the amount they would pay for minimum essential coverage exceeds 7.97 percent of their annual household income. Catastrophic plans protect consumers from very high medical costs by only providing coverage when they need a lot of care. However, they do cover certain preventive services with no cost sharing and also cover at least three primary care visits per year before the deductible is met. Generally, Catastrophic plans have lower premiums than the other health plan categories, but consumers are responsible for higher cost-sharing amounts (CSRs). Consumers can't use advance payments of the premium tax credit (APTC) and CSRs to lower the costs of a Catastrophic plan like they can with other health plan categories. For more information, visit HealthCare.gov/choose-a-plan/catastrophic-health-plans/.
- **Identify what pharmaceutical assistance programs may be available**. Some pharmaceutical companies offer assistance programs for the drugs they manufacture. You can help consumers find out if assistance is available for the medications they take by visiting Medicare.gov/Pharmaceutical-Assistance-Program.
- **Obtain a short-term plan**. Consumers may enroll in short-term, limited-duration insurance policies designed for people who experience a temporary gap in health coverage.

You should always follow Centers for Medicare & Medicaid Services (CMS) guidance when working with or referring consumers to organizations that aren't other Federally-facilitated Marketplace (FFM) assister organizations or the Department of Health & Human Services (HHS) entities. Working with and referrals to outside organizations are covered in the *Customer Service and Community Outreach Basics* training course.

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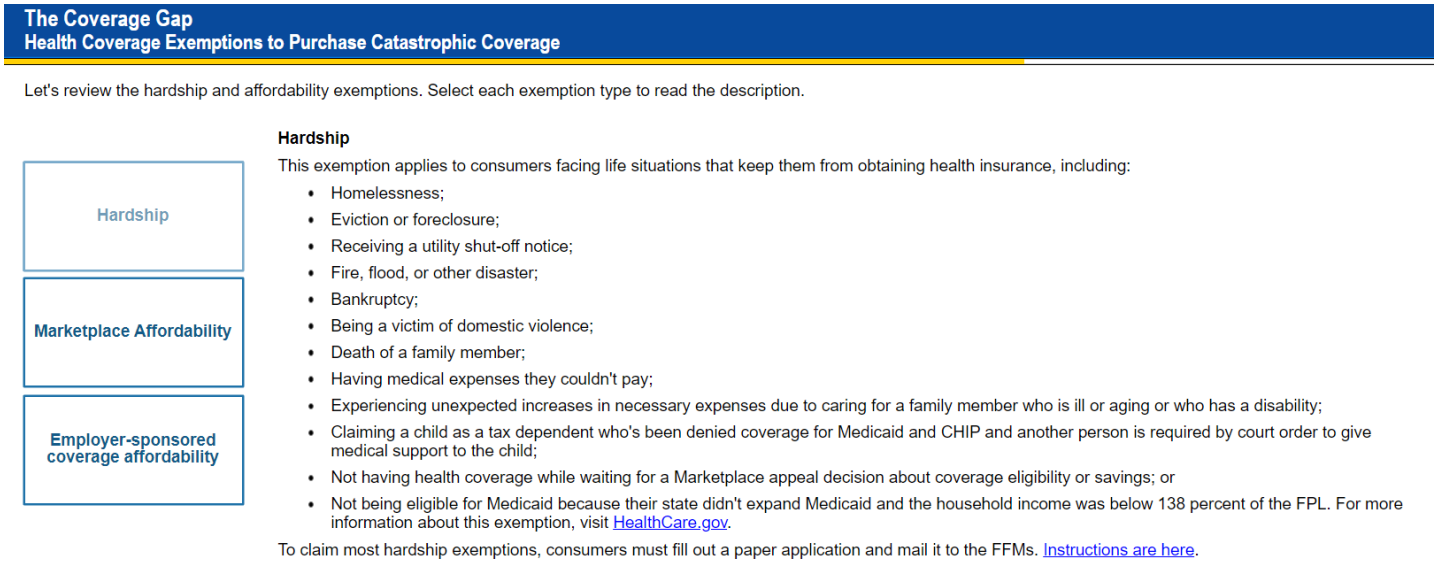
Identify what pharmaceutical assistance programs may be available. Some pharmaceutical companies offer assistance programs for the drugs they manufacture. You can help consumers find out if assistance is available for the medications they take by visiting Medicare.gov/Pharmaceutical-Assistance-Program.

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

You should always follow CMS guidance when working with or referring consumers to organizations that aren’t other FFM assister organizations or HHS entities. Working with and referrals to outside organizations are covered in the *Customer Service and Community Outreach Basics* training course.

Health Coverage Exemptions to Purchase Catastrophic Coverage



Let's review the hardship and affordability exemptions. Select each exemption type to read the description.

Hardship

This exemption applies to consumers facing life situations that keep them from obtaining health insurance, including:

- Homelessness;
- Eviction or foreclosure;
- Receiving a utility shut-off notice;
- Fire, flood, or other disaster;
- Bankruptcy;
- Being a victim of domestic violence;
- Death of a family member;
- Having medical expenses they couldn't pay;
- Experiencing unexpected increases in necessary expenses due to caring for a family member who is ill or aging or who has a disability;
- Claiming a child as a tax dependent who's been denied coverage for Medicaid and CHIP and another person is required by court order to give medical support to the child;
- Not having health coverage while waiting for a Marketplace appeal decision about coverage eligibility or savings; or
- Not being eligible for Medicaid because their state didn’t expand Medicaid and the household income was below 138 percent of the FPL. For more information about this exemption, visit HealthCare.gov.

To claim most hardship exemptions, consumers must fill out a paper application and mail it to the FFMs. Instructions are here.

Marketplace Affordability

Consumers age 30 or over who wish to enroll in Catastrophic coverage apply for this exemption through the Marketplace based on their projected annual household income at the beginning of a plan year. They qualify for the exemption if the lowest-price Bronze-level plan available through a Marketplace would cost more than 7.97

percent (2024) of the consumer's projected household income.

You can find affordability exemption application information here.

Employer-sponsored coverage affordability

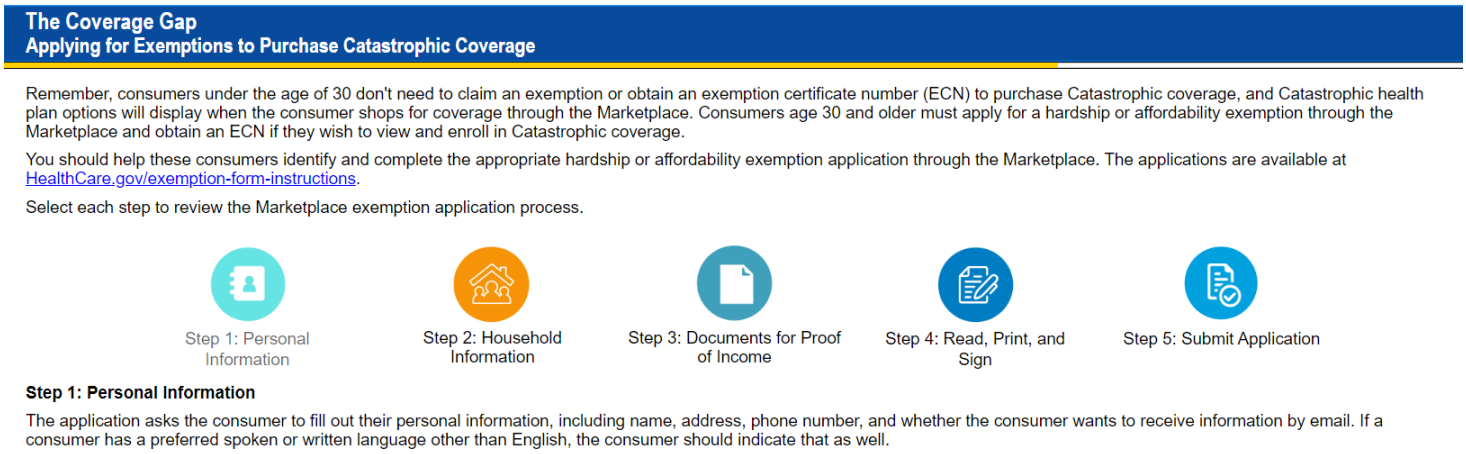
Employer-sponsored health insurance is considered unaffordable in different ways depending on how the coverage is offered:

- For an employee: If the annual premium for the lowest-cost self-only plan is more than 7.97 percent (2024) of their annual household income.
- For the employee's spouse and dependents: If the annual premium for the lowest-cost family plan is more than 7.97 percent (2024) of their annual household income

Notes:

- It's possible that an employee won't be eligible for this exemption because the self-only plan available to them is affordable. But other members of the household could be eligible for this exemption if family coverage offered to them is unaffordable.
- If the lowest-price self-only plan an employer offers costs more than 9.12 percent (2023) of an employee's total household income, the employee may be eligible for a premium tax credit if they buy a Marketplace insurance plan.
- If the lowest-price family plan (an employer plan that would cover all members of the tax household) an employer offers costs more than 9.12 percent (2023) of an employee’s total household income, the family members may be eligible for a premium tax credit if they buy a Marketplace insurance plan.

Applying for Exemptions through the Marketplace to Purchase Catastrophic Coverage



Remember, consumers under the age of 30 don’t need to claim an exemption or obtain an exemption certificate number (ECN) to purchase Catastrophic coverage, and Catastrophic health plan options will display when the consumer shops for coverage through the Marketplace. Consumers age 30 and older must apply for a hardship or affordability exemption through the Marketplace and obtain an ECN if they wish to view and enroll in Catastrophic coverage.

You should help these consumers identify and complete the appropriate hardship or affordability exemption application through the Marketplace. The applications are available at HealthCare.gov/exemption-form-instructions.

Review the Marketplace exemption application process.

Step 1: Personal Information

The application asks the consumer to fill out their personal information, including name, address, phone number, and whether the consumer wants to receive information by email. If a consumer has a preferred spoken or written language other than English, the consumer should indicate that as well.

