Federally-facilitated Marketplace Assister Curriculum: Marketplace Enrollment and Appeals Assistance

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Center for Consumer Information & Insurance Oversight

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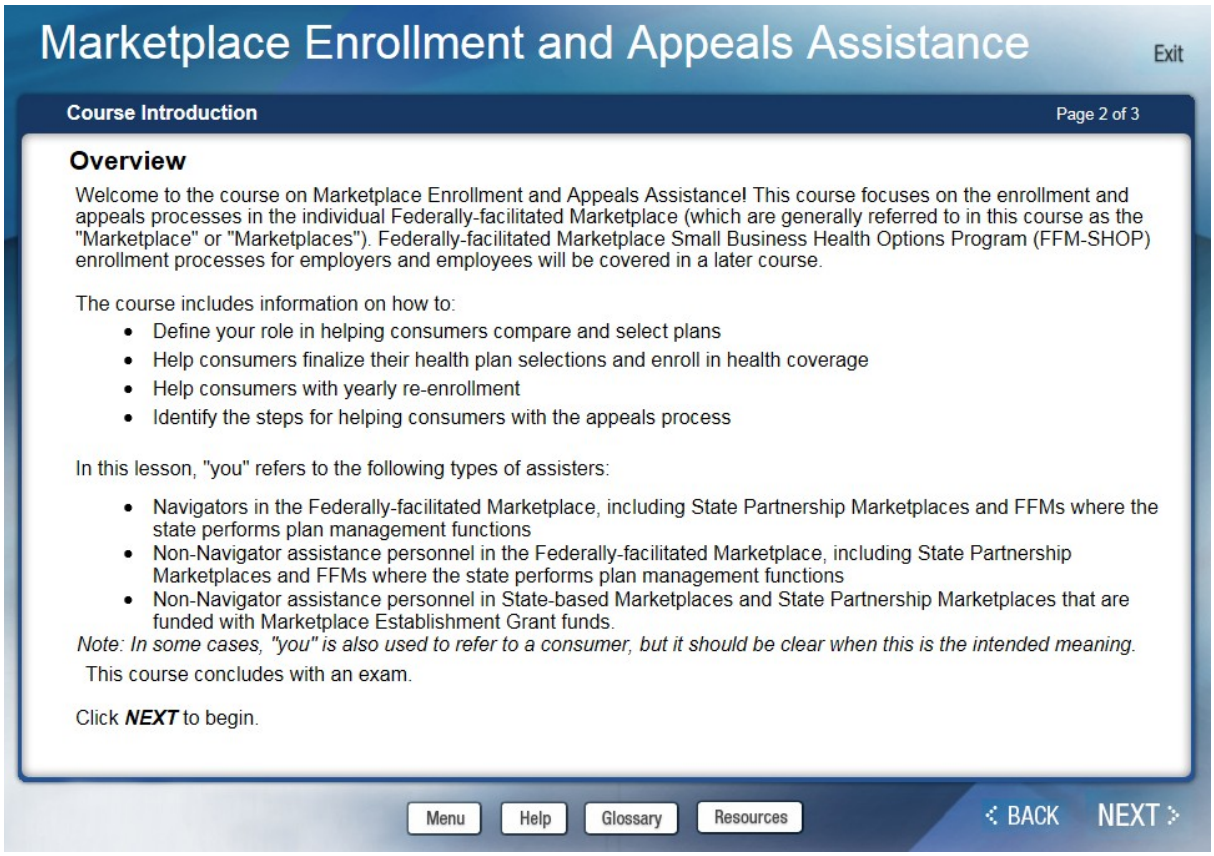
Marketplace Enrollment and Appeals Course

Course Introduction Module

Course Title

Welcome to the Market Enrollment and Appeals Assistance Course



Overview

Welcome to the course on Marketplace Enrollment and Appeals Assistance! This course focuses on the enrollment and appeals processes in the individual Federally-facilitated Marketplace (which are generally referred to in this course as the "Marketplace" or "Marketplaces"). Federally-facilitated Marketplace Small Business Health Options Program (FFM-SHOP) enrollment processes for employers and employees will be covered in a later course.

The course includes information on how to:

- Define your role in helping consumers compare and select plans
- Help consumers finalize their health plan selections and enroll in health coverage
- Help consumers with yearly re-enrollment
- Identify the steps for helping consumers with the appeals process

In this lesson, "you" refers to the following types of assisters:

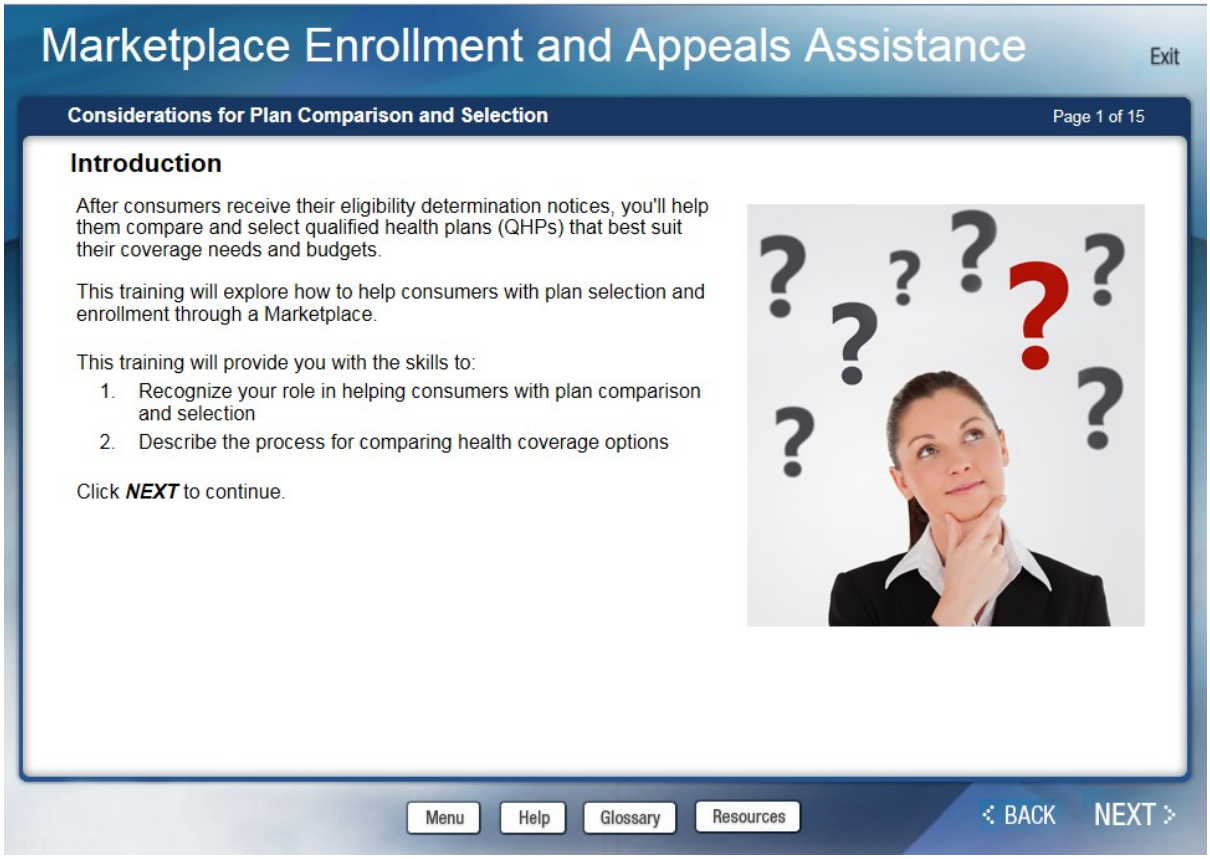
- Navigators in the Federally-facilitated Marketplace, including State Partnership Marketplaces and FFMs where the state performs plan management functions

- Non-Navigator assistance personnel in the Federally-facilitated Marketplace, including State Partnership Marketplaces and FFMs where the state performs plan management functions
- Non-Navigator assistance personnel in State-based Marketplaces and State Partnership Marketplaces that are funded with Marketplace Establishment Grant funds.

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

This course concludes with an exam.

Considerations for Plan Comparison and Selection Module



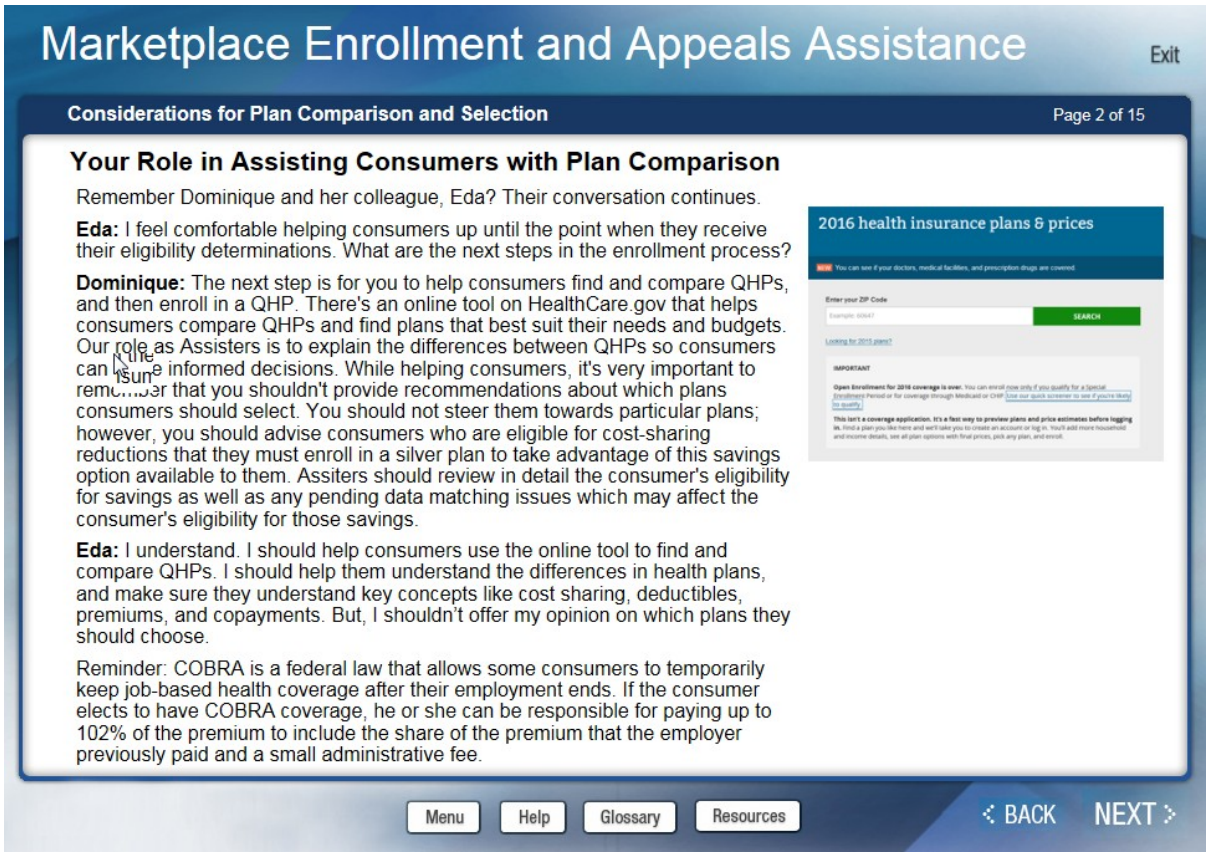
Introduction

After consumers receive their eligibility determination notices, you'll help them compare and select qualified health plans (QHPs) that best suit their coverage needs and budgets.

This training will explore how to help consumers with plan selection and enrollment through a Marketplace.

This training will provide you with the skills to:

1. Recognize your role in helping consumers with plan comparison and selection
2. Describe the process for comparing health coverage options



Your Role in Assisting Consumers with Plan Comparison

Remember Dominique and her colleague, Eda? Their conversation continues.

Eda: I feel comfortable helping consumers up until the point when they receive their eligibility determinations. What are the next steps in the enrollment process?

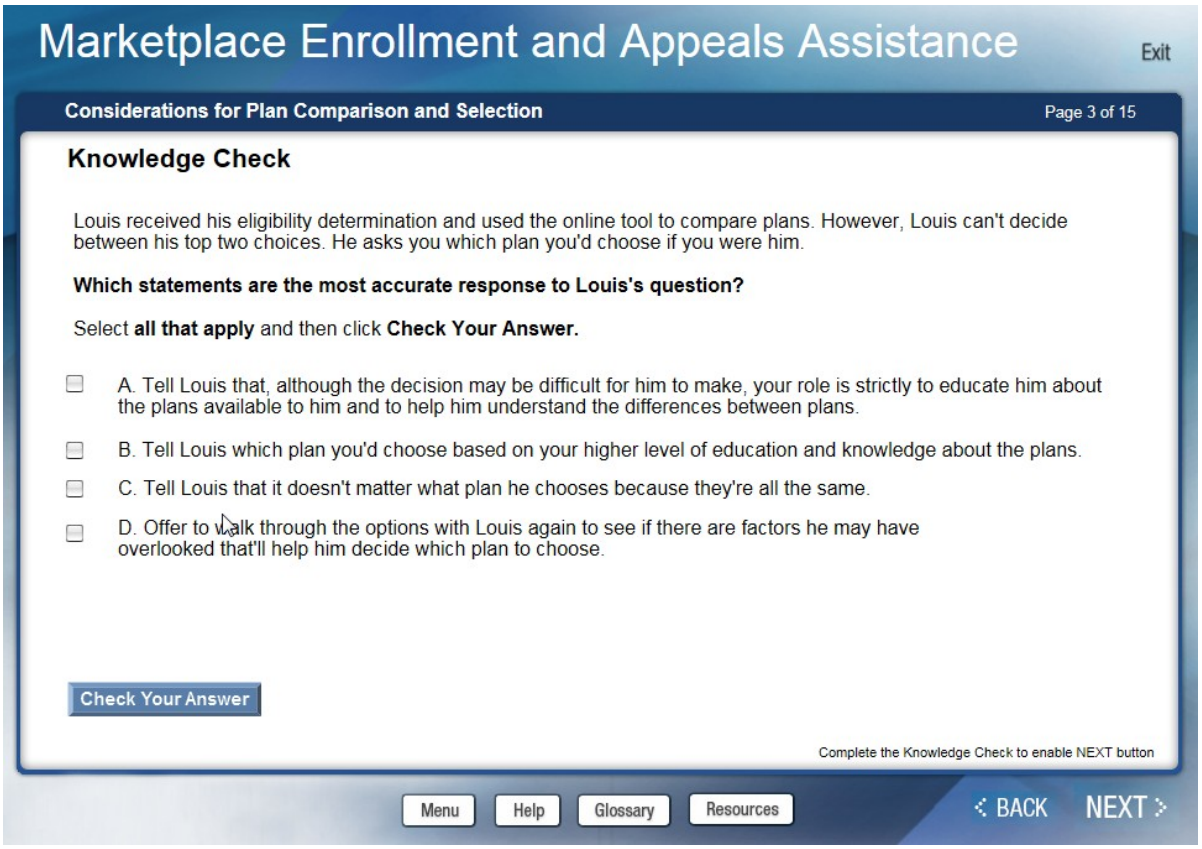
Dominique: The next step is for you to help consumers find and compare QHPs, and then enroll in a QHP. There's an online tool on HealthCare.gov that helps consumers compare QHPs and find plans that best suit their needs and budgets. Our role as Assisters is to explain the differences between QHPs so consumers can make informed decisions.