Step 2: Household Information

This section asks the consumer which household members they would like to include on the application. Consumers should provide demographic information for each household member, including income, any offers of employer-sponsored coverage, the type of hardship they're applying for, and dates of the hardship.

Key Tip: Consumers may need to claim all members of their tax household on an exemption application for their household to be considered for an exemption.

Step 3: Documents for Proof of Income

To claim an affordability exemption, consumers must provide "proof of income" documents, like a recent pay stub and/or a letter from the consumer's employer verifying the consumer’s income. Consumers may need to submit different documents depending on the type of exemption they're applying for.

Even if a consumer doesn't have all the required documents, you can encourage the consumer to start filling out the exemption application and identifying the documents they will need to gather and submit with the application.

Step 4: Read, Print, 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. Consumers must mail all exemption applications to the Marketplaces with copies of their supporting documents to following address:

Health Insurance Marketplace®

Attn: Exemption Processing 465 Industrial Blvd.

London, KY 40741

Obtaining an ECN to Purchase Catastrophic Coverage

The Coverage Gap
Obtaining an ECN to Purchase Catastrophic Coverage

When consumers submit Marketplace exemption applications, the Marketplaces review them and determine their eligibility for an exemption. Response times may vary depending on:

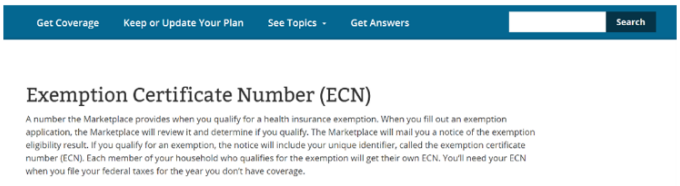
- How complicated a request is,
- How complete an application is, or
- Whether a consumer needs to submit additional supporting documents after applying.

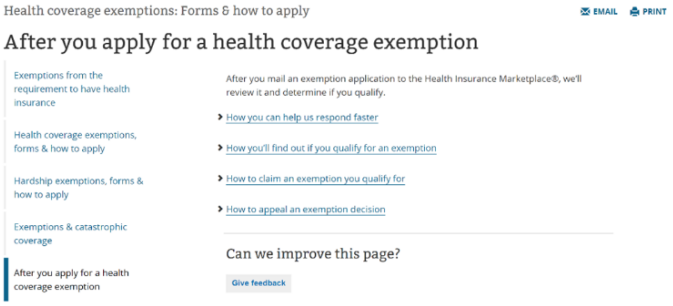
Depending on their communication preferences, consumers who qualify for exemptions through an FFM receive exemption notices by mail or email. Exemption notices include a six- or seven-digit ECN in the "Eligibility Results" column. Consumers can also find this number online in their Marketplace account profile.

Additional Information:

If multiple individuals in a household qualify for exemptions granted by a Marketplace, each will receive a separate ECN.

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 they need to follow up later.





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- How complicated a request is,
- How complete an application is, or
- Whether a consumer needs to submit additional supporting documents after applying.

Depending on their communication preferences, consumers who qualify for exemptions through an FFM receive exemption notices by mail or email. Exemption notices include a six- or seven-digit ECN in the "Eligibility Results" column. Consumers can also find this number online in their Marketplace account profile.

Additional Information:

If multiple individuals in a household qualify for exemptions granted by a Marketplace, each will receive a separate ECN.

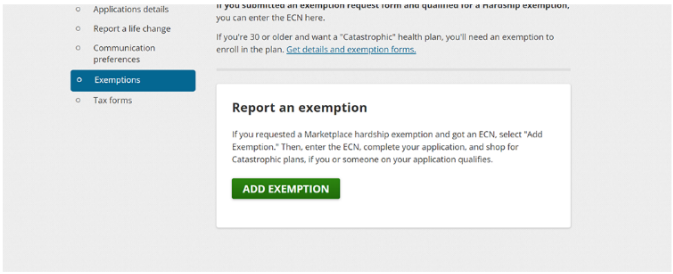
Remind consumers to keep their ECNs and approval notices in a safe place. Consumers should also keep a copy of their submitted exemption applications and supporting documents in case they need to follow up later.

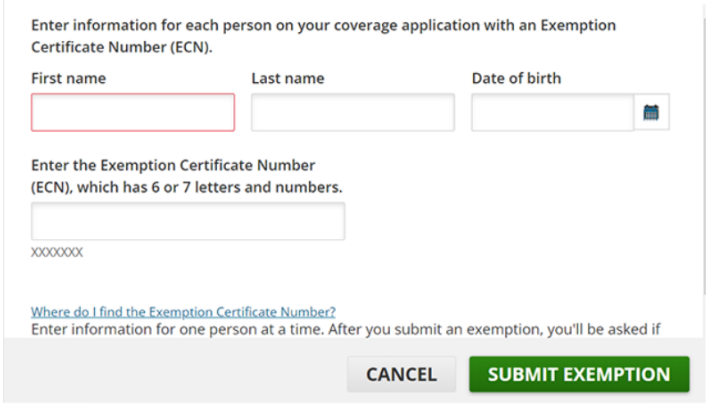
Providing ECNs When Purchasing Catastrophic Coverage

The Coverage Gap
Providing ECNs When Purchasing Catastrophic Coverage

To enroll in a Catastrophic plan, consumers age 30 and above should log into their Marketplace account and select **Exemption** at the left of the "Application Status" page. They must enter an ECN for each person in their household who qualifies for an exemption on this page so they can proceed with enrolling in a Catastrophic plan.

Visit HealthCare.gov/choose-a-plan/catastrophic-health-plans for more information on Catastrophic plans.





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Visit HealthCare.gov/choose-a-plan/catastrophic-health-plans for more information on Catastrophic plans.

Tips for Helping Consumers Apply for Exemptions

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 exemption application.
- Make sure consumers who seek exemptions on behalf of other people are designated authorized representatives. Otherwise, they must be 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 the Marketplaces can't process exemption applications until they receive consumers' supporting documents.
- 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 ECNs (if an exemption was granted).
- Make sure you return any hard copies of consumers' records when you assist them. 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.

Tips for Helping Consumers Apply for Exemptions

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- Make sure you return any hard copies of consumers' records when you assist them. 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.

Knowledge Check

The Coverage Gap
Knowledge Check

Consumers age ____ and above who wish to purchase Catastrophic coverage must apply for a _____ or _____ exemption through the Marketplace. Select the correct answer and then select **Check Your Answer**.

- A. 26; Loss of coverage or hardship
- B. 26; Hardship or affordability
- C. 30; Loss of coverage or hardship
- D. 30; Hardship or affordability

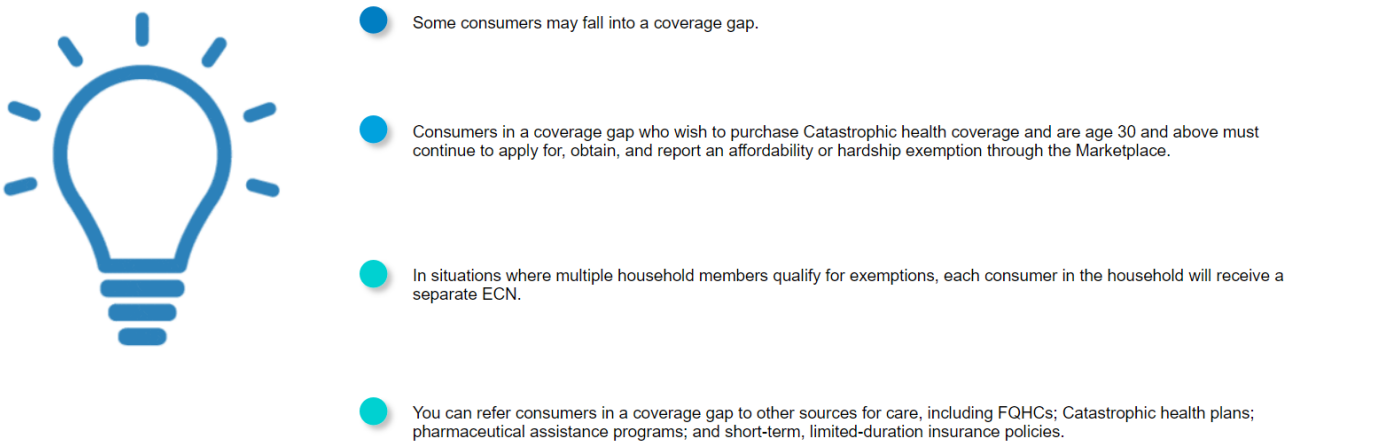
Check Your Answer

Correct!
Consumers age 30 and above who wish to purchase Catastrophic coverage must apply for a hardship or affordability exemption through the Marketplace. Consumers under age 30 don't need an exemption to purchase Catastrophic coverage.

Fill in the blanks: Consumers age **BLANK** and above who wish to purchase Catastrophic coverage must apply for a **BLANK** or **BLANK** exemption through the Marketplace.

Answer: Consumers age 30 and above who wish to purchase Catastrophic coverage must apply for a hardship or affordability exemption through the Marketplace. Consumers under age 30 don’t need an exemption to purchase Catastrophic coverage.

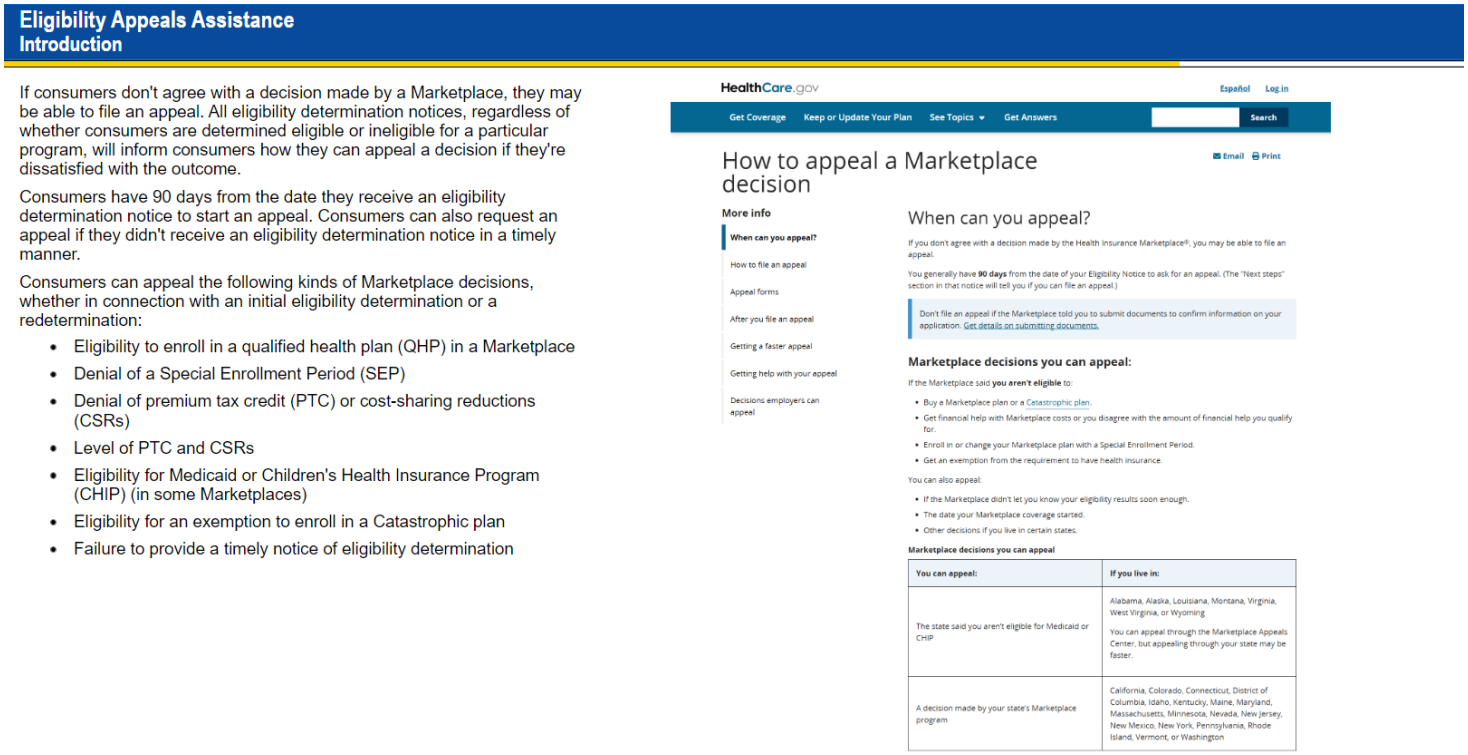
Key Points



- Some consumers may fall into a coverage gap.
- Consumers in a coverage gap who wish to purchase Catastrophic health coverage and are age 30 and above must continue to apply for, obtain, and report an affordability or hardship exemption through the Marketplace.
- In situations where multiple household members qualify for exemptions, each consumer in the household will receive a separate ECN.
- You can refer consumers in a coverage gap to other sources for care, including FQHCs; Catastrophic health plans; pharmaceutical assistance programs; and short-term, limited-duration insurance policies.

Eligibility Appeals Assistance

Introduction



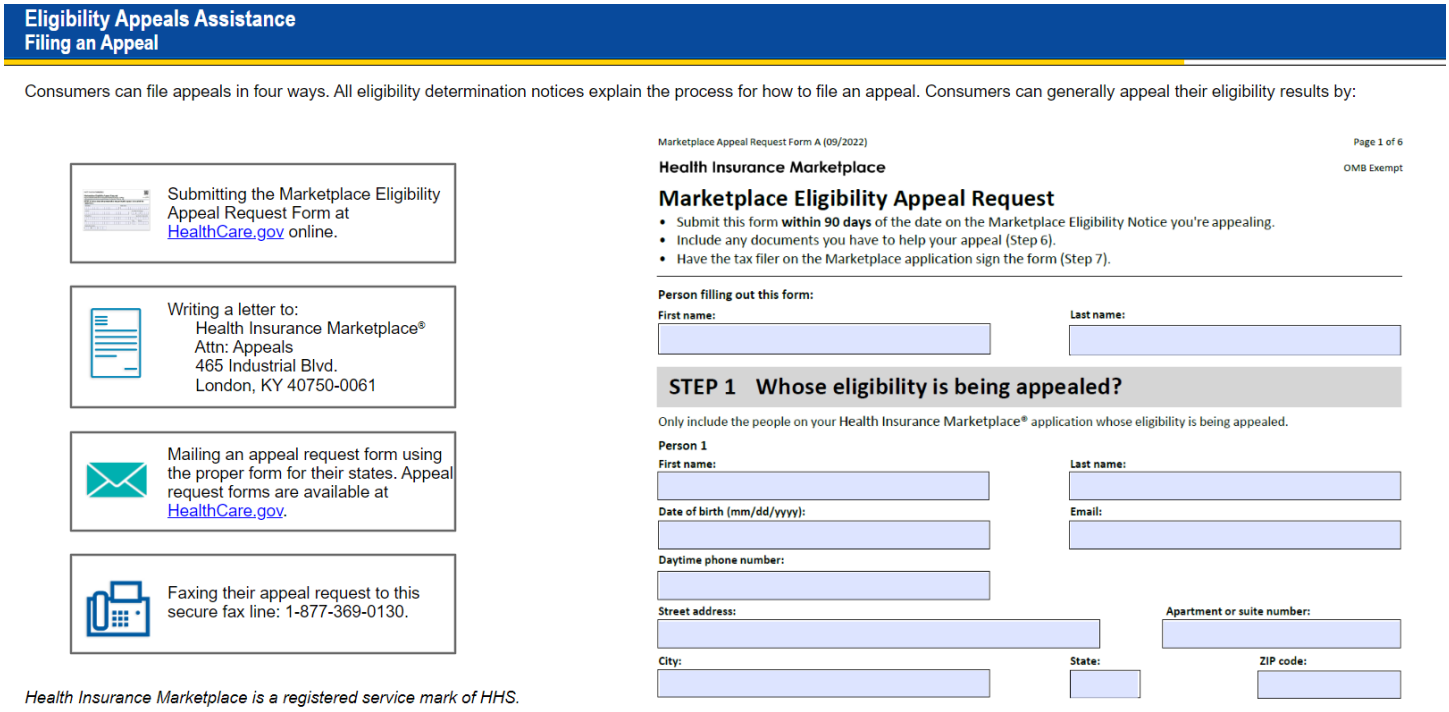
If consumers don't agree with a decision made by a Marketplace, they may be able to file an appeal. All eligibility determination notices, regardless of whether consumers are determined eligible or ineligible for a particular program, will inform consumers how they can appeal a decision if they're dissatisfied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

Consumers have 90 days from the date they receive an eligibility determination notice to start an appeal. Consumers can also request an appeal if they didn't receive an 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 premium tax credit or CSRs
- Level of premium tax credit and CSRs
- Eligibility for Medicaid or CHIP (in some Marketplaces)
- Eligibility for an exemption to enroll in a Catastrophic plan
- Failure to provide a timely notice of eligibility determination

Filing an Appeal



Eligibility Appeals Assistance
Filing an Appeal

Consumers can file appeals in four ways. All eligibility determination notices explain the process for how to file an appeal. Consumers can generally appeal their eligibility results by:

Submitting the Marketplace Eligibility Appeal Request Form at HealthCare.gov online.

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. Appeal request forms are available at HealthCare.gov.

Faxing their appeal request to this secure fax line: 1-877-369-0130.

Health Insurance Marketplace is a registered service mark of HHS.

Marketplace Appeal Request Form A (09/2022) Page 1 of 6

Health Insurance Marketplace OMB Exempt

Marketplace Eligibility Appeal Request

- Submit this form **within 90 days** of the date on the Marketplace Eligibility Notice you're appealing.
- Include any documents you have to help your appeal (Step 6).
- Have the tax filer on the Marketplace application sign the form (Step 7).

Person filling out this form:

First name: Last name:

STEP 1 Whose eligibility is being appealed?

Only include the people on your Health Insurance Marketplace® application whose eligibility is being appealed.

Person 1

First name: Last name:

Date of birth (mm/dd/yyyy): Email:

Daytime phone number:

Street address: Apartment or suite number:

City: State: ZIP code:

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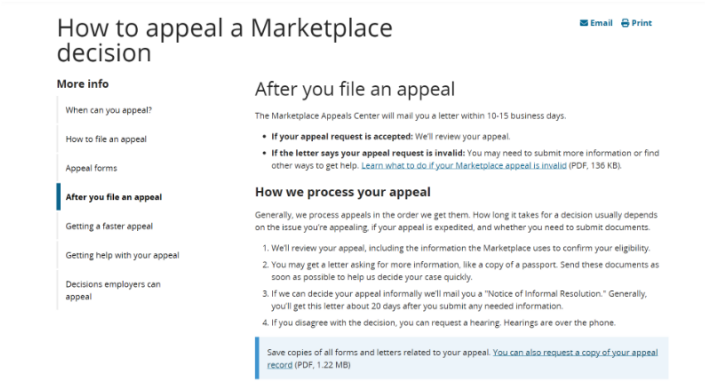
After Filing an Appeal

Eligibility Appeals Assistance
After Filing an Appeal



How to appeal a Marketplace decision

Email Print

More info

When can you appeal?

How to file an appeal

Appeal forms

After you file an appeal

Getting a faster appeal

Getting help with your appeal

Decisions employers can appeal

After you file an appeal

The Marketplace Appeals Center will mail you a letter within 10-15 business days.