While helping consumers, it's very important to remember that you shouldn't provide recommendations about which plans consumers should select. You should not steer them towards particular plans; however, you should advise consumers who are eligible for cost-sharing reductions that they must enroll in a silver plan to take advantage of this savings option available to them. Assiters should review in detail the consumer's eligibility for savings as well

as any pending data matching issues which may affect the consumer's eligibility for those savings.

Eda: I understand. I should help consumers use the online tool to find and compare QHPs. I should help them understand the differences in health plans, and make sure they understand key concepts like cost sharing, deductibles, premiums, and copayments. But, I shouldn't offer my opinion on which plans they should choose.

Reminder: COBRA is a federal law that allows some consumers to temporarily keep job-based health coverage after their employment ends. If the consumer elects to have COBRA coverage, he or she can be responsible for paying up to 102% of the premium to include the share of the premium that the employer previously paid and a small administrative fee.



Knowledge Check

Louis received his eligibility determination and used the online tool to compare plans. However, Louis can't decide between his top two choices. He asks you which plan you'd choose if you were him.

Which statements are the most accurate response to Louis's question?

Select **all that apply.**

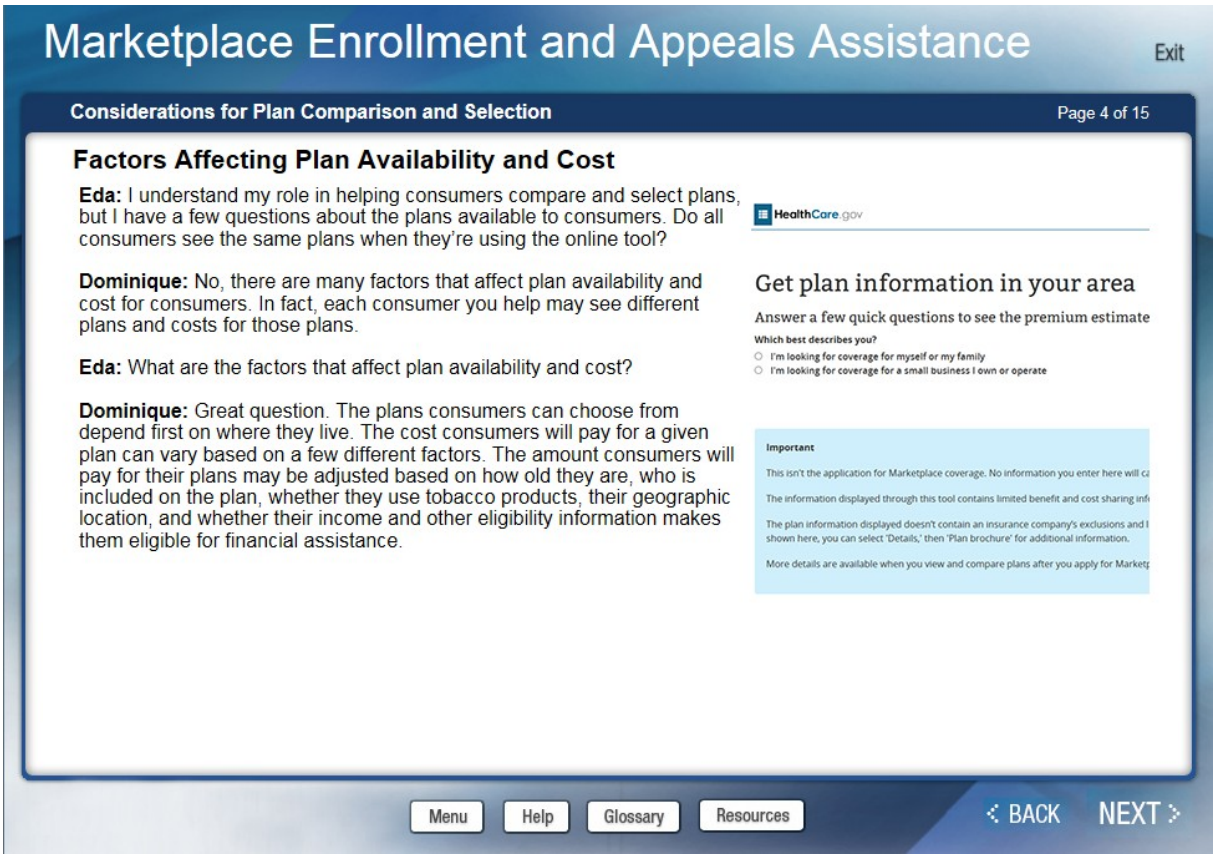
A. Tell Louis that, although the decision may be difficult for him to make, your role is strictly to educate him about the plans available to him and to help him understand the differences between plans.

B. Tell Louis which plan you'd choose based on your higher level of education and knowledge about the plans.

C. Tell Louis that it doesn't matter what plan he chooses because they're all the same.

D. Offer to walk through the options with Louis again to see if there are factors he may have overlooked that'll help him decide which plan to choose.

Feedback: The correct answers are A and D. You shouldn't tell Louis which plan you'd choose; instead, help him understand the differences between the plans by offering to review the options with him again.



Factors Affecting Plan Availability and Cost

Eda: I understand my role in helping consumers compare and select plans, but I have a few questions about the plans available to consumers. Do all consumers see the same plans when they're using the online tool?

Dominique: No, there are many factors that affect plan availability and cost for consumers. In fact, each consumer you help may see different plans and costs for those plans.

Eda: What are the factors that affect plan availability and cost?

Dominique: Great question. The plans consumers can choose from depend first on where they live. The cost consumers will pay for a given plan can vary based on a few different factors. The amount consumers will pay for their plans may be adjusted based on how old they are, who is included on the plan, whether they use tobacco products, their geographic location, and whether their income and other eligibility information makes them eligible for financial assistance.

Essential Health Benefits Considerations

Eda: I understand now that consumers will see different plans depending on their personal situations. Is each plan that consumers see completely different?

Dominique: No, not completely. Every plan offered through a Marketplace includes a minimum set of essential health benefits, or EHB. Offering these EHB is part of being certified as a QHP. There are also four plan categories that are based on how consumers and the health insurance companies share the cost of care. These plan categories have nothing to do with the quality or the amount of care that consumers get.

Eda: I do remember learning about EHB and the plan categories. Is there any other information that I should know?

Dominique: Yes, it's important to let consumers know that all QHPs offered through a Marketplace offer ten EHB health care service categories.

Different Plans for Different Consumers

Eda: That's helpful. Can you explain more about how consumers can see the differences between plans?

Dominique: I'd be glad to. As an Assister, it's very important for you to develop a basic understanding of what consumers are looking for in a plan so you can guide them through the many options. Remember that QHPs provide different categories of coverage and they also vary in how they share the costs of that coverage with consumers, which can be an important consideration for consumers in choosing their plans.

For example, a QHP with a low deductible and higher monthly premium may be the right choice for consumers who have a lot of regular medical costs, because these consumers will meet the plan's deductible sooner, and the plan will cover their costs sooner. However, a QHP with a higher deductible and lower monthly premium may be a better choice for consumers who don't have a lot of regular medical costs, because they may not need the coverage as often.

Eda: Yes, I do remember now that there are different categories of coverage and, even within those categories, the plans can vary. I also remember that most consumers who qualify for income-based cost-sharing reductions must enroll in a Silver category QHP to get the savings.

Different categories of coverage Pop-up: The plan categories of coverage are Platinum, Gold, Silver, and Bronze.

Dominique: Exactly.

Here's a key tip that you should remember about plan variation and consumer preference.

Key Tip

Plans may also differ by which providers are in their networks, and which prescription drugs they cover. Consumers who travel a lot outside of the states where they live may be interested in finding a plan with a national provider network. It's possible that members of the same family may want to enroll in different plans due to their different situations and preferences. However, if they do, it's important to remind these consumers that each plan will have a separate deductible to meet.

Plan Comparison at Different Stages of the Application Process

Eda: I know you suggested that consumers compare plans once they get their eligibility determinations, but I met with a consumer yesterday who wasn't ready to complete an application. He wanted to explore his options first to see what plans are available in his area. Is this possible?

Dominique: Yes, consumers can compare QHPs at any point during the process of applying without completing a Marketplace application for health coverage. However, depending on where they are in the process of applying for health coverage, they may be able to see more or less detailed information. For example, consumers who submitted applications to the Marketplace and received eligibility determinations can view plan information that is more personalized.

Since you'll likely work with consumers who are at each stage of the application process, you should be prepared to help them compare plans, regardless of where they are in the application process.

Eda: What are the differences in the information consumers will see, depending on where they are in the application process?

Dominique: I've created a quick cheat sheet with this exact information.

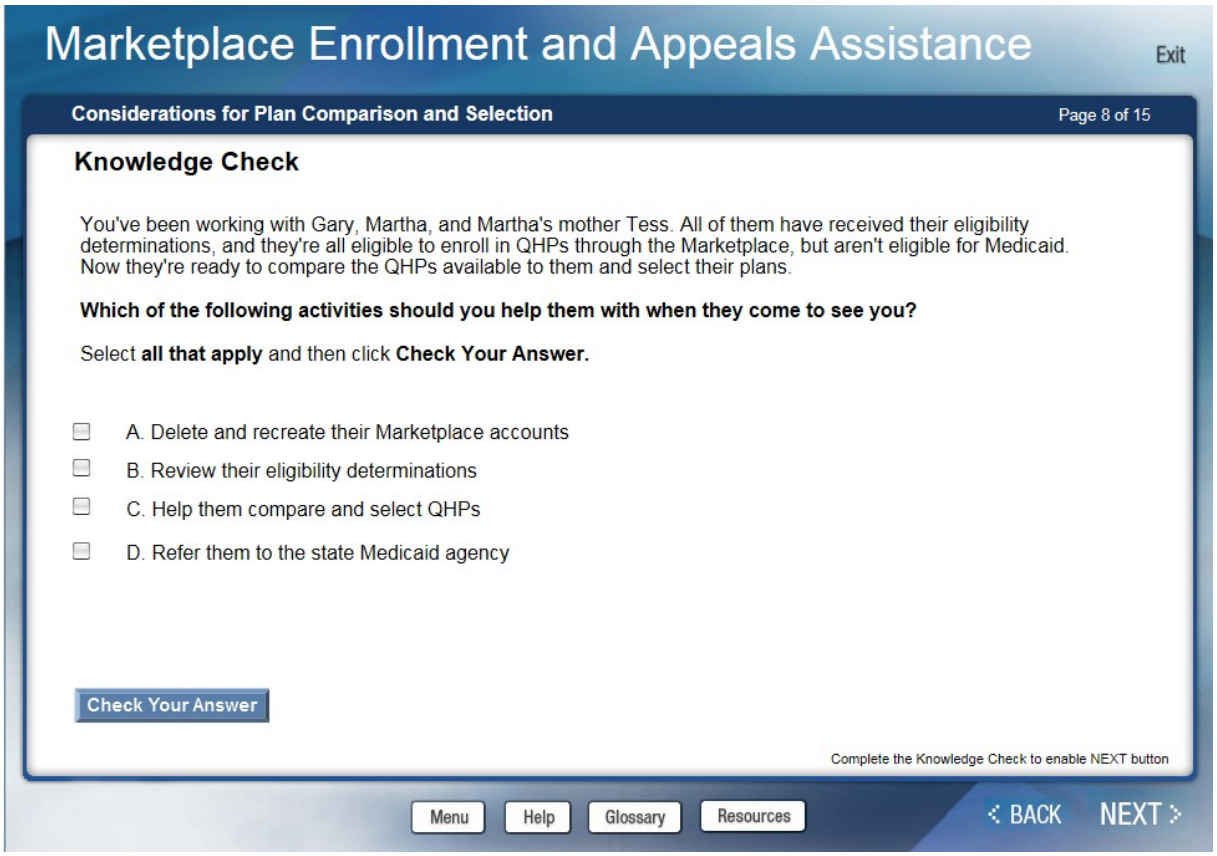
1. Consumers who haven't created Marketplace accounts or applied through the Marketplace
2. Consumers who have created a Marketplace account and received eligibility determinations

Consumers who haven't created Marketplace accounts or applied through the Marketplace:

Using the plan comparison tool on HealthCare.gov, these consumers can see all plans available to them and the associated premium costs (with an estimated amount of advance payments of the premium tax credit reflected). These consumers will only be able to see an estimate of the financial assistance they could get, because they haven't applied for health coverage through the Marketplace and had a formal eligibility determination. Be sure to warn consumers that the final cost of their coverage may change once their personal information, including household income, is entered as part of the application process and verified by the Marketplace.

Consumers who have created a Marketplace account and received an eligibility determination:

These consumers can perform all of the same activities as consumers without Marketplace accounts. In addition, they can save their plan comparisons and refer to them in the future. They can also view plan costs that reflect any advance payments of the premium tax credit and cost-sharing reductions for which they've been determined eligible, and select plans for enrollment.



Knowledge Check

You've been working with Gary, Martha, and Martha's mother Tess. All of them have received their eligibility determinations, and they're all eligible to enroll in QHPs through the Marketplace, but aren't eligible for Medicaid. Now they're ready to compare the QHPs available to them and select their plans.

Which of the following activities should you help them with when they come to see you?