- **If your appeal request is accepted:** We'll review your appeal.
- **If the letter says your appeal request is invalid:** You may need to submit more information or find other ways to get help. Learn what to do if your Marketplace appeal is invalid (PDF, 136 KB).

How we process your appeal

Generally, we process appeals in the order we get them. How long it takes for a decision usually depends on the issue you're appealing, if your appeal is expedited, and whether you need to submit documents.

1. We'll review your appeal, including the information the Marketplace uses to confirm your eligibility.
2. You may get a letter asking for more information, like a copy of a passport. Send these documents as soon as possible to help us decide your case quickly.
3. If we can decide your appeal informally we'll mail you a "Notice of Informal Resolution." Generally, you'll get this letter about 20 days after you submit any needed information.
4. If you disagree with the decision, you can request a hearing. Hearings are over the phone.

Save copies of all forms and letters related to your appeal. You can also request a copy of your appeal record (PDF, 1.22 MB)

After consumers file an appeal, they receive a letter that:

- Confirms their appeal request was received
- Provides a description of the appeals process
- Includes instructions for submitting additional material for consideration, if applicable

To check on the status of an appeal, consumers can call the Marketplace Appeals Center at 1-855-231-1751 (TTY 711). Consumers who need additional assistance with the appeals process may visit the Marketplace Appeals Center at HealthCare.gov/marketplace-appeals.

When helping consumers understand the process of filing Marketplace eligibility appeals, keep in mind that you shouldn't provide legal advice or become a consumer's legally authorized representative in your role as an assister.

Appeals Process Summary

Eligibility Appeals Assistance
Appeals Process Summary

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

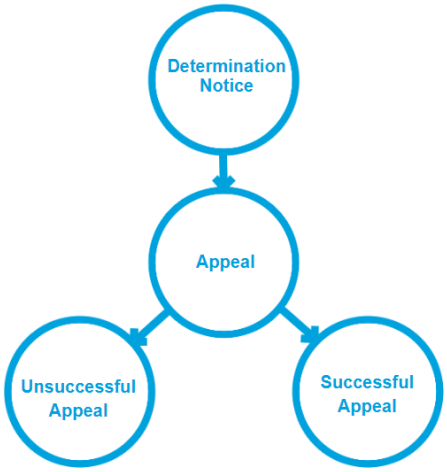
Select each step in the image for more information about the appeals process.

1. A consumer disagrees with an eligibility determination.
2. The consumer submits a complete appeal request.
3. An informal resolution is attempted.
4. The consumer decides whether or not to accept the informal resolution results.
   a. If the consumer accepts, the appeal is closed, and the decision is communicated through a notice.
   b. If the consumer doesn't accept, a formal hearing is scheduled and then conducted.
5. After the hearing, the appeal is closed, and the decision is communicated to the consumer through a notice.
6. If the consumer is dissatisfied with the appeal decision, the consumer can seek review in court to the extent it's available by law. Beginning January 1, 2024, consumers can request review by the Centers for Medicare & Medicaid Services (CMS) Administrator of the eligibility appeal decision prior to judicial review.

If a consumer didn't enroll in a QHP and the consumer's initial eligibility determination turned out to be incorrect, the consumer qualifies for an SEP to enroll in coverage through a Marketplace.

If an initial eligibility determination was correct, a consumer generally can't 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.



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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.

Medicaid/CHIP Determination States

Consumers in states that delegated authority to the Marketplace to make final modified adjusted gross income (MAGI)-based Medicaid and CHIP eligibility determinations may receive eligibility determination notices from the Marketplace that indicate they're eligible to enroll in Marketplace plans but not eligible to enroll in Medicaid or CHIP. If consumers believe they should have qualified for Medicaid or CHIP, they may wish to file an appeal. All Marketplace eligibility determination notices state that consumers who think there’s a mistake in their final eligibility notice can file an appeal.

Medicaid/CHIP Assessment States

Some states do not delegate authority to the Marketplaces to make final eligibility determinations for Medicaid and CHIP. In these states, the Marketplaces make a preliminary assessment as to whether consumers are

eligible for Medicaid or CHIP. If consumers in assessment states apply for help paying for coverage, they will receive a notice from the Marketplace that states whether they're eligible to enroll in a QHP and receive advance payments of the premium tax credit (APTC)/CSRs. The notice also includes an initial assessment from the Marketplace of their eligibility for MAGI-based Medicaid or CHIP. However, the state Medicaid or CHIP agency will provide final Medicaid or CHIP eligibility determination notices to consumers who the Marketplaces assess as eligible.

If consumers are determined ineligible by their state Medicaid or CHIP agency, they may wish to file an appeal, and they should follow the instructions in their eligibility determination notice from the state agency for filing an appeal with the state. Consumers in Medicaid assessment states can't file Medicaid or CHIP appeals with the Marketplace.

Appeal

Consumers in Medicaid assessment states should follow the instructions on their Medicaid or CHIP eligibility determination notice if they wish to appeal determinations indicating that they're not eligible for Medicaid or CHIP.

Unsuccessful Appeal

If the appeal process results in a decision that the initial eligibility determination was correct, that determination applies, and the consumer isn't eligible for Medicaid or CHIP. That concludes the administrative process, but the appeal decision explaining this outcome includes information about any available judicial reviews.

If individuals are unsuccessful in appealing their eligibility for Medicaid or CHIP coverage, they can still enroll in Marketplace insurance through an SEP, if eligible. Additionally, consumers who were originally determined eligible for APTC/CSRs through a Marketplace remain eligible for those programs. Remember, consumers can appeal their eligibility determinations for premium tax credits (PTCs) and CSRs as well.

Sometimes consumers may appeal because they think they should have been determined eligible for a larger PTC and don't want to pay the premium for coverage through a Marketplace until they get the larger PTC amount. If it turns out that the initial eligibility determination was correct, the consumer can't enroll in or change plans through the Marketplace if the original enrollment period in which they applied has ended.

Successful Appeal

If it turns out the initial eligibility determination was wrong and consumers didn't enroll in a plan, they will receive an SEP to enroll in Marketplace insurance.

Legal Advice and Appeals

Eligibility Appeals Assistance
Legal Advice and Appeals

Beginning with Navigator grants awarded in 2022, including non-competing continuation awards, Navigators are required to provide information on and assistance with understanding the process of filing Marketplace eligibility appeals; certified application counselors (CACs) in Federally-facilitated Marketplaces (FFMs) are permitted but not required to assist consumers with Marketplace appeals. However, if you don't provide appeals assistance, you should refer consumers to another individual who can.

In your role as an assister, remember that you shouldn't provide legal advice regarding appeals or any other matter. For example, the Marketplace appeal request form has an option for an expedited (faster) appeal. While you may help consumers understand the difference between an appeal and an expedited appeal, you shouldn't help a consumer decide which one is best suited to their circumstances. Consumers can decide to file requests for expedited 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.

You can tell consumers that they can have a friend, lawyer, or someone else help them with their appeal, but you can't provide legal advice within your capacity as an assister. You can also refer consumers to free and low-cost legal service providers in your community, including 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, always follow CMS guidance at Marketplace.cms.gov/technical-assistance-resources/assister-guidance-on-referrals-to-outside-organizations.pdf.

You can also tell consumers they can choose to have someone they trust (like a family member, friend, advocate, or attorney) act on their behalf for their appeal by giving them permission to be their authorized representative. To appoint a representative, they'll need to send a form or letter to the Marketplace Appeals Center — even if they already appointed an authorized representative for their Marketplace application. If they appoint an authorized representative, they'll be the main contact during their appeal.

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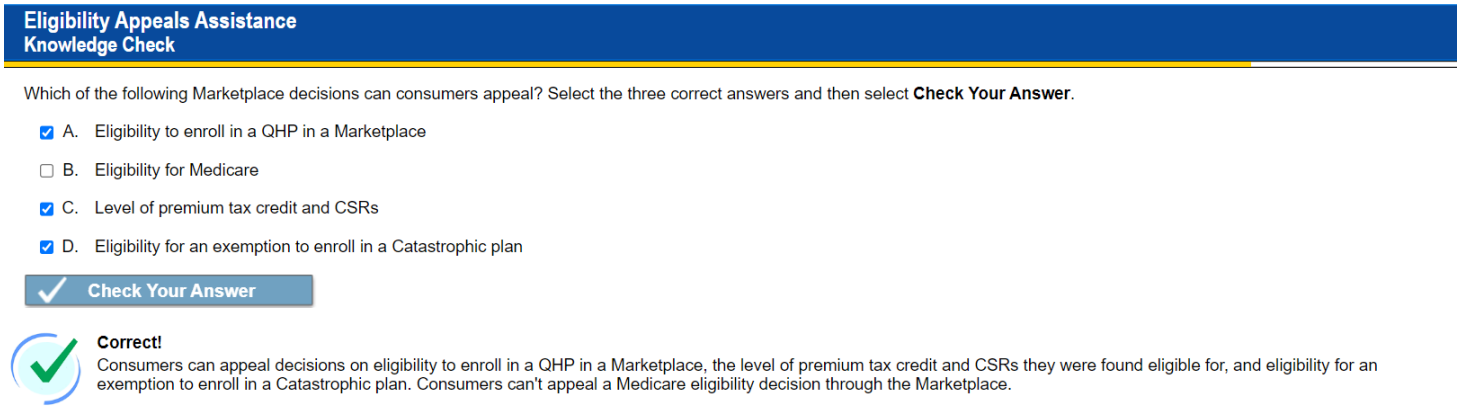
Knowledge Check



What are examples of Marketplace decisions consumers can appeal?

Answer: Consumers can appeal decisions on eligibility to enroll in a QHP in a Marketplace, the level of premium tax credit and CSRs they were found eligible for, and eligibility for an exemption to enroll in a Catastrophic plan. Consumers can’t appeal a Medicare eligibility decision through the Marketplace.