Select **all that apply.**

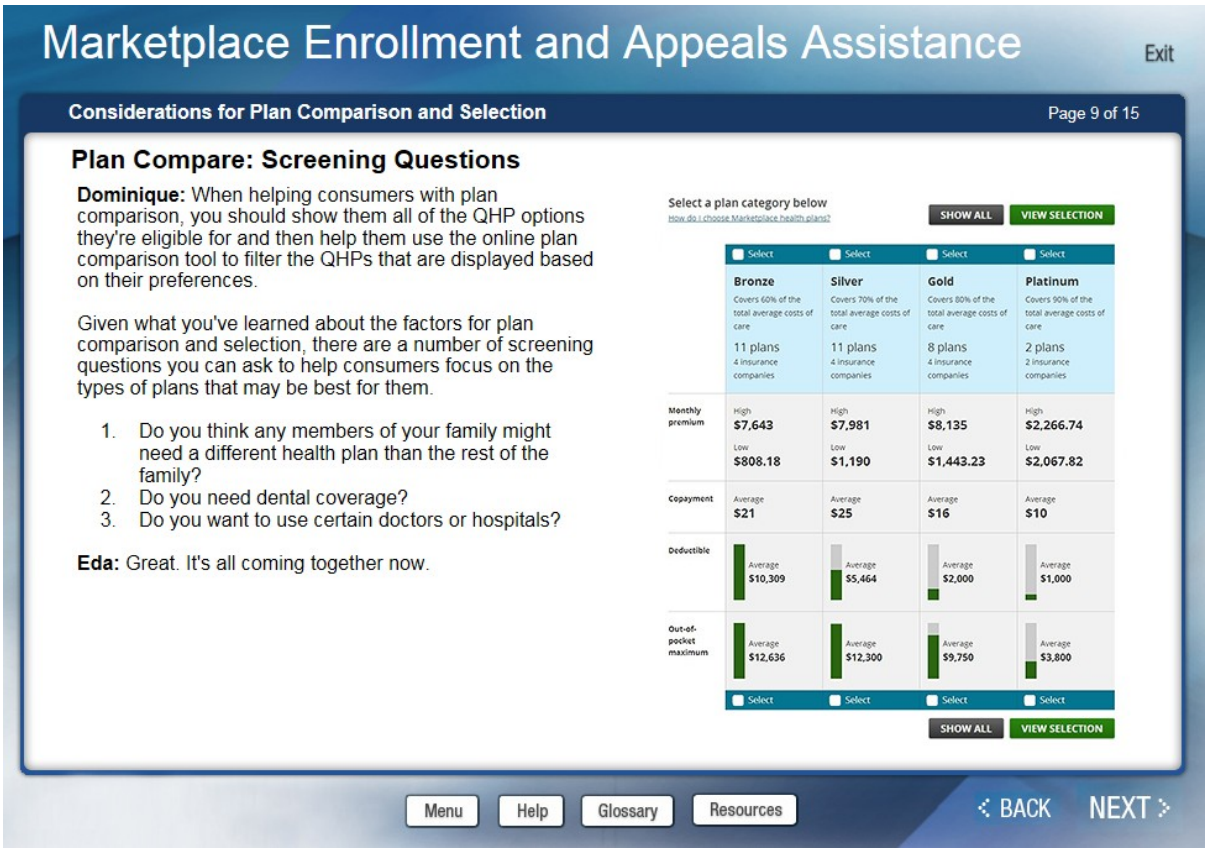
A. Delete and recreate their Marketplace accounts

B. Review their eligibility determinations

C. Help them compare and select QHPs

D. Refer them to the state Medicaid agency

Feedback: The correct answers are B and C. Gary, Martha, and Tess already set up their Marketplace accounts and received their eligibility determinations. They may want you to help them review their eligibility determinations, and you should help them compare and select QHPs through the Marketplace. You shouldn't delete and recreate their Marketplace accounts or refer them to their state Medicaid agency.



Plan Compare: Screening Questions

Dominique: When helping consumers with plan comparison, you should show them all of the QHP options they're eligible for and then help them use the online plan comparison tool to filter the QHPs that are displayed based on their preferences.

Given what you've learned about the factors for plan comparison and selection, there are a number of screening questions you can ask to help consumers focus on the types of plans that may be best for them.

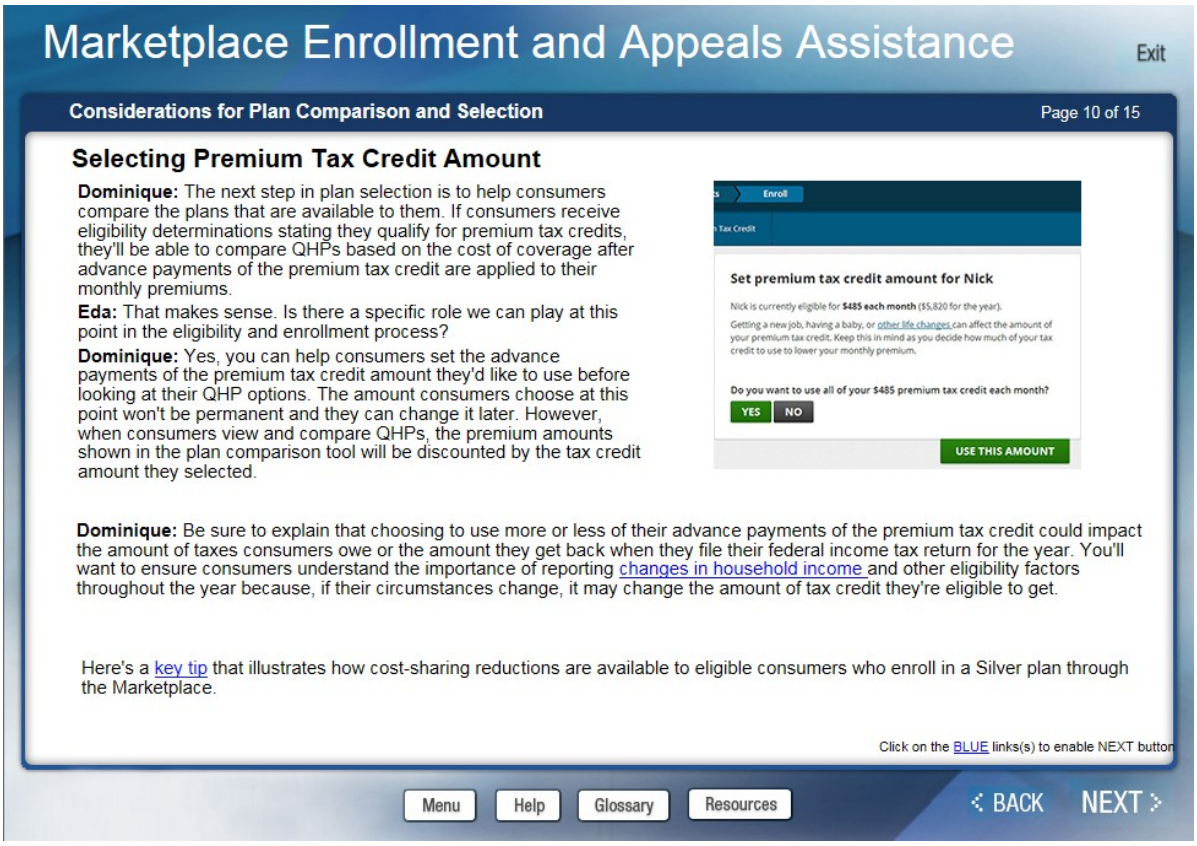
1. Do you think any members of your family might need a different health plan than the rest of the family?
2. Do you need dental coverage?
3. Do you want to use certain doctors or hospitals?

Eda: Great. It's all coming together now.

Example of Comparison of QHPs

This example provides information for Bronze, Silver, Gold, and Platinum qualified health plans.

- Bronze
  - Covers 60% of the total average costs of care
  - 11 plans from 4 insurance companies
  - Monthly premium: high $7,643 and low $808.18
  - Copayment average $21
  - Deductible average $10,309
  - Out-of-pocket maximum average $12,636
- Silver
  - Covers 70% of the total average costs of care
  - 11 plans from 4 insurance companies
  - Monthly premium: high $7,981 and low $1,190
  - Copayment average $25
  - Deductible average $5,464
  - Out-of-pocket maximum average $12,300
- Gold
  - Covers 80% of the total average costs of care
  - 8 plans from 4 insurance companies
  - Monthly premium: high $8,135 and low $1,443.23
  - Copayment average $16
  - Deductible average $2,000
  - Out-of-pocket maximum average $9,750
- Platinum
  - Covers 90% of the total average costs of care
  - 2 plans from 2 insurance companies
  - Monthly premium: high $2,266.74 and low $2,067.82
  - Copayment average $10
  - Deductible average $1,000
  - Out-of-pocket maximum average $3,800



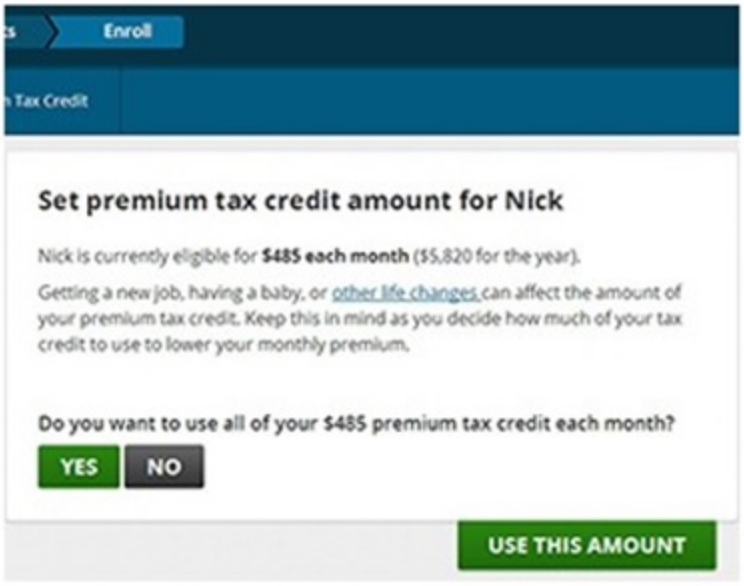
Selecting Premium Tax Credit Amount

Dominique: The next step in plan selection is to help consumers compare the plans that are available to them. If consumers receive eligibility determinations stating they qualify for premium tax credits, they'll be able to compare QHPs based on the cost of coverage after advance payments of the premium tax credit are applied to their monthly premiums.

Eda: That makes sense. Is there a specific role we can play at this point in the eligibility and enrollment process?

Dominique: Yes, you can help consumers set the advance payments of the premium tax credit amount they'd like to use before looking at their QHP options. The amount consumers choose at this point won't be permanent and they can change it later. However, when consumers view and compare QHPs, the premium amounts shown in the plan comparison tool will be discounted by the tax credit amount they selected.

Dominique: Be sure to explain that choosing to use more or less of their advance payments of the premium tax credit could impact the amount of taxes consumers owe or the amount they get back when they file their federal income tax return for the year. You'll want to ensure consumers understand the importance of reporting changes in household income and other eligibility factors throughout the year because, if their circumstances change, it may change the amount of tax credit they're eligible to get.



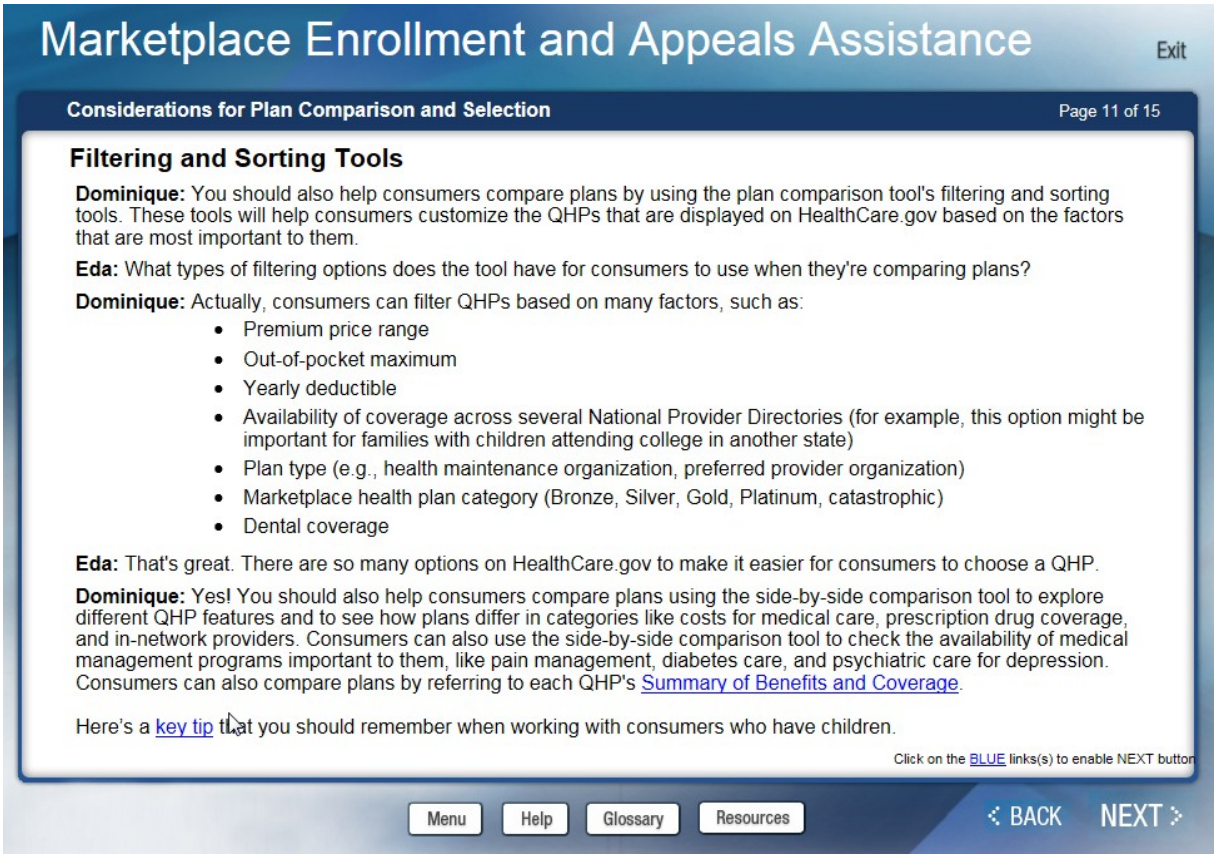
Here's a key tip that illustrates how cost-sharing reductions are available to eligible consumers who enroll in a Silver plan through the Marketplace.

Key Tip

In addition to premium tax credits, which are available for eligible consumers who enroll in any Marketplace health plan category, consumers may also be eligible for cost-sharing reductions if they enroll in a Silver plan and meet income requirements. American Indians and Alaska Natives can get income-based cost-sharing reductions even if they choose a plan in another metal level.

Examples of Changes to Report

Some examples of changes that consumers should report to the Marketplace include if consumers' salaries increase, and if consumers are offered health coverage through a new job or a spouse's job (which would affect eligibility for premium tax credits or cost- sharing reductions).



Filtering and Sorting Tools

Dominique: You should also help consumers compare plans by using the plan comparison tool's filtering and sorting tools. These tools will help consumers customize the QHPs that are displayed on HealthCare.gov based on the factors that are most important to them.

Eda: What types of filtering options does the tool have for consumers to use when they're comparing plans?

Dominique: Actually, consumers can filter QHPs based on many factors, such as:

- Premium price range
- Out-of-pocket maximum
- Yearly deductible
- Availability of coverage across several National Provider Directories (for example, this option might be important for families with children attending college in another state)
- Plan type (e.g., health maintenance organization, preferred provider organization)
- Marketplace health plan category (Bronze, Silver, Gold, Platinum, catastrophic)
- Dental coverage

Eda: That's great. There are so many options on HealthCare.gov to make it easier for consumers to choose a QHP.

Dominique: Yes! You should also help consumers compare plans using the side-by-side comparison tool to explore different QHP features and to see how plans differ in categories like costs for medical care, prescription drug coverage, and in-network providers. Consumers can also use the side-by-side comparison tool to check the availability of medical management programs important to them, like pain management, diabetes care, and psychiatric care for depression. Consumers can also compare plans by referring to each QHP's Summary of Benefits and Coverage.

Here's a key tip that you should remember when working with consumers who have children.

Key Tip

If you're working with consumers who have children, you should remind them that they may have additional costs, like different out-of-pocket maximums, if they enroll their children in a stand-alone dental plan in addition to a QHP. Some QHPs have dental coverage included, some do not. If dental coverage is important to the consumer, make sure that they check out those benefits.

Summary of Benefits and Coverage

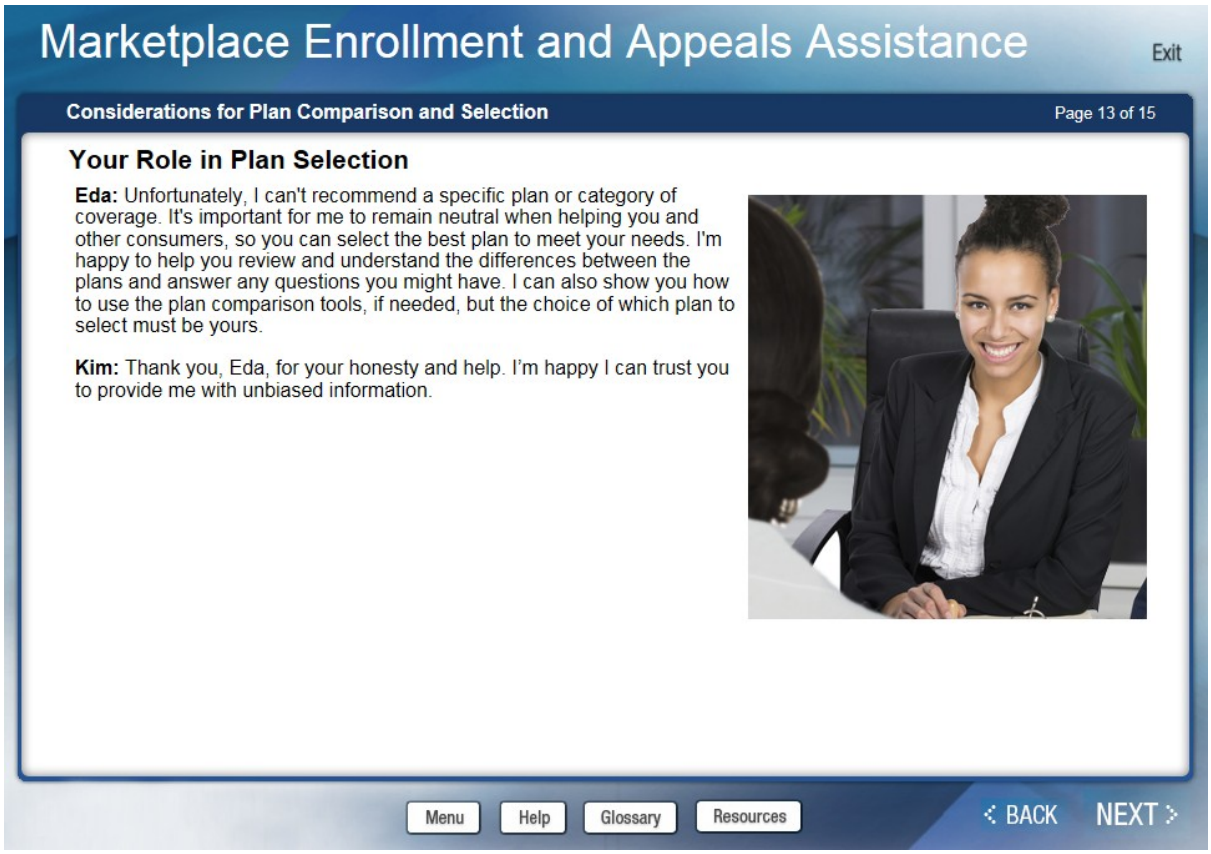
Consumers can also compare plans by referring to each QHP's Summary of Benefits and Coverage, which will give consumers information like how much they'll pay for a doctor visit or hospital stay and what costs will count toward the deductible and out-of-pocket limit. The Summary of Benefits and Coverage also tells consumers how to access the plan's list of covered drugs, called its formulary, and a list of in-network or participating providers in a provider directory.

Scenario: Assisting a Consumer with Plan Comparison

Eda is meeting with Kim today. Kim is a single female working as a waitress and making $31,000 a year. Kim tells Eda she doesn't mind switching doctors, but she does have high blood pressure and high cholesterol. Kim hopes to keep her monthly costs down as much as possible. She's meeting with Eda today because she received her eligibility determination and started comparing her QHP options through the online plan comparison tool, but needs help making a QHP selection.

Eda: Hi, Kim. What can I help you with today?

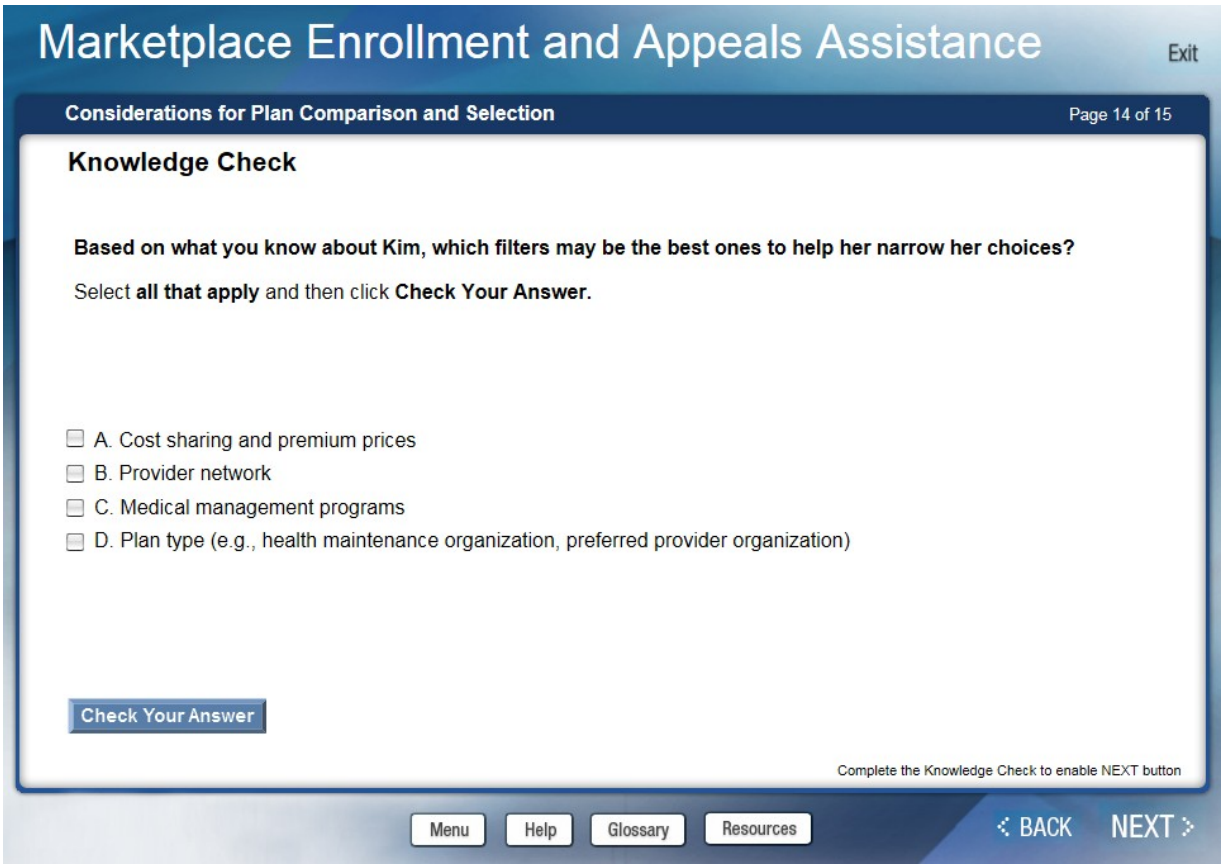
Kim: Well, I've compared my QHP options, but I still can't make up my mind. If you were me, which option would you choose?



Your Role in Plan Selection

Eda: Unfortunately, I can't recommend a specific plan or category of coverage. It's important for me to remain neutral when helping you and other consumers, so you can select the best plan to meet your needs. I'm happy to help you review and understand the differences between the plans and answer any questions you might have. I can also show you how to use the plan comparison tools, if needed, but the choice of which plan to select must be yours.

Kim: Thank you, Eda, for your honesty and help. I'm happy I can trust you to provide me with unbiased information



Knowledge Check

Based on what you know about Kim, which filters may be the best ones to help her narrow her choices?

Select **all that apply**.

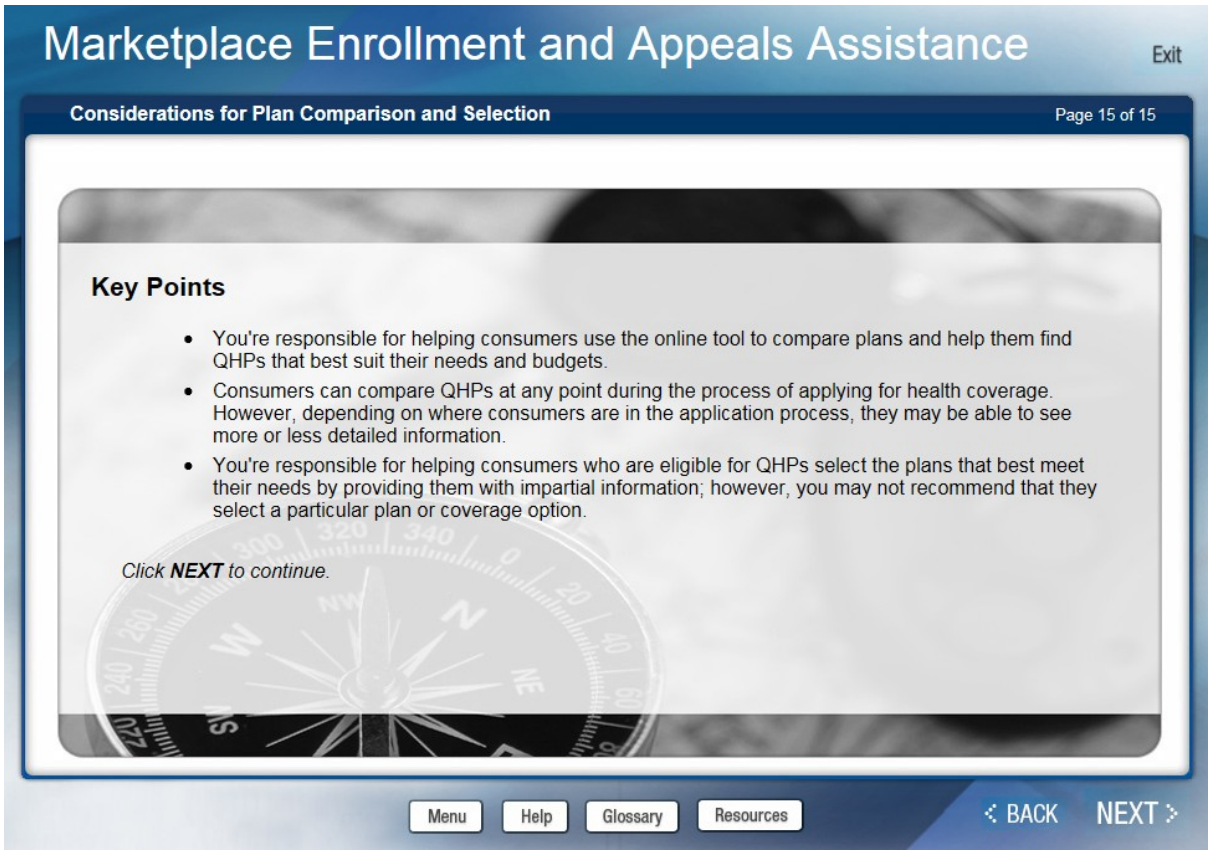
A. Cost sharing and premium prices

B. Provider network

C. Medical management programs

D. Plan type (e.g., health maintenance organization, preferred provider organization)

Feedback: The correct answers are A and C. Due to Kim's specific concerns, it's best to focus on the cost of premiums and the availability of blood pressure and cholesterol management programs. Since Kim hasn't expressed a preference for a specific insurance plan type and doesn't need to keep seeing her current doctor, at this point, those filters may be less useful.



Key Points

- You're responsible for helping consumers use the online tool to compare plans and help them find QHPs that best suit their needs and budgets.
- Consumers can compare QHPs at any point during the process of applying for health coverage. However, depending on where consumers are in the application process, they may be able to see more or less detailed information.
- You're responsible for helping consumers who are eligible for QHPs select the plans that best meet their needs by providing them with impartial information; however, you may not recommend that they select a particular plan or coverage option.

Assisting Consumers with Enrollment Module

Introduction

Once consumers have selected a QHP that meets their needs, you can help them complete their enrollment.

This training will provide you with the skills to:

1. Help consumers finalize their QHP selections and enroll in QHPs
2. Explain to consumers how to make their first premium payment

Enrollment Introduction

Dominique is continuing to prepare her colleague Eda to help consumers with the enrollment process.