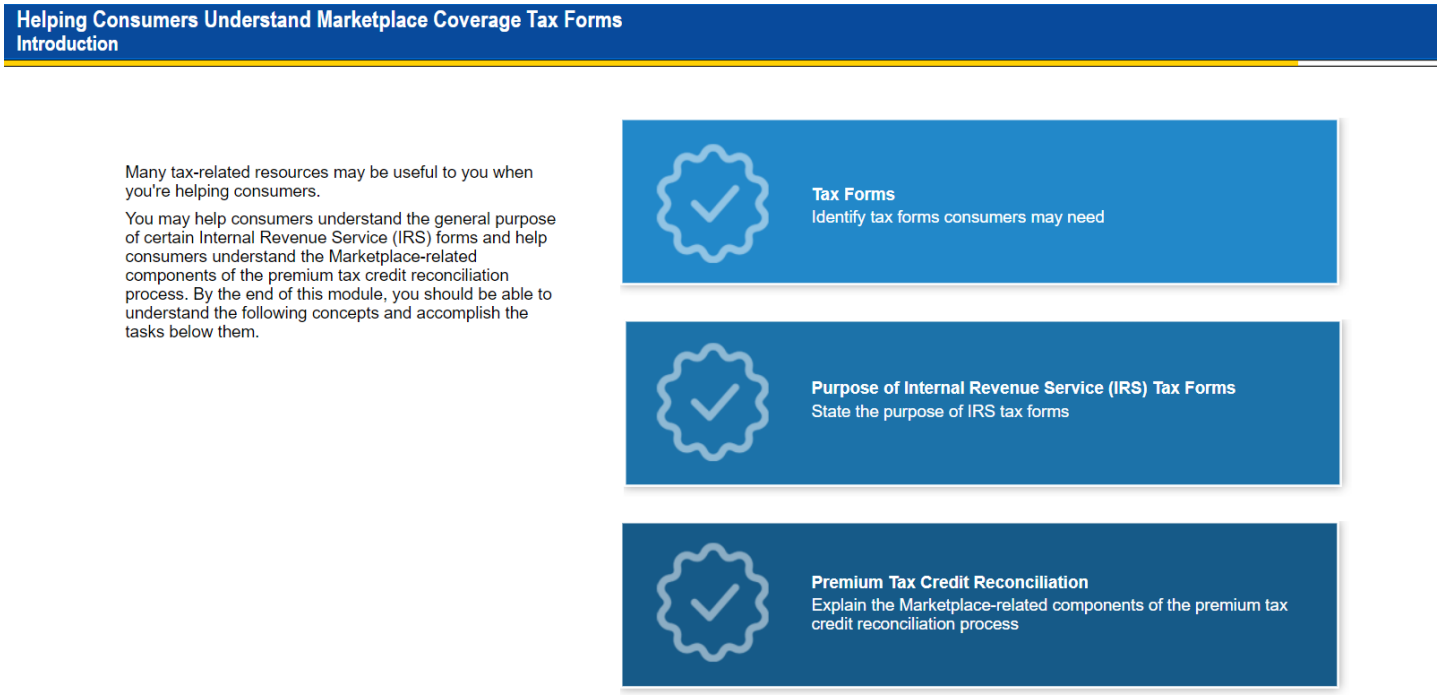
Key Points

Eligibility Appeals Assistance
Key Points

- If consumers don't agree with a decision made by a Marketplace, they may be able to file an appeal.
- Consumers may contact the Marketplace Appeals Center at 1-855-231-1751 (TTY 711) for assistance with filing an eligibility appeal.
- When you're assisting consumers, you should never provide tax or legal advice regarding exemptions, appeals, or any other matter.

Helping Consumers Understand Marketplace Coverage Tax Forms

Introduction



Many tax-related resources may be useful to you when you're helping consumers.

You may help consumers understand the general purpose of certain Internal Revenue Service (IRS) forms and help consumers understand the Marketplace-related components of the premium tax credit reconciliation process. By the end of this module, you should be able to understand the following concepts and accomplish the tasks below them.

Tax Forms

Identify tax forms consumers may need.

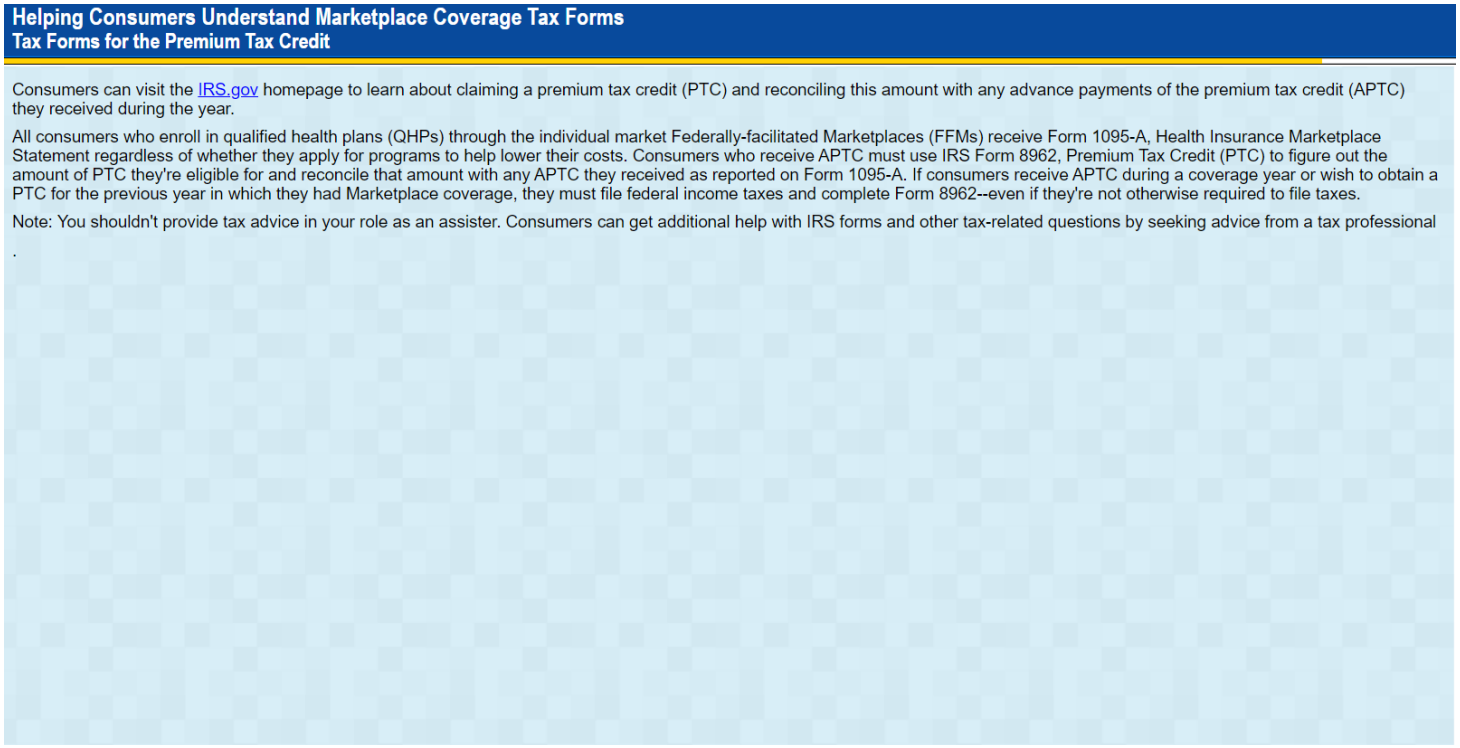
Purpose of IRS Tax Forms

State the purpose of IRS tax forms.

Premium Tax Credit Reconciliation

Explain the Marketplace-related components of the premium tax credit reconciliation process.

Tax Forms for the Premium Tax Credit



Consumers can visit the IRS.gov homepage to learn about claiming a PTC and reconciling this amount with any APTC they received during the year.

All consumers who enroll in QHPs through the individual market FFMs receive Form 1095-A, Health Insurance Marketplace Statement regardless of whether they apply for programs to help lower their costs. Consumers who receive APTC must use IRS Form 8962, Premium Tax Credit (PTC) to figure out the amount of PTC they’re eligible for and reconcile that amount with any APTC they received as reported on Form 1095-A. If consumers receive APTC during a coverage year or wish to obtain a PTC for the previous year in which they had Marketplace coverage, they must file federal income taxes and complete Form 8962--even if they’re not otherwise required to file taxes.

Note: You shouldn’t provide tax advice in your role as an assister. Consumers can get additional help with IRS forms and other tax-related questions by seeking advice from a tax professional.

IRS Form 1095-A

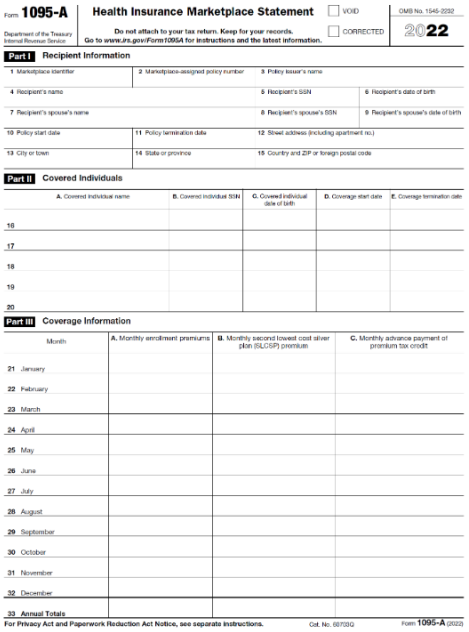
Helping Consumers Understand Marketplace Coverage Tax Forms
IRS Form 1095-A

Consumers who have enrolled in a QHP through an individual market FFM will receive Form 1095-A, Health Insurance Marketplace Statement from the Marketplaces by mail. The form will also be available online through their Marketplace account. If household members enroll in different policies during the coverage year, they will receive one 1095-A for each policy in a household. Consumers should use the information on their Form 1095-A to complete Form 8962, Premium Tax Credit (PTC). Form 1095-A contains the following information:

- Names and other information for the consumer or family members enrolled in a QHP
- Coverage information for a QHP, like the premium amount, second lowest cost Silver plan (SLCSP) premium, and monthly APTC, if paid to the QHP or insurance company

Consumers need to review the information provided on Form 1095-A to make sure it's accurate. In addition, consumers may want to make sure the SLCSP information is correct.