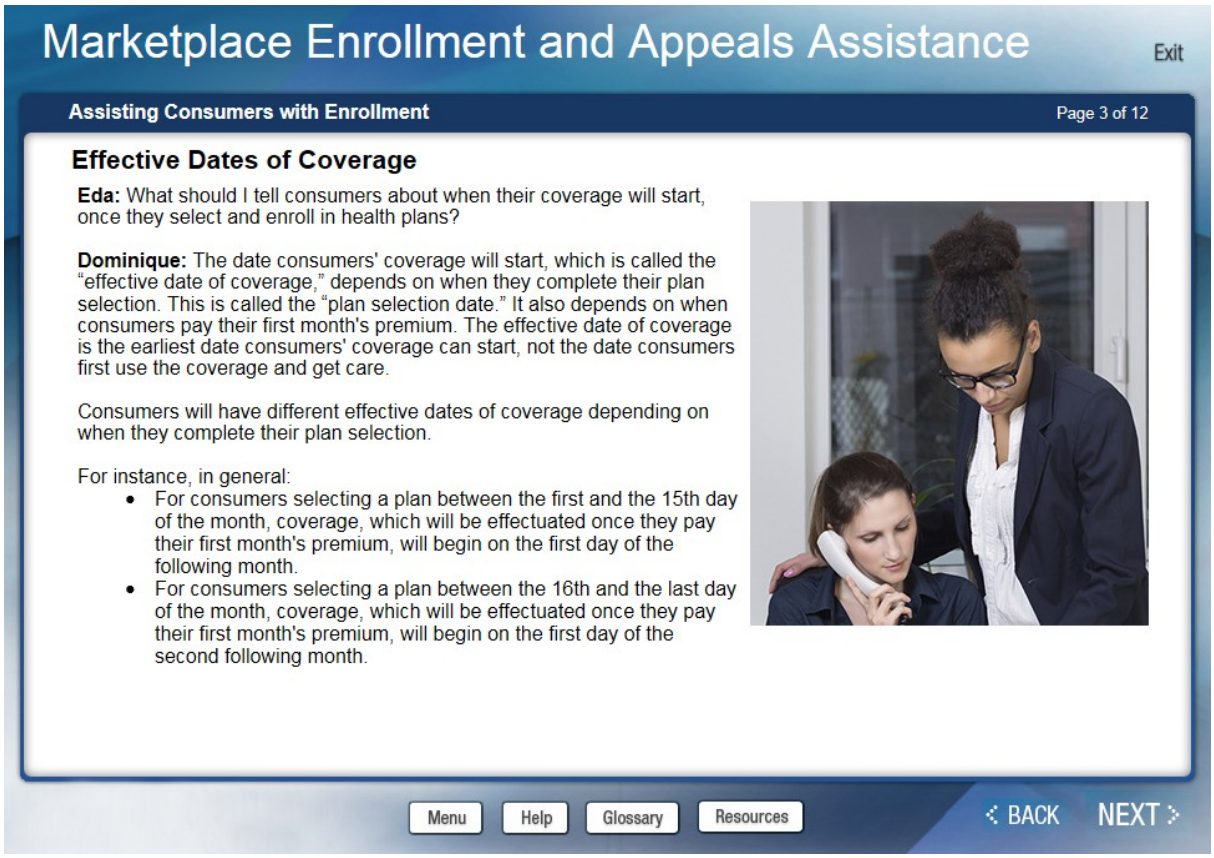
Dominique: We just discussed the steps consumers should take to compare plans after they receive their eligibility determinations. The next step is to help consumers enroll in the plans of their choice through the Marketplace.

Eda: Sounds great.

Here's a key tip that you should remember when assisting consumers with enrollment.

Key Tip

Some states allow the Marketplace in that state to make Medicaid and CHIP eligibility determinations, in other states the Marketplace makes an initial assessment and then forwards information to the state. The Marketplace will send information on consumers who are eligible or potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP) to their state Medicaid or CHIP agencies for final eligibility determinations and/or enrollment. You should be prepared to refer consumers to the relevant agencies for assistance.



Effective Dates of Coverage

Eda: What should I tell consumers about when their coverage will start, once they select and enroll in health plans?

Dominique: The date consumers' coverage will start, which is called the "effective date of coverage," depends on when they complete their plan selection. This is called the "plan selection date." It also depends on when consumers pay their first month's premium. The effective date of coverage is the earliest date consumers' coverage can start, not the date consumers first use the coverage and get care.

Consumers will have different effective dates of coverage depending on when they complete their plan selection.

For instance, in general:

- For consumers selecting a plan between the first and the 15th day of the month, coverage, which will be effectuated once they pay their first month's premium, will begin on the first day of the following month.
- For consumers selecting a plan between the 16th and the last day of the month, coverage, which will be effectuated once they pay their first month's premium, will begin on the first day of the second following month.

Examples of Effective Dates of Coverage

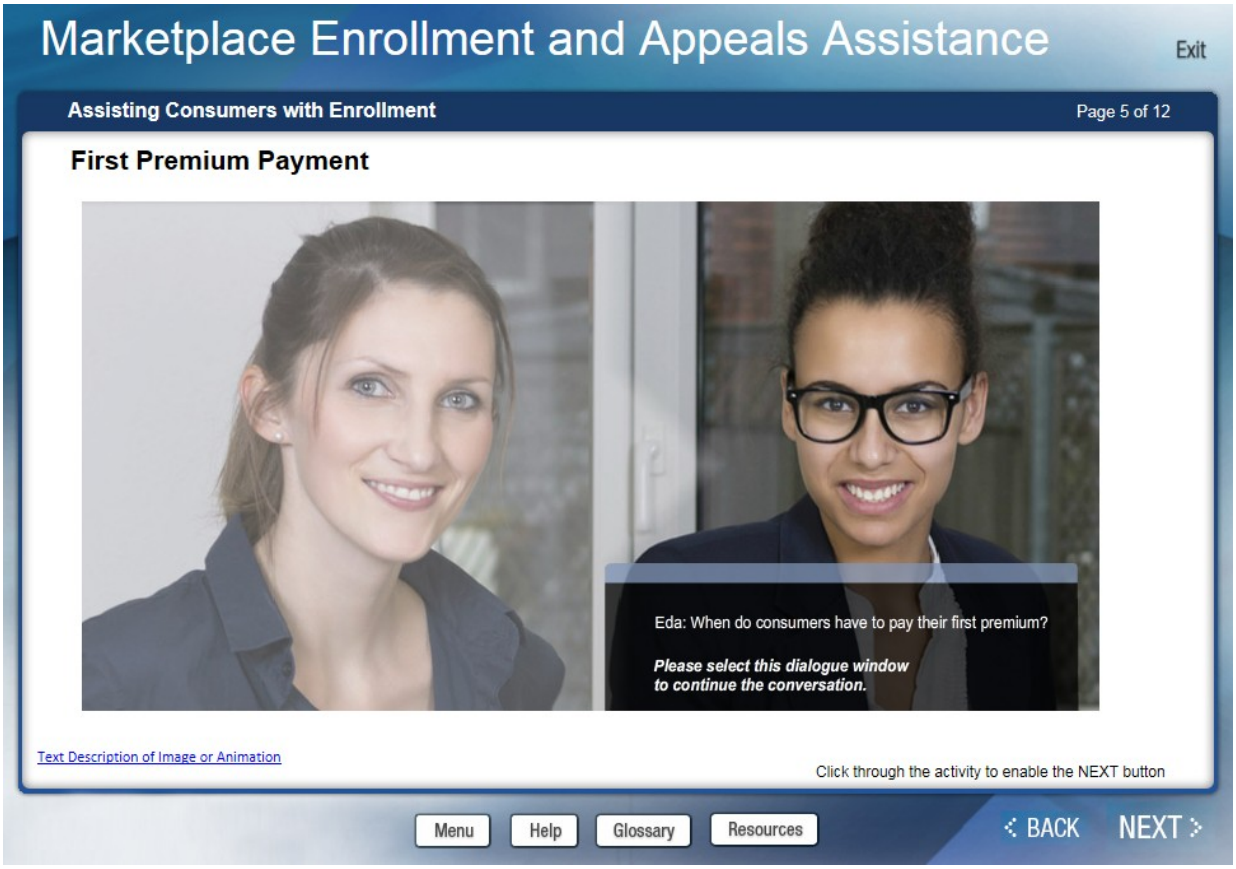
Eda: That makes sense. Can you give me an example of this for the next Open Enrollment period for the individual market?

Dominique: Sure. The Open Enrollment period for 2017 individual market coverage is November 1, 2016, through January 31, 2017. Generally, for plan selections completed under the Open Enrollment period.

- If consumers select a QHP on or before December 15, 2016, their effective date of coverage, which will be effectuated once they pay their first month's premium, will be January 1, 2017.
- If consumers select a QHP between December 16, 2016 and January 15, 2017, the effective date of coverage, which will be effectuated once they pay their first month's premium, will be February 1, 2017.
- If consumers select a QHP between January 16 and 31, 2017, the effective date of coverage, which will be effectuated once they pay their first month's premium, will be March 1, 2017.

Eda: So, if a consumer enrolls in a plan on January 17, 2017, coverage would become effective on March 1, 2017, and will be effectuated once the consumer pays his/her first month's premium, right?

Dominique: Exactly.



First Premium Payment

Eda: When do consumers have to pay their first premium?

Dominique: Once consumers select their plans, it's important they understand their QHP enrollment isn't complete until the health insurance company gets the payment in full for the first month's premium prior to the premium due date. If the premium payment isn't received, their enrollment may be canceled.

To help consumers complete the enrollment process by paying their first premium, here are a few key things to keep in mind:

- Help consumers access the plan selection confirmation screen on HealthCare.gov so they can view their selected QHPs and premium payment amounts.
- Determine whether consumers want to make their premium payments electronically, by mail, or by phone, if applicable.
- Walk consumers through the steps necessary to complete payment with their selected payment method.

Monthly Premium Payment

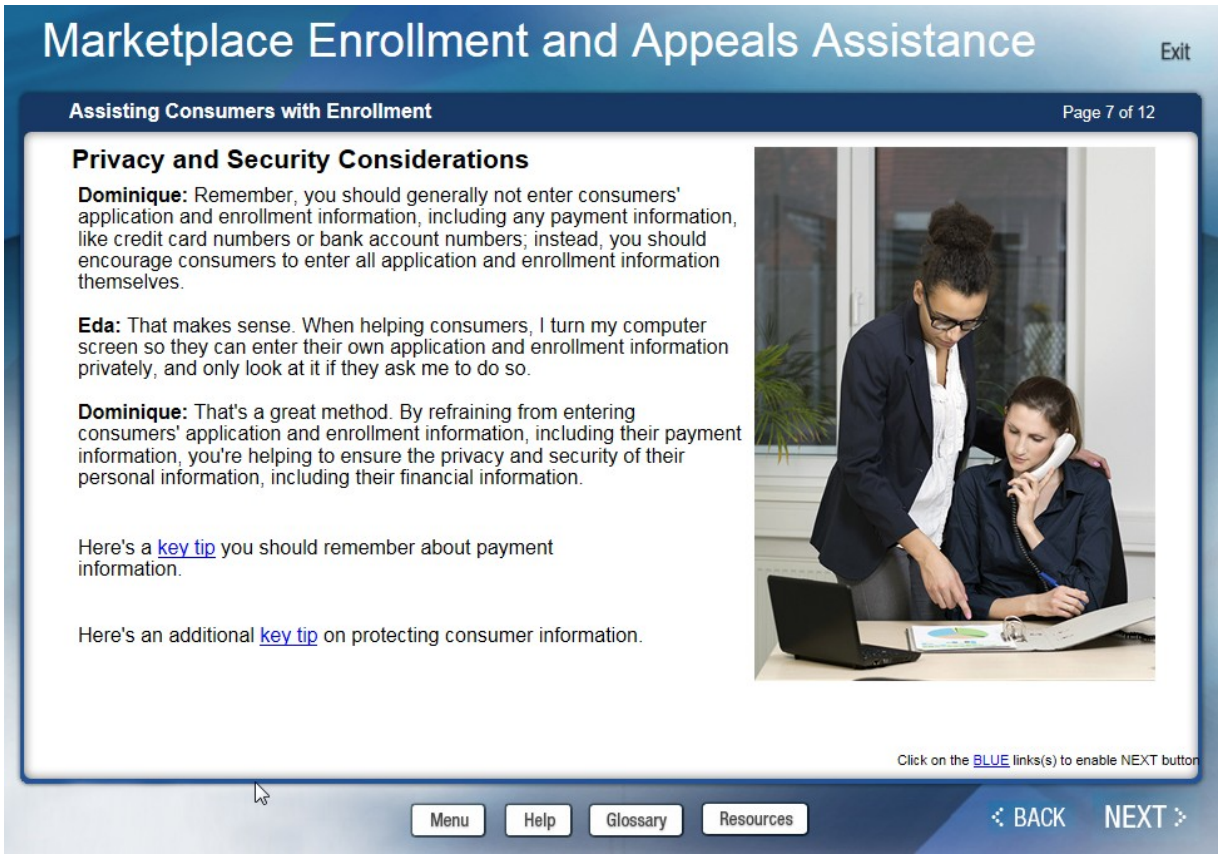
Dominique: It's also important to help consumers understand they must pay their premium in full every month to keep their coverage.

Eda: So, if consumers don't pay their premiums in full by the due date, the QHP could terminate their coverage?

Dominique: Yes, remind consumers that they have options for how to pay their premiums, but they must make their full premium payments, or the QHP could terminate their coverage (unless a grace period for non-payment of premiums applies).

More Information about the Grace Period

There's a three-month grace period for consumers who get advance payments of the premium tax credit and have previously paid at least the first full month's premium ("binder payment") since enrolling. The QHP may continue to pay claims during the first month of the grace period, but may delay payment of claims in the second and third months until these consumers pay their overdue premiums. After the third month, if these consumers still haven't paid their premiums in full, their plans must terminate their coverage, effective retroactively to the end of the first month of the grace period. This means the consumer could be responsible for payment of any claims made on the consumer's behalf during the second and third months of the grace period.



Privacy and Security Considerations

Dominique: Remember, you should generally not enter consumers' application and enrollment information, including any payment information, like credit card numbers or bank account numbers; instead, you should encourage consumers to enter all application and enrollment information themselves.

Eda: That makes sense. When helping consumers, I turn my computer screen so they can enter their own application and enrollment information privately, and only look at it if they ask me to do so.

Dominique: That's a great method. By refraining from entering consumers' application and enrollment information, including their payment information, you're helping to ensure the privacy and security of their personal information, including their financial information.

Here's a key tip you should remember about payment information.

Key Tip: Payment Information

Consumers who don't have bank accounts can make payments through alternate methods, such as cashier's checks, money orders, or pre-paid debit cards. Some health insurance companies may allow consumers to pay premiums through other methods as well.

Here's an additional key tip on protecting consumer information.

Key Tip: Protecting Consumer Information

You must obtain a consumer's consent for you to access his or her personally identifiable information (PII) before providing assistance. As a best practice, always return originals or copies of official documents that contain a consumer's PII to consumers and only make copies for yourself or others if necessary to carry out required duties. If information is left with you by accident, store the documents in a safe, locked location, and return PII to consumers as soon as possible.