Note: If a consumer believes enrollment-related information may be incorrect, the consumer should contact the FFM Call Center. Consumers may also contact the FFM Call Center if they didn't receive Form 1095-A by mail or through their Marketplace account.



Form 1095-A Health Insurance Marketplace Statement — VOID — CORRECTED — OMB No. 1545-2232 — 2022

Department of the Treasury Internal Revenue Service

Do not attach to your tax return. Keep for your records.
Go to www.irs.gov/Form1095A for instructions and the latest information.

Part I Recipient Information

1 Marketplace identifier | 2 Marketplace-assigned policy number | 3 Policy issuer's name

4 Recipient's name | 5 Recipient's SSN | 6 Recipient's date of birth

7 Recipient's spouse's name | 8 Recipient's spouse's SSN | 9 Recipient's spouse's date of birth

10 Policy start date | 11 Policy termination date | 12 Street address (including apartment no.)

13 City or town | 14 State or province | 15 Country and ZIP or foreign postal code

Part II Covered Individuals

A. Covered individual name	B. Covered individual SSN	C. Covered individual date of birth	D. Coverage start date	E. Coverage termination date
16				
17				
18				
19				
20				

Part III Coverage Information

Month	A. Monthly enrollment premiums	B. Monthly second lowest cost silver plan (SLCSP) premium	C. Monthly advance payment of premium tax credit
21 January			
22 February			
23 March			
24 April			
25 May			
26 June			
27 July			
28 August			
29 September			
30 October			
31 November			
32 December			
33 Annual Totals			

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60703Q Form 1095-A (2022)

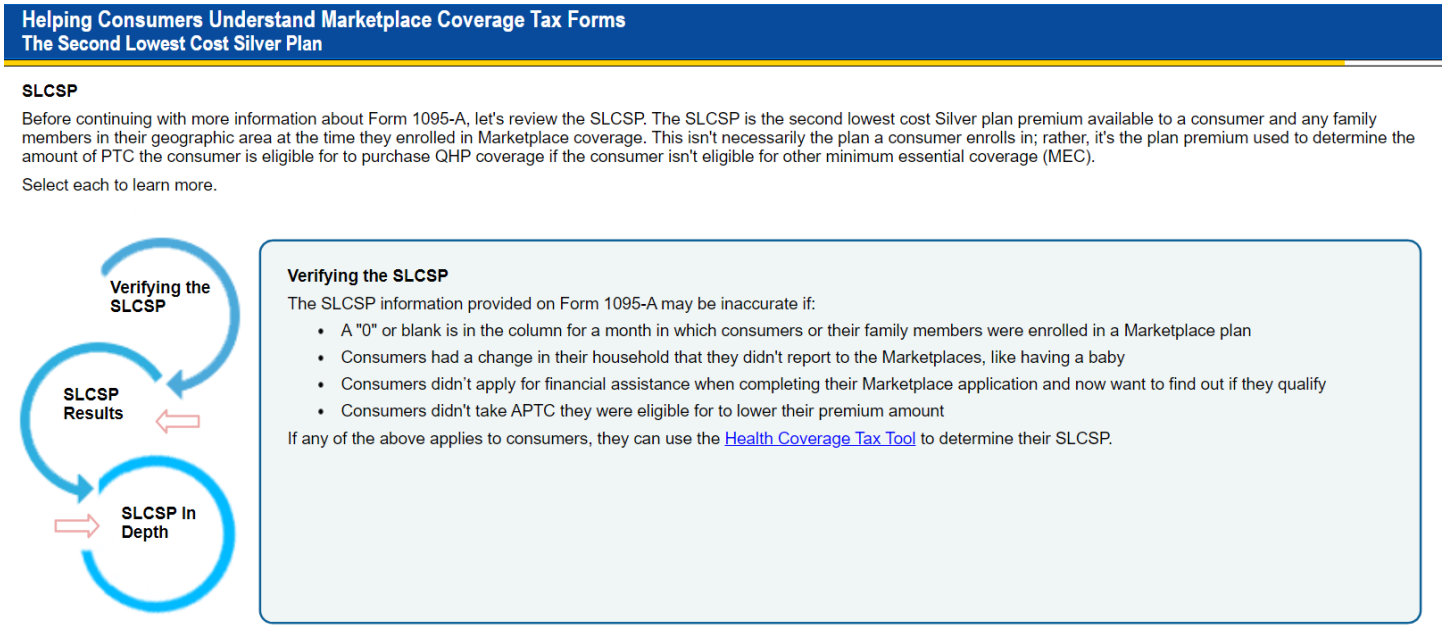
Consumers who have enrolled in a QHP through an individual market FFM will receive Form 1095-A, Health Insurance Marketplace Statement from the Marketplaces by mail. The form will also be available online through their Marketplace account. If household members enroll in different policies during the coverage year, they will receive one 1095-A for each policy in a household. Consumers should use the information on their Form 1095-A to complete Form 8962, Premium Tax Credit (PTC). Form 1095-A contains the following information:

- Names and other information for the consumer or family members enrolled in a QHP
- Coverage information for a QHP, like the premium amount, second lowest cost Silver plan (SLCSP) premium, and monthly APTC, if paid to the QHP or insurance company

Consumers need to review the information provided on Form 1095-A to make sure it's accurate. In addition, consumers may want to make sure the SLCSP information is correct.

Note: If a consumer believes enrollment-related information may be incorrect, the consumer should contact the FFM Call Center. Consumers may also contact the FFM Call Center if they didn’t receive Form 1095-A by mail or through their Marketplace account.

The Second Lowest Cost Silver Plan



SLCSP

Before continuing with more information about Form 1095-A, let's review the SLCSP. The SLCSP is the second lowest cost Silver plan premium available to a consumer and any family members in their geographic area at the time they enrolled in Marketplace coverage. This isn't necessarily the plan a consumer enrolls in; rather, it's the plan premium used to determine the amount of PTC the consumer is eligible for to purchase QHP coverage if the consumer isn't eligible for other minimum essential coverage.

Verifying the SLCSP

The SLCSP information provided on Form 1095-A may be inaccurate if:

- A "0" or blank is in the column for a month in which consumers or their family members were enrolled in a Marketplace plan
- Consumers had a change in their household that they didn’t report to the Marketplaces, like having a baby
- Consumers didn't apply for financial assistance when completing their Marketplace application and now want to find out if they qualify
- Consumers didn't take APTC they were eligible for to lower their premium amount

If any of the above applies to consumers, they can use the Health Coverage Tax Tool to determine their SLCSP.

SLCSP Results

Consumers can complete simple questions using the tax tool to find the SLCSP in their geographic area. When using the tool, it is important for consumers to select each month they had Marketplace coverage and paid their premiums. Remember, you shouldn’t help consumers fill out IRS Form 8962 or help them file their taxes.

View the example of SLCSP results from the tool. The results provide the premium amount used to calculate the premium tax credit on Form 8962. Again, the premium amount is the second lowest premium in the Silver plan category available to consumers in their geographic area and will be used to compare or reconcile on Form 8962. If the SLCSP results and the amounts on the form are different, a consumer doesn’t need to request a new Form 1095-A. Consumers can print out their results from the tax tool and submit them when filing their federal income tax returns.

SLCSP In Depth

Premium Tax Credit Calculation and Premium Increases

PTCs are calculated in a way that protects consumers financially against rising premium costs. Generally, PTCs

for eligible consumers are likely to increase as average premium prices increase. Remember, PTCs are calculated as the difference between consumers' monthly premium costs and the premium of the SLCSP available to them. If consumers' household incomes remain the same from one year to the next while the SLCSP premium amount increases significantly, they will likely receive PTCs that cover the increase in cost.

If consumers enroll in plans with higher monthly premiums than the available SLCSP, they may still experience a price increase. However, if consumers enroll in the available SLCSP or a plan with a lower monthly premium than the SLCSP, their PTCs will likely compensate the increase in cost.

Note: As described earlier in this course, consumers may determine how to use or distribute PTC amounts during the year. The amount of PTC a consumer distributes may need to be adjusted if premiums increase to ensure that monthly premiums are discounted to meet the consumer's needs. This may also affect a consumer's federal tax refund amount at the end of the year.

Additional IRS Forms 1095

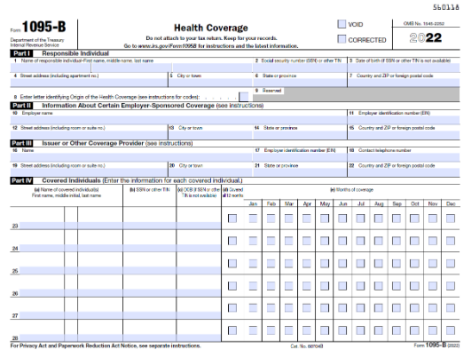
Helping Consumers Understand Marketplace Coverage Tax Forms
Additional IRS Forms 1095

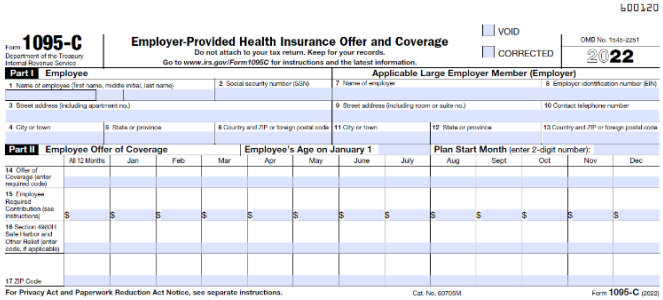
Consumers may also receive other 1095 forms, including 1095-B or 1095-C. They will receive these forms if they or someone in their household had coverage through a job or other source of insurance.

For example, consider a consumer who starts the year with employer-sponsored insurance. This consumer then loses his job and qualifies for Medicaid. Later, the consumer finds a new job and no longer qualifies for Medicaid, but that job doesn't offer health insurance coverage. Assuming he buys a QHP through a Marketplace, he will get three different 1095 forms at the end of the year:

- 1095-A for the Marketplace QHP
- 1095-B for the Medicaid coverage
- 1095-C for the employer-sponsored insurance

This consumer would need to use all three of these 1095 forms when filing federal income tax returns.





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- 1095-A for the Marketplace QHP
- 1095-B for the Medicaid coverage
- 1095-C for the employer-sponsored insurance

This consumer would need to use all three of these 1095 forms when filing federal income tax returns.

IRS Form 8962

Helping Consumers Understand Marketplace Coverage Tax Forms
IRS Form 8962

After consumers receive Form 1095-A and confirm the information on it is accurate, they can complete Form 8962, Premium Tax Credit (PTC). Form 8962 helps consumers determine the amount of PTC they actually qualified for during a tax year and reconcile that amount with the amount of APTC they received. To reconcile Form 8962, consumers should include the premium and SLCSP amounts from Form 1095-A and contribution amounts as described in Form 8962.

Remember, APTC is the amount paid to an insurance company to reduce or subsidize a consumer's premium amount. The amount of PTC a consumer actually qualifies for during the year may affect the amount of taxes they owe to the IRS or the amount they get back when they reconcile their APTC when they file their federal income tax returns for the year:

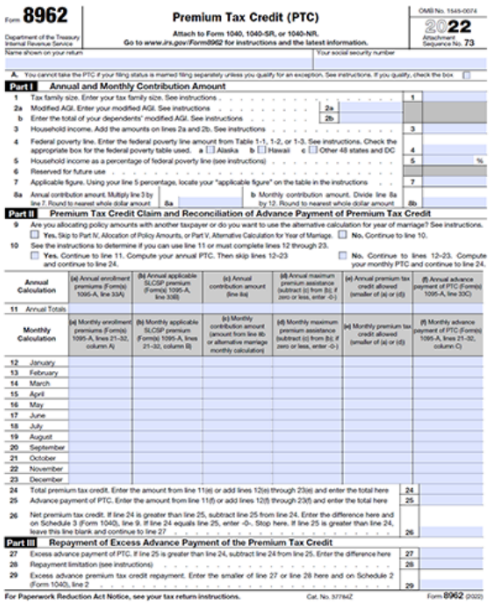
- If consumers use more APTC than the premium tax credit they're determined eligible for, they or their taxpayer may be required to repay the difference when they file their federal income tax returns.
- If consumers use less APTC than the premium tax credit they're determined eligible for, they may receive the difference as a refundable credit.

Additional information is available at IRS.gov/uac/About-Form-8962.

Instructions to complete Form 8962 are at IRS.gov/pub/irs-pdf/i8962.pdf. As a reminder, in your role as an assister, you shouldn't provide tax advice. You shouldn't help consumers fill out tax forms, and you shouldn't help consumers file their taxes. Consumers may also seek assistance from a tax specialist to complete the form.

If APTC is paid on behalf of a tax filer or someone in their tax household, and the tax filer does not file a federal income tax return and reconcile APTC with IRS Form 8962 for the tax year for which APTC was paid, they and their tax household will typically not be eligible for APTC or income-based cost-sharing reductions (CSRs) to help pay for their Marketplace coverage in the next following coverage year. This means that they will be responsible for the full cost of their monthly premiums and health care costs through the Marketplace unless they file their federal income tax return and reconcile past APTC for the year for which APTC was paid.

Note: This is not applicable for PYs 2022 and 2023. Centers for Medicare & Medicaid Services (CMS) will not end APTC eligibility for consumers whose tax filer has not filed or reconciled APTC for tax year 2020 or 2021, respectively.



Form **8962** — Premium Tax Credit (PTC)

Department of the Treasury, Internal Revenue Service

Attach to Form 1040, 1040-SR, or 1040-NR.
Go to www.irs.gov/Form8962 for instructions and the latest information.

OMB No. 1545-0074 — 2022 — Attachment Sequence No. 73

Name shown on your return | Your social security number

A. You cannot take the PTC if your filing status is married filing separately unless you qualify for an exception. See instructions. If you qualify, check the box

Part I Annual and Monthly Contribution Amount

1 Tax family size. Enter your tax family size. See instructions
2a Modified AGI. Enter your modified AGI. See instructions
b Enter the total of your dependents' modified AGI. See instructions
3 Household income. Add the amounts on lines 2a and 2b. See instructions
4 Federal poverty line. Enter the federal poverty line amount from Table 1-1, 1-2, or 1-3. See instructions. Check the appropriate box for the federal poverty table used. a Alaska b Hawaii c Other 48 states and DC
5 Household income as a percentage of federal poverty line (see instructions) %
6 Reserved for future use
7 Applicable figure. Using your line 5 percentage, locate your "applicable figure" on the table in the instructions
8a Annual contribution amount. Multiply line 3 by line 7. Round to nearest whole dollar amount
b Monthly contribution amount. Divide line 8a by 12. Round to nearest whole dollar amount

Part II Premium Tax Credit Claim and Reconciliation of Advance Payment of Premium Tax Credit

9 Are you allocating policy amounts with another taxpayer or do you want to use the alternative calculation for year of marriage? See instructions. Yes. Skip to Part IV, Allocation of Policy Amounts, or Part V, Alternative Calculation for Year of Marriage. No. Continue to line 10.
10 See the instructions to determine if you can use line 11 or must complete lines 12 through 23. Yes. Continue to line 11. Compute your annual PTC. Then skip lines 12-23 and continue to line 24. No. Continue to lines 12-23. Compute your monthly PTC and continue to line 24.

Annual Calculation	(a) Annual enrollment premiums (Form(s) 1095-A, line 33A)	(b) Annual applicable SLCSP premium (Form(s) 1095-A, line 33B)	(c) Annual contribution amount (line 8a)	(d) Annual maximum premium assistance (subtract (c) from (b); if zero or less, enter -0-)	(e) Annual premium tax credit allowed (smaller of (a) or (d))	(f) Annual advance payment of PTC (Form(s) 1095-A, line 33C)
11 Annual Totals						

Monthly Calculation	(a) Monthly enrollment premiums (Form(s) 1095-A, lines 21–32, column A)	(b) Monthly applicable SLCSP premium (Form(s) 1095-A, lines 21–32, column B)	(c) Monthly contribution amount (amount from line 8b, or alternative marriage monthly calculation)	(d) Monthly maximum premium assistance (subtract (c) from (b); if zero or less, enter -0-)	(e) Monthly premium tax credit allowed (smaller of (a) or (d))	(f) Monthly advance payment of PTC (Form(s) 1095-A, lines 21–32, column C)
12 January						
13 February						
14 March						
15 April						
16 May						
17 June						
18 July						
19 August						
20 September						
21 October						
22 November						
23 December						

24 Total premium tax credit. Enter the amount from line 11(e) or add lines 12(e) through 23(e) and enter the total here 24
25 Advance payment of PTC. Enter the amount from line 11(f) or add lines 12(f) through 23(f) and enter the total here 25
26 Net premium tax credit. If line 24 is greater than line 25, subtract line 25 from line 24. Enter the difference here and on Schedule 3 (Form 1040), line 9. If line 24 equals line 25, enter -0-. Stop here. If line 25 is greater than line 24, leave this line blank and continue to line 27 26

Part III Repayment of Excess Advance Payment of the Premium Tax Credit

27 Excess advance payment of PTC. If line 25 is greater than line 24, subtract line 24 from line 25. Enter the difference here 27
28 Repayment limitation (see instructions) 28
29 Excess advance premium tax credit repayment. Enter the smaller of line 27 or line 28 here and on Schedule 2 (Form 1040), line 2 29

For Paperwork Reduction Act Notice, see your tax return instructions. Cat. No. 37784Z Form **8962** (2022)

After consumers receive Form 1095-A and confirm the information on it is accurate, they can complete Form 8962, Premium Tax Credit (PTC). Form 8962 helps consumers determine the amount of PTC they actually qualified for during a tax year and reconcile that amount with the amount of APTC they received. To reconcile Form 8962, consumers should include the premium and SLCSP amounts from Form 1095-A and contribution amounts as described in Form 8962.

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Additional information is available at IRS.gov/uac/About-Form-8962.

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Note: This is not applicable for PYs 2022 and 2023. CMS will not end APTC eligibility for consumers whose tax filer has not filed or reconciled APTC for tax year 2020 or 2021, respectively.

Scenario: Tax Forms

Helping Consumers Understand Marketplace Coverage Tax Forms
Scenario: Tax Forms

Let's say you're preparing to meet with consumers to help them review the tax forms received for their premium tax credit. What information should you be prepared to assist them with or explain to them?

Information you can provide:

- Why they are receiving Form 1095-A
- That Form 1095-A is used to complete Form 8962
- The general purpose of Form 1095-A and Form 8962
- Why more than one copy of Form 1095-A was received, if applicable
- How to locate Form 1095-A online at their Marketplace account
- Explain next steps if the consumer finds incorrect information on Form 1095-A, like wrong address, incorrect premium amounts or SLCSP*, or dependents that the consumer added to coverage but were not included on the form

*The SLCSP on Form 1095-A may be incorrect if: there is a zero or blank in a column for a month the consumer or family members were enrolled in a Marketplace plan, the consumer didn't take APTC or didn't apply for financial assistance previously, or the consumer didn't report a household change to the FFM.