Scenario: Assisting a Consumer with the Enrollment Process

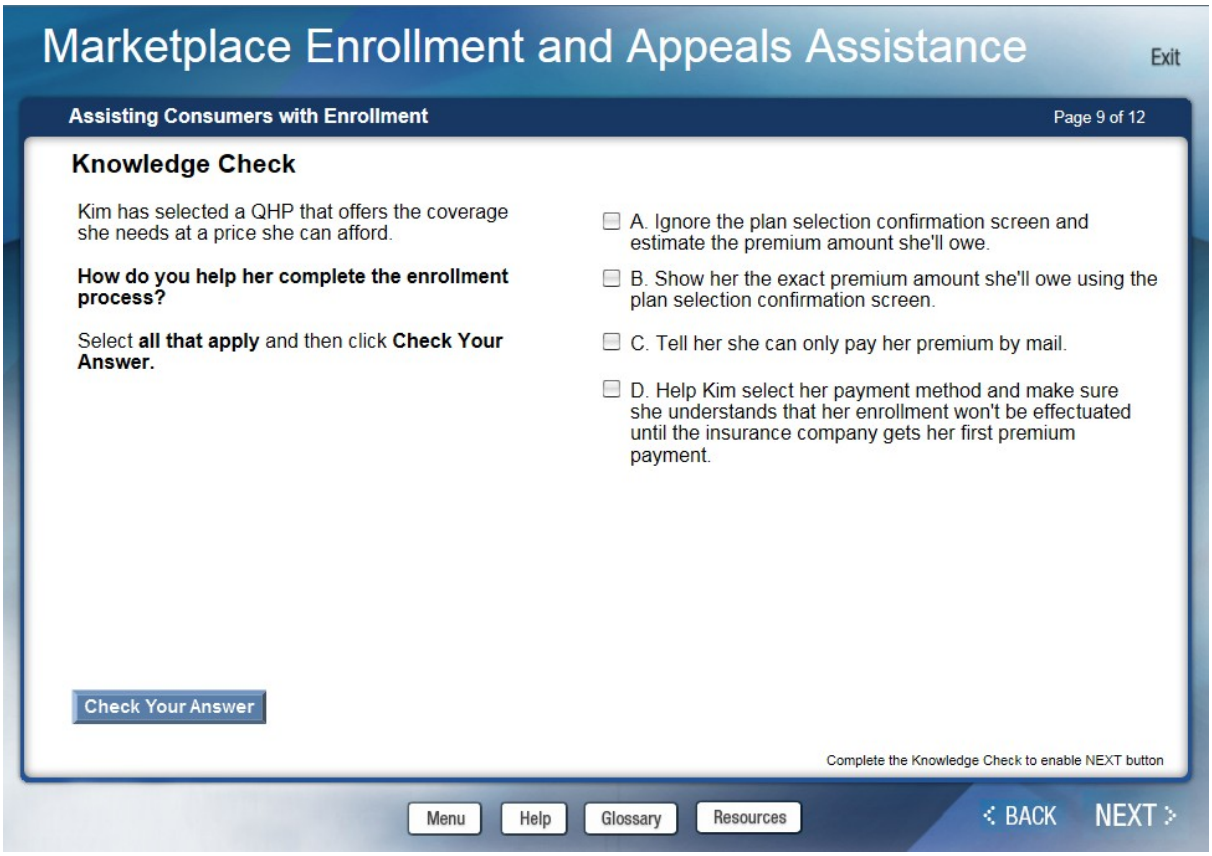
Eda helps Kim complete the enrollment process. Kim has selected a QHP in which she wants to enroll.

Kim: I think I've finally chosen the plan that's best for me. I'm all done, right?

Eda: Not quite, Kim. When you make your final selection, the Marketplace is going to give you two options:

1. You can go to the health insurance company's website to make arrangements for premium payment; or
2. You can wait for the insurance company to send you a bill.

Your enrollment in the plan won't be effective until the health insurance company gets your first premium payment. If you don't make your premium payment by the due date, your enrollment will be canceled.



Knowledge Check

Kim has selected a QHP that offers the coverage she needs at a price she can afford.

How do you help her complete the enrollment process?

Select **all that apply**.

A. Ignore the plan selection confirmation screen and estimate the premium amount she'll owe.

B. Show her the exact premium amount she'll owe using the plan selection confirmation screen.

C. Tell her she can only pay her premium by mail.

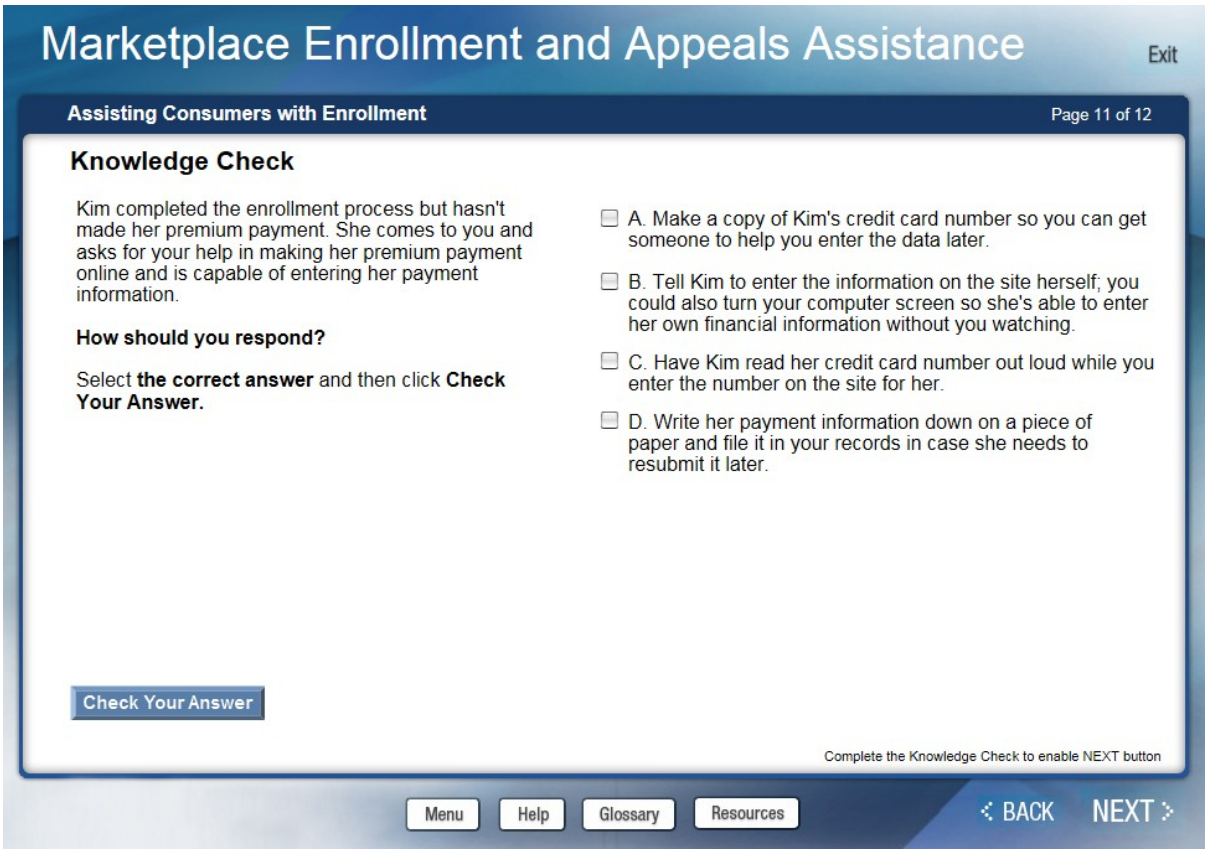
D. Help Kim select her payment method and make sure she understands that her enrollment won't be effectuated until the insurance company gets her first premium payment.

Feedback: The correct answers are B and D. To help Kim complete the enrollment process, you should show her the exact premium payment amount she'll owe for the plan she selected using the plan selection confirmation screen. You should also help her select a payment method, like mail, phone, or online, and make sure she understands her QHP enrollment won't be effectuated until the insurance company gets the first premium payment in full.

Scenario: Privacy and Security Considerations

Kim made her final QHP selection and completed all of the steps for enrollment in health coverage through the Marketplace with the exception of making a payment. She is capable of entering her payment information herself, but asks if she can give Eda her credit card to make the payment for her.

Eda: I'm sorry, Kim, but our policy is that you should enter your financial information, such as your credit card number. I can tell you how to enter the information yourself, and I won't watch while you do so, unless you ask me to look at what you are entering so I can help you complete the enrollment process. This is one of the steps we take to ensure the safety and security of your personal and financial information.



Knowledge Check

Kim completed the enrollment process but hasn't made her premium payment. She comes to you and asks for your help in making her premium payment online and is capable of entering her payment information.

How should you respond?

Select **the correct answer**.

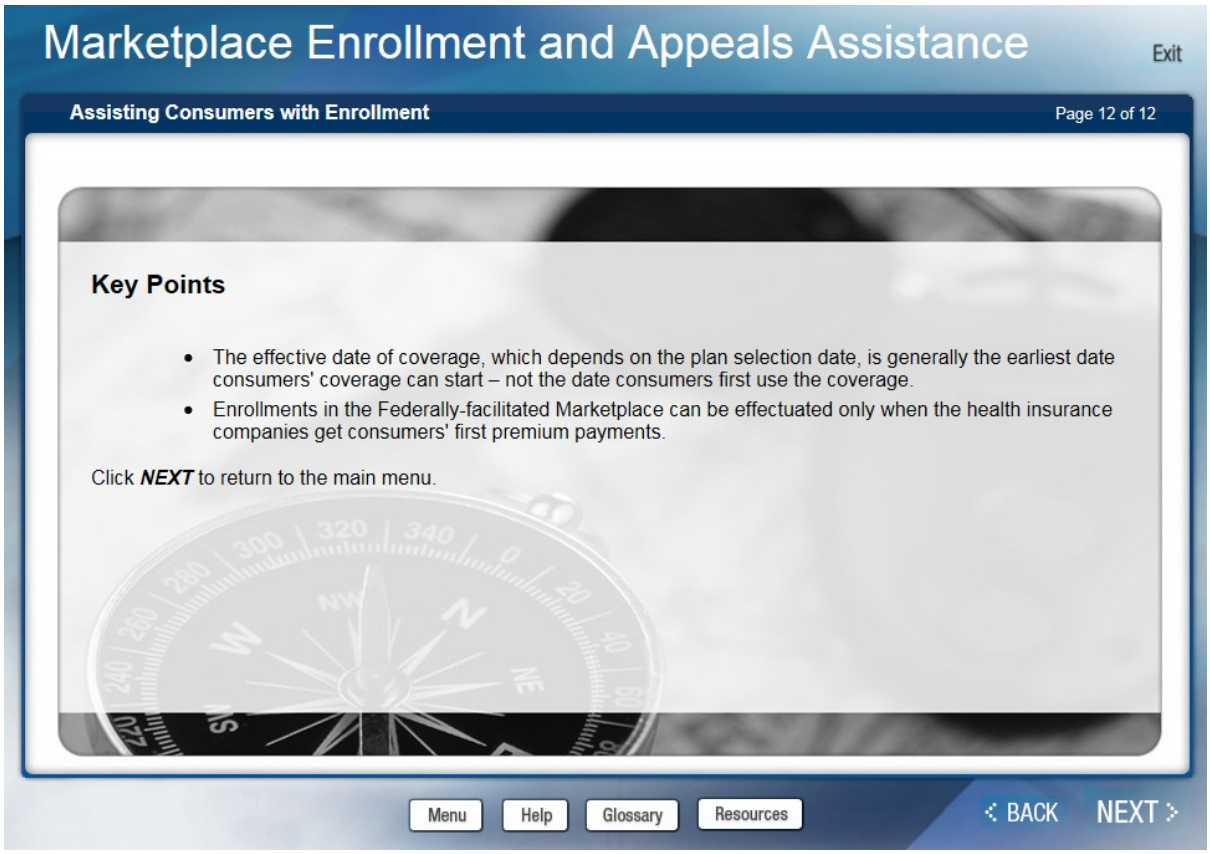
A. Make a copy of Kim's credit card number so you can get someone to help you enter the data later.

B. Tell Kim to enter the information on the site herself; you could also turn your computer screen so she's able to enter her own financial information without you watching.

C. Have Kim read her credit card number out loud while you enter the number on the site for her.

D. Write her payment information down on a piece of paper and file it in your records in case she needs to resubmit it later.

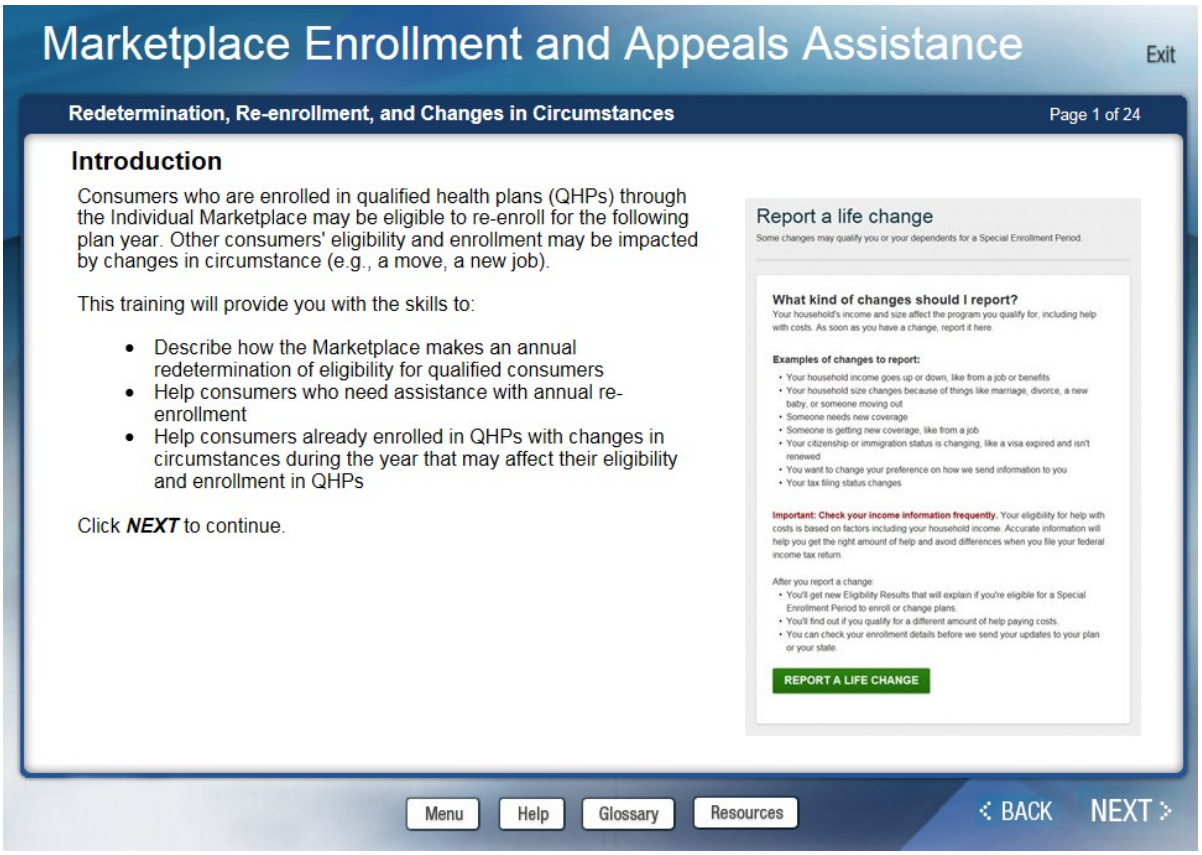
Feedback: The correct answer is B. To protect Kim’s privacy, you should tell her to enter the information on the site herself; you could also turn your computer screen so that she’s able to privately enter her own financial information without you watching.