Keep in mind that you shouldn't provide tax advice when acting in your role as an assister. Providing basic information about Form 1095-A and informing the consumer about IRS resources is the most appropriate action you should take when helping consumers. The consumer should fill out Form 8962 on their own behalf. You shouldn't help the consumer fill out Form 8962. You shouldn't advise consumers about whether to file an amended tax return and shouldn't help them complete their federal income tax return. You should direct consumers to IRS resources or to licensed tax advisers or tax preparers for assistance with tax preparation and tax advice related to these forms.

Additional Information

Let’s say you’re preparing to meet with consumers to help them review the tax forms received for their premium tax credit. What information should you be prepared to assist them with or explain to them?

- Why they are receiving Form 1095-A
- That Form 1095-A is used to complete Form 8962
- The general purpose of Form 1095-A and Form 8962
- Why more than one copy of Form 1095-A was received, if applicable
- How to locate Form 1095-A online at their Marketplace account
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The SLCSP on Form 1095-A may be incorrect if: there is a zero or blank in a column for a month the consumer or family members were enrolled in a Marketplace plan, the consumer didn’t take APTC or didn’t apply for financial assistance previously, or the consumer didn’t report a household change to the FFM.

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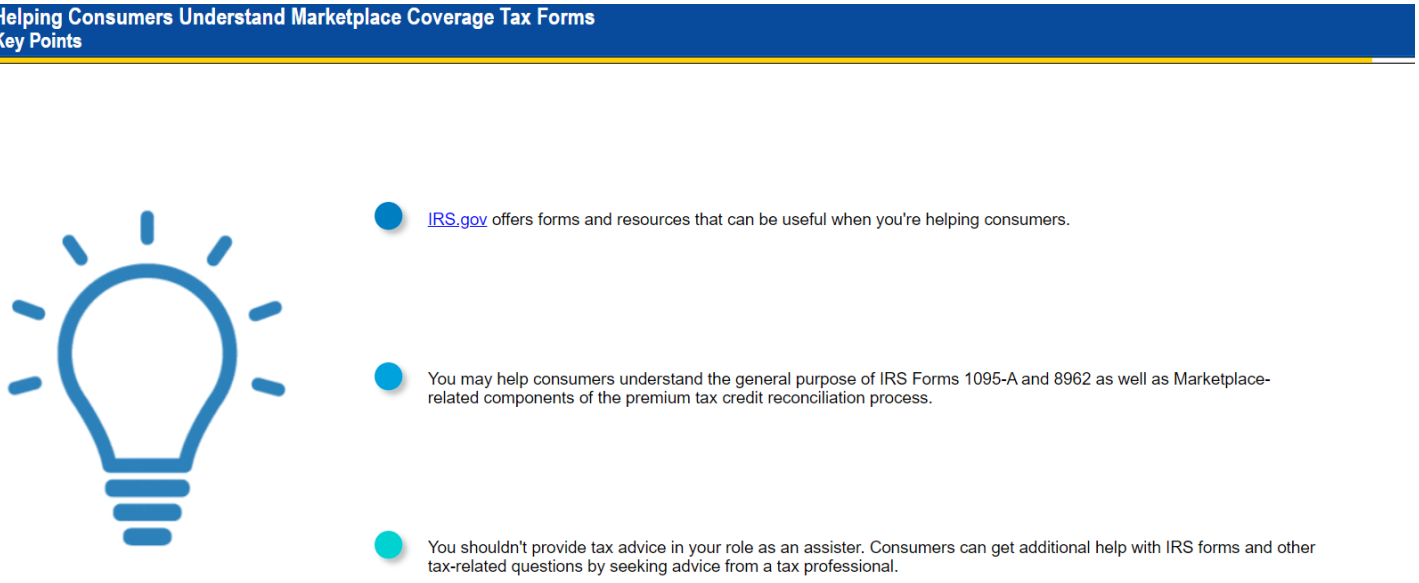
Additional Information

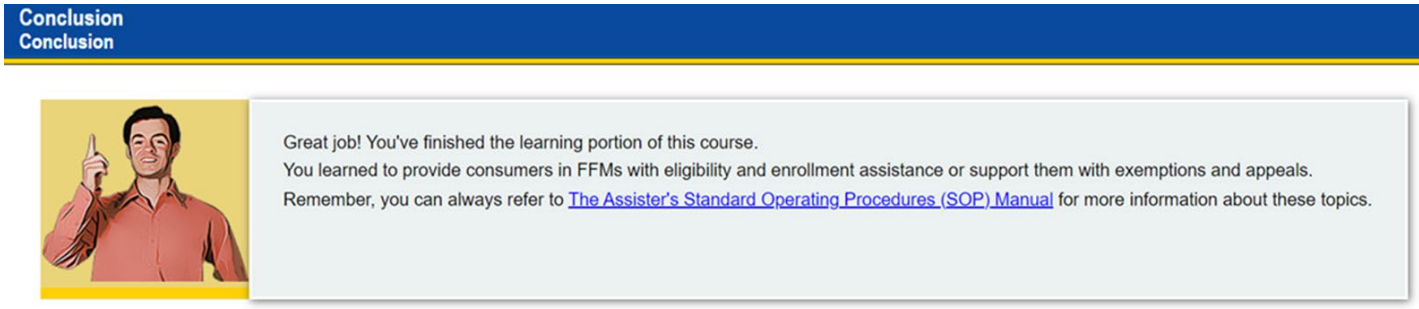
Beginning with Navigator grants awarded in 2022, Navigators are required to provide information on and assistance with referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice related to consumer questions about the Marketplace application and enrollment process, and premium tax credit reconciliations.

Key Points



- IRS.gov offers forms and resources that can be useful when you're helping consumers.
- You may help consumers understand the general purpose of IRS Forms 1095-A and 8962 as well as Marketplace-related components of the premium tax credit reconciliation process.
- You shouldn't provide tax advice in your role as an assister. Consumers can get additional help with IRS forms and other tax-related questions by seeking advice from a tax professional.

Conclusion



Great job! You've finished the learning portion of this course.

You learned to provide consumers in FFMs with eligibility and enrollment assistance or support them with exemptions and appeals.

Remember, you can always refer to The Assister's Standard Operating Procedures (SOP) Manual for more information about these topics.

You can return to the web-based training to take the Marketplace Application Essentials exam, or you can close this document and return to the exam later. If you choose to take the exam, the code to access this exam is: 860951.

Resources

Resources Page for Assisters on Medicare.gov:

Information on joining a Medicare health plan or drug plan.

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.

HealthCare.gov/small-businesses/provide-shop-coverage/shop-marketplace-overview

The Assister's Standard Operation Procedures (SOP) Manual

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

Marketplace.cms.gov/technical-assistance-resources/the-assisters-sop-manual.html

Tips to get started in the Health Insurance Marketplace®

4 tips about the Health Insurance Marketplace®.

HealthCare.gov/quick-guide/one-page-guide-to-the-marketplace

Savings Estimator Tool

Provides consumers with a quick view of income levels that qualify for savings in 2019.

HealthCare.gov/lower-costs

Identity Proofing in the Marketplace

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

Marketplace.cms.gov/outreach-and-education/your-marketplace-application.pdf

Logging Into Your Account

Tips on troubleshooting login issues for Marketplace accounts at HealthCare.gov.

HealthCare.gov/tips-and-troubleshooting/logging-in

5 Things Assisters Should Know about Data Matching Terminations

Information about how data matching issues impact consumers.

HHS.gov/guidance/document/job-aid-5-things-assisters-should-know-about-data-matching-terminations

Income Definitions for Marketplace and Medicaid Coverage

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

Healthreformbeyondthebasics.org/key-facts-income-definitions-for-marketplace-and-medicaid-coverage

Medicaid and CHIP Overview

Summary of important facts regarding Medicaid and CHIP eligibility.

Marketplace.cms.gov/technical-assistance-resources/fast-facts-medicaid-chip.pdf

Federal Poverty Level (FPL) Guidelines

Up-to-date information regarding the Federal Poverty Guidelines (FPL) for families and individuals.

Aspe.hhs.gov/poverty-guidelines

COBRA coverage and the Marketplace

A description of COBRA health coverage and how it relates to the Marketplace.

HealthCare.gov/unemployed/cobra-coverage

Tips for Working with Outside Organizations

Marketplace.cms.gov/technical-assistance-resources/assister-guidance-on-referrals-to-outside-organizations.pdf

How to find low-cost health care in your community

Use the following tool to find a community health center near the consumer.

HealthCare.gov/community-health-centers

Catastrophic Plans

A definition of Catastrophic health plans and their role in the Marketplace.

HealthCare.gov/choose-a-plan/catastrophic-health-plans

Pharmaceutical Assistance Programs

A tool to see if a pharmaceutical company offers an assistance program for the drugs they manufacture.

Medicare.gov/pharmaceutical-assistance-program

If you have job-based insurance

An explanation of how job-based insurance affects Marketplace coverage.

HealthCare.gov/have-job-based-coverage

Health coverage for retirees

An explanation of the different choices retirees have for health coverage.

HealthCare.gov/retirees

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 or your lowest cost Bronze plan.

HealthCare.gov/tax-tool

Exemptions from the requirement to have health insurance

A description of the different types of exemptions available under the ACA and how to apply for them.

HealthCare.gov/health-coverage-exemptions/exemptions-from-the-fee

Individual Shared Responsibility Provision

IRS.gov/affordable-care-act/individuals-and-families/individual-shared-responsibility-provision

Individual Shared Responsibility Provision – Exemptions: Claiming or Reporting

IRS.gov/affordable-care-act/individuals-and-families/aca-individual-shared-responsibility-provision-exemptions

Hardship and Affordability Health Coverage Exemption Forms

HealthCare.gov/exemption-form-instructions

HealthCare.gov/health-coverage-exemptions/hardship-exemptions

Types of Health Insurance that Count as MEC

HealthCare.gov/fees/plans-that-count-as-coverage

Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) Worksheet

HealthCare.gov/downloads/qsehra-worksheet