Key Points

- The effective date of coverage, which depends on the plan selection date, is generally the earliest date consumers' coverage can start – not the date consumers first use the coverage.
- Enrollments in the Federally-facilitated Marketplace can be effectuated only when the health insurance companies get consumers' first premium payments.

Redetermination, Re-enrollment, Changes in Circumstances Module



Introduction

Consumers who are enrolled in qualified health plans (QHPs) through the Individual Marketplace may be eligible to re-enroll for the following plan year. Other consumers' eligibility and enrollment may be impacted by changes in circumstance (e.g., a move, a new job).

This training will provide you with the skills to:

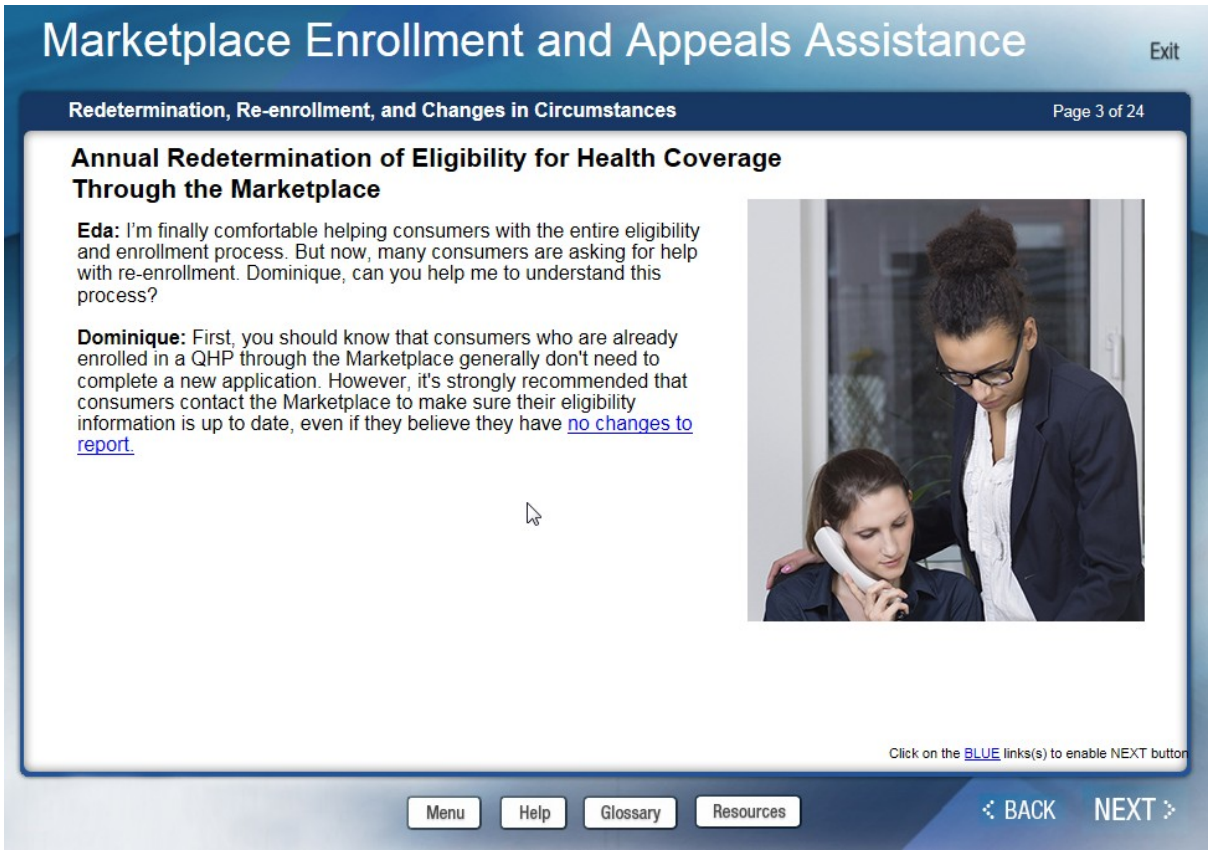
- Describe how the Marketplace makes an annual redetermination of eligibility for qualified consumers
- Help consumers who need assistance with annual re-enrollment
- Help consumers already enrolled in QHPs with changes in circumstances during the year that may affect their eligibility and enrollment in QHPs

Helping Consumers Renewing or Selecting New Marketplace Plans

Some consumers you help will already have experience with and coverage through the Marketplace 2016, and they'll need your help re-enrolling in coverage for 2017.

Asking consumers the following questions will help you understand how to move forward with potential re-enrollments in Marketplace plans:

- Do you currently have a Marketplace plan?
- Do you use your Marketplace plan?
- What was your experience like with your Marketplace plan?
- What questions do you have about using your current plan?
- Was your current Marketplace plan sufficient for your needs?
- Why or why not?



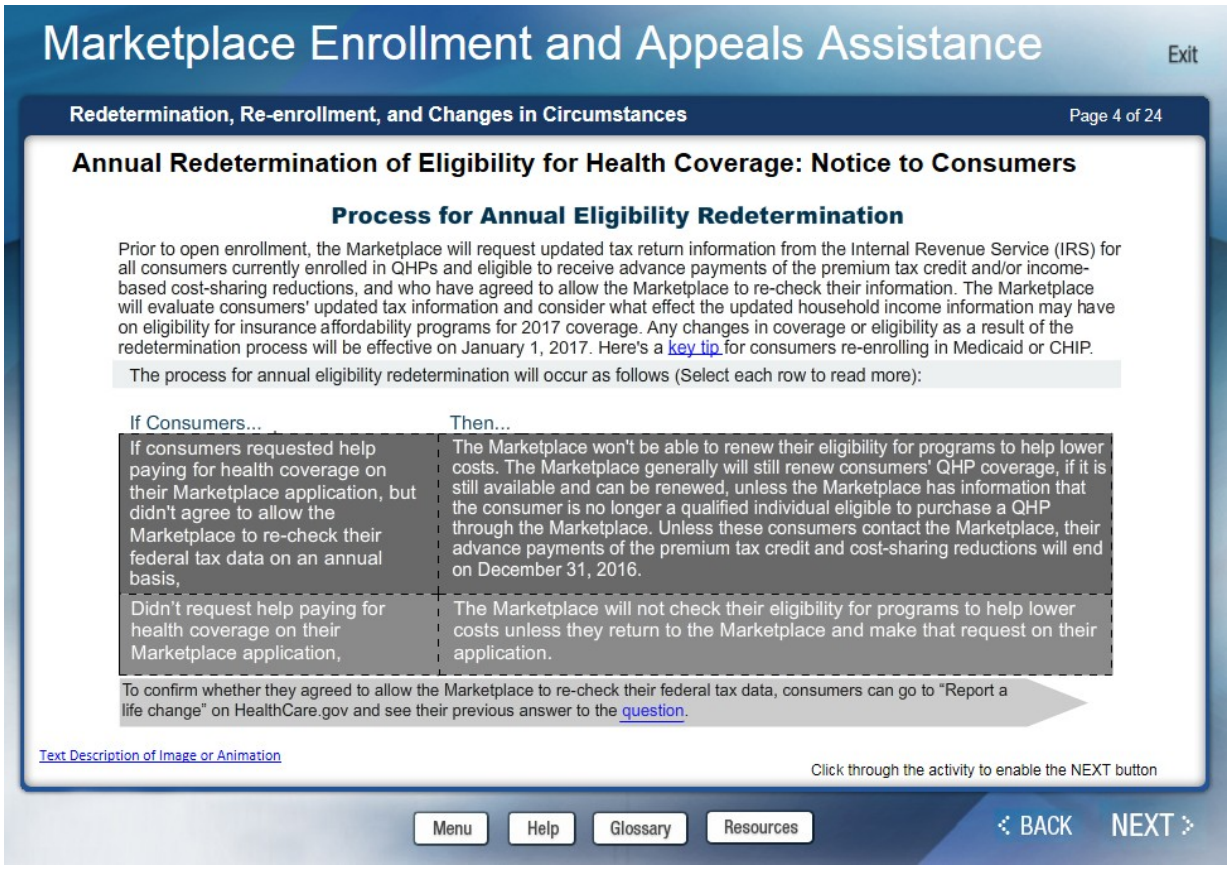
Annual Redetermination of Eligibility for Health Coverage Through the Marketplace

Eda: I'm finally comfortable helping consumers with the entire eligibility and enrollment process. But now, many consumers are asking for help with re-enrollment. Dominique, can you help me to understand this process?

Dominique: First, you should know that consumers who are already enrolled in a QHP through the Marketplace generally don't need to complete a new application. However, it's strongly recommended that consumers contact the Marketplace to make sure their eligibility information is up to date, even if they believe they have no changes to report.

More Information about Changes to Report

As a reminder, consumers currently enrolled in QHPs are required to report changes that affect eligibility for enrollment and, if applicable, for advance payments of the premium tax credit and/or cost-sharing reductions, within 30 days of the change.



Annual Redetermination of Eligibility for Health Coverage: Notice to Consumers

Process for Annual Eligibility Redetermination

Prior to open enrollment, the Marketplace will request updated tax return information from the Internal Revenue Service (IRS) for all consumers currently enrolled in QHPs and eligible to receive advance payments of the premium tax credit and/or income- based cost-sharing reductions, and who have agreed to allow the Marketplace to re- check their information. The Marketplace will evaluate consumers' updated tax information and consider what effect the updated household income information may have on eligibility for insurance affordability programs for 2017 coverage. Any changes in coverage or eligibility as a result of the redetermination process will be effective on January 1, 2017. Here's a key tip for consumers re-enrolling in Medicaid or CHIP.

Key Tip

For consumers covered by Medicaid or CHIP, the state's Medicaid or CHIP agency will redetermine their eligibility for the program on an annual basis. These consumers should be directed to the applicable state agency.

The process for annual eligibility redetermination will occur as follows:

If Consumer…	Then…
If consumers requested help paying for health coverage on their Marketplace application, but didn't agree to allow the Marketplace to re-check their federal tax data on an annual basis	Then the Marketplace won't be able to renew their eligibility for programs to help lower costs. The Marketplace generally will still renew consumers' QHP coverage, if it is still available and can be renewed, unless the Marketplace has information that the consumer is no longer a qualified individual eligible to purchase a QHP through the Marketplace. Unless these consumers contact the Marketplace, their advance payments of the premium tax credit and cost-sharing reductions will end on December 31, 2016.
Didn't request help paying for health coverage on their Marketplace application	The Marketplace will not check their eligibility for programs to help lower costs unless they return to the Marketplace and make that request on their applications. To confirm whether they agreed to allow the Marketplace to re-check their federal tax data, consumers can go to "Report a life change" on HealthCare.gov and see their previous answer to the question.

More Information about This Question

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns, for the next 5 years (the maximum number of years allowed). The marketplace will send me a notice, let me make any changes, and I can opt out at any time.

- Agree
- Disagree

Eligibility Redetermination Notice to Consumers

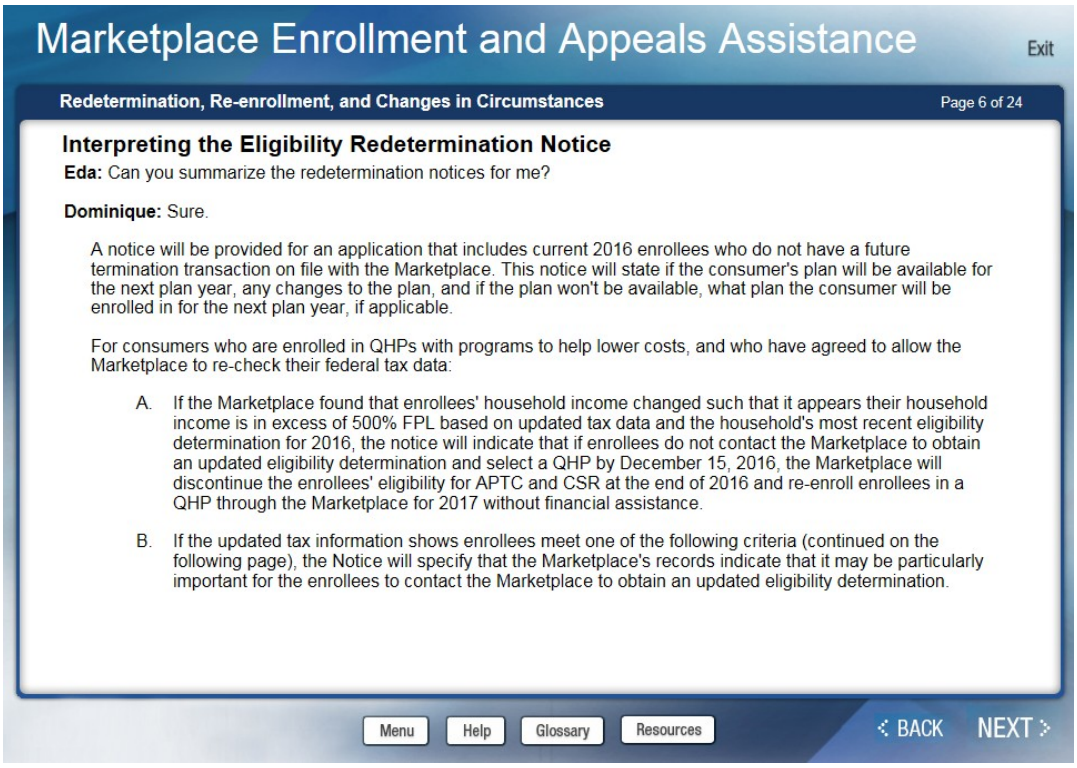
Eda: What type of notices should current consumers expect leading up to OEP?

Dominique: The Marketplace will send consumers a notice in 2016 summarizing their eligibility for the coming year. There are four variations of the eligibility notice: the standard eligibility notice, an income-based outreach notice, the did-not-reconcile notice, and a special notice. It's important that consumers review the notice and notify the Marketplace if anything is incorrect. All consumers who enrolled in Marketplace coverage during the 2016 plan year will get a notice.

Consumers who are enrolled in a plan will also get a notice from their insurance company about their plan and whether it can be renewed, and any changes to the plan.

More Information about the Four Variations

Four variations of the eligibility redetermination notice will be covered in more depth in the Advanced Marketplace Issues course.



Interpreting the Eligibility Redetermination Notice

Eda: Can you summarize the redetermination notices for me?

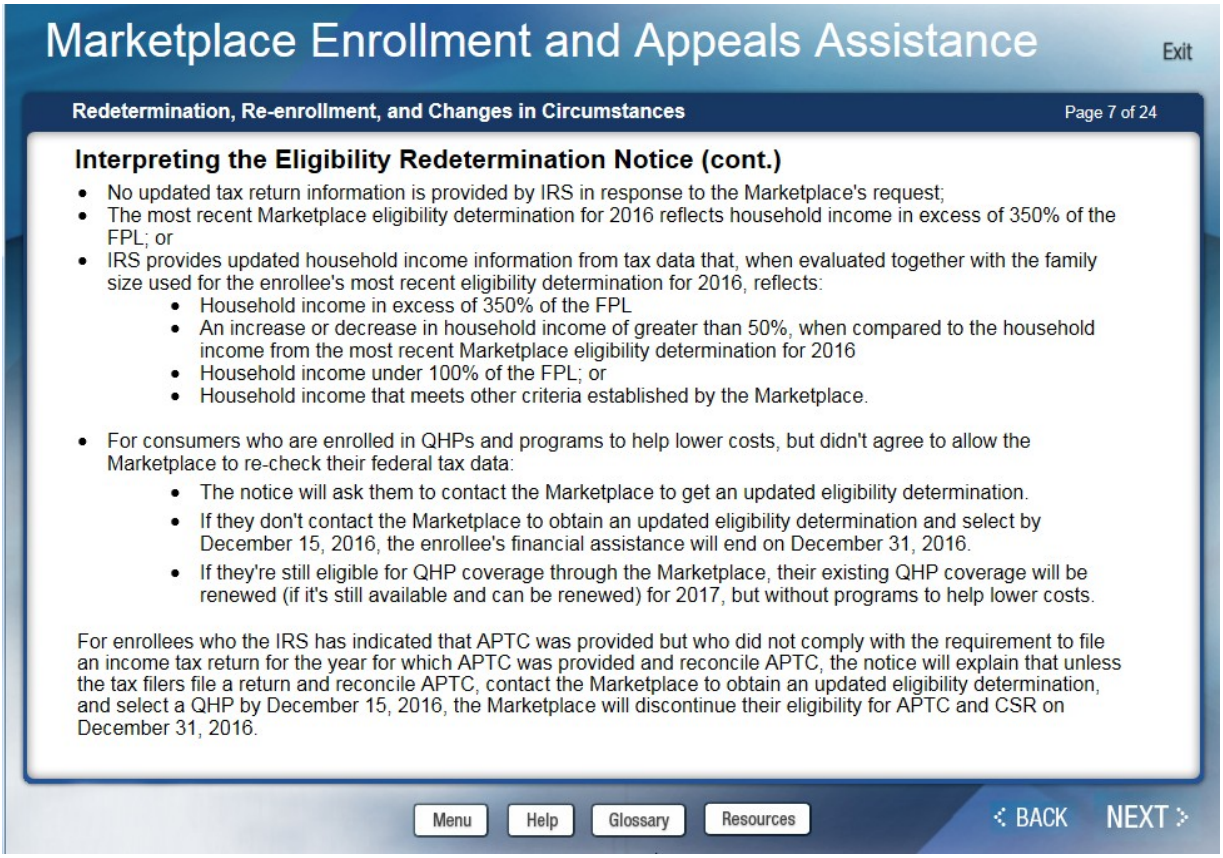
Dominique: Sure.

A notice will be provided for an application that includes current 2016 enrollees who do not have a future termination transaction on file with the Marketplace. This notice will state if the consumer's plan will be available for the next plan year, any changes to the plan, and if the plan won't be available, what plan the consumer will be enrolled in for the next plan year, if applicable.

For consumers who are enrolled in QHPs with programs to help lower costs, and who have agreed to allow the Marketplace to re-check their federal tax data:

A. If the Marketplace found that enrollees' household income changed such that it appears their household income is in excess of 500% FPL based on updated tax data and the household's most recent eligibility determination for 2016, the notice will indicate that if enrollees do not contact the Marketplace to obtain an updated eligibility determination and select a QHP by December 15, 2016, the Marketplace will discontinue the enrollees' eligibility for APTC and CSR at the end of 2016 and re-enroll enrollees in a QHP through the Marketplace for 2017 without financial assistance.

B. If the updated tax information shows enrollees meet one of the following criteria (continued on the following page), the Notice will specify that the Marketplace's records indicate that it may be particularly important for the enrollees to contact the Marketplace to obtain an updated eligibility determination.

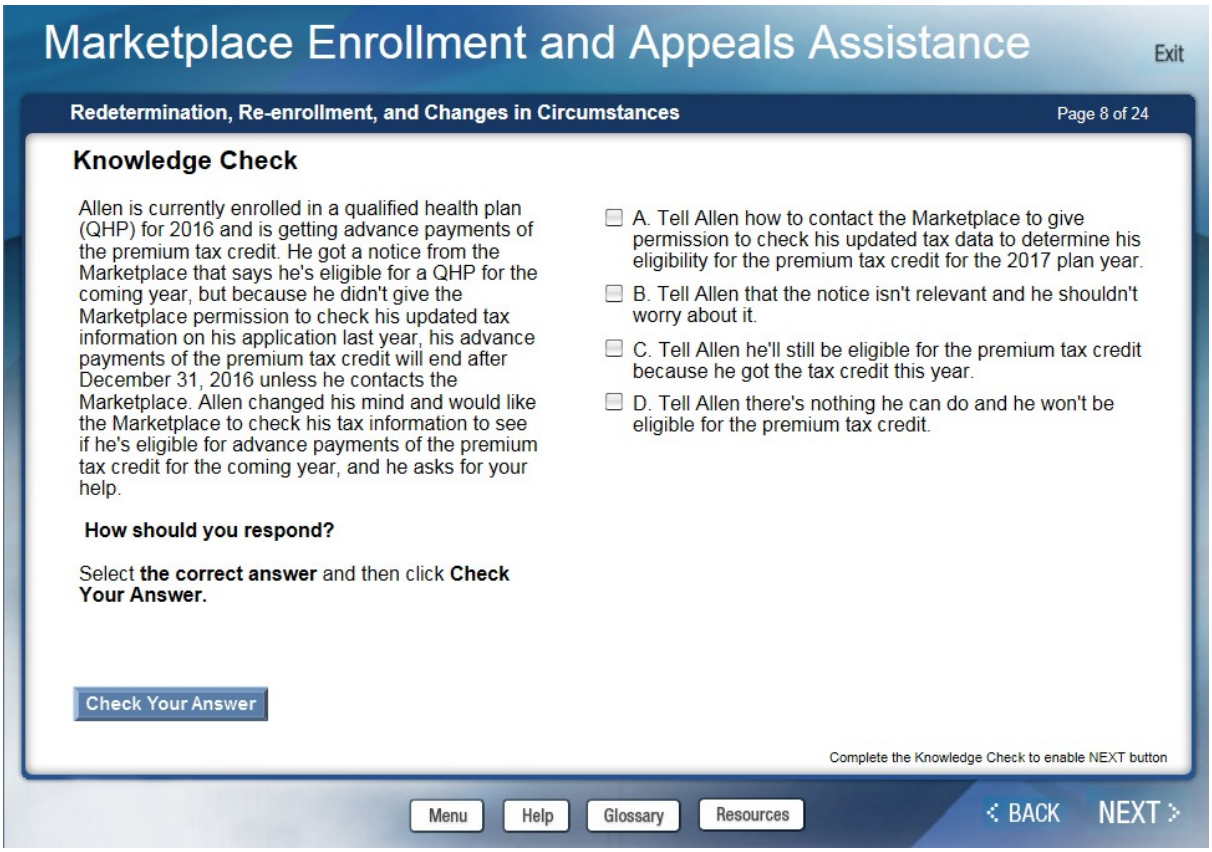


Interpreting the Eligibility Redetermination Notice (cont.)

- No updated tax return information is provided by IRS in response to the Marketplace's request;
- The most recent Marketplace eligibility determination for 2016 reflects household income in excess of 350% of the FPL; or
- IRS provides updated household income information from tax data that, when evaluated together with the family size used for the enrollee's most recent eligibility determination for 2016, reflects:
    - Household income in excess of 350% of the FPL
    - An increase or decrease in household income of greater than 50%, when compared to the household income from the most recent Marketplace eligibility determination for 2016
    - Household income under 100% of the FPL; or
    - Household income that meets other criteria established by the Marketplace.
- For consumers who are enrolled in QHPs and programs to help lower costs, but didn't agree to allow the Marketplace to re-check their federal tax data:

- The notice will ask them to contact the Marketplace to get an updated eligibility determination.
- If they don't contact the Marketplace to obtain an updated eligibility determination and select by December 15, 2016, the enrollee's financial assistance will end on December 31, 2016.
- If they're still eligible for QHP coverage through the Marketplace, their existing QHP coverage will be renewed (if it's still available and can be renewed) for 2017, but without programs to help lower costs.

For enrollees who the IRS has indicated that APTC was provided but who did not comply with the requirement to file an income tax return for the year for which APTC was provided and reconcile APTC, the notice will explain that unless the tax filers file a return and reconcile APTC, contact the Marketplace to obtain an updated eligibility determination, and select a QHP by December 15, 2016, the Marketplace will discontinue their eligibility for APTC and CSR on December 31, 2016.



Knowledge Check

Allen is currently enrolled in a qualified health plan (QHP) for 2016 and is getting advance payments of the premium tax credit. He got a notice from the Marketplace that says he's eligible for a QHP for the coming year, but because he didn't give the Marketplace permission to check his updated tax information on his application last year, his advance payments of the premium tax credit will end after December 31, 2016 unless he contacts the Marketplace. Allen changed his mind and would like the Marketplace to check his tax information to see if he's eligible for advance payments of the premium tax credit for the coming year, and he asks for your help.

How should you respond?

Select **the correct answer.**

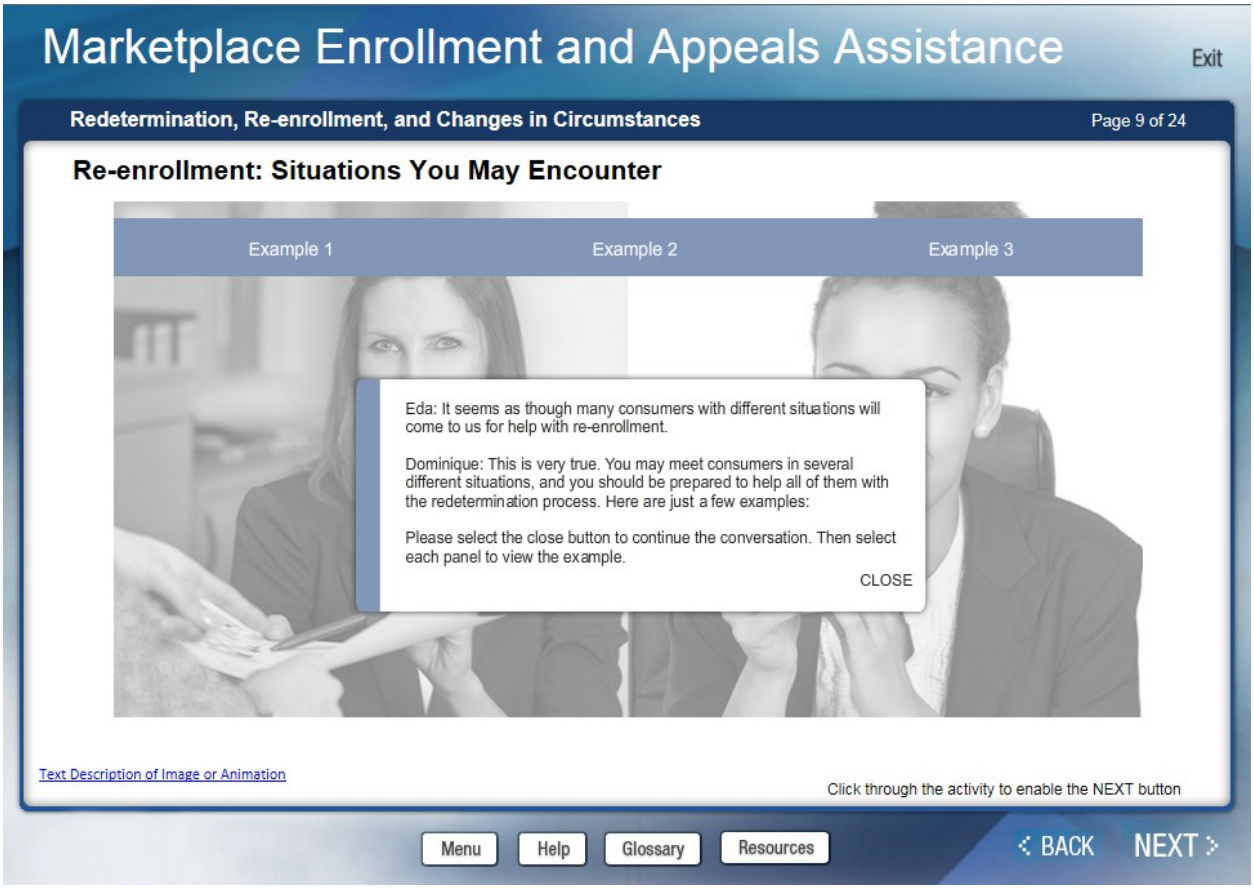
A. Tell Allen how to contact the Marketplace to give permission to check his updated tax data to determine his eligibility for the premium tax credit for the 2016 plan year.

B. Tell Allen that the notice isn't relevant and he shouldn't worry about it.

C. Tell Allen he'll still be eligible for the premium tax credit because he got the tax credit this year.

D. Tell Allen there's nothing he can do and he won't be eligible for the premium tax credit.

Feedback: The correct answer is A. You should tell Allen how to contact the Marketplace so that he can give permission for the Marketplace to check his updated tax information to determine his eligibility for advance payments of the premium tax credit for the coming year.



Re-enrollment: Situations You May Encounter

Eda: It seems as though many consumers with different situations will come to us for help with re-enrollment.

Dominique: This is very true. You may meet consumers in several different situations and you should be prepared to help all of them with the redetermination process. Here are just a few examples:

Example 1

For consumers who are enrolled in a QHP and provided the Marketplace with income information for 2016 that, together with household size and 2016 FPL tables, indicates that the projected annual household income is within the APTC-eligible range, the Marketplace will use this projected annual household income and family size from the most recent application, and updated FPL tables to determine the amount of APTC and CSR these consumers will receive.

Example 2

Consumers who are enrolled in a QHP and got a notice that they're still eligible for QHP enrollment and programs to help lower costs, but aren't planning to contact the Marketplace to update their eligibility or make any changes. The amount of APTC and CSR these consumers get

will be based on tax data from the IRS adjusted to 2017, family-size from the most recent application, and updated FPL tables.

Example 3

Consumers who did not file an income tax return for the year for which APTC was provided and reconcile APTC. Unless these consumers file an income tax return and reconcile APTC, contact the Marketplace to obtain an updated eligibility determination, and enroll in a Marketplace plan by December 15, 2016, the Marketplace will discontinue consumers' eligibility for APTC and CSR on December 31, 2016.

Reminder: Advise consumers that even if they will be auto re-enrolled they should confirm with the Marketplace that their information is still current. Consumes also need to make sure their current plan is still the best one for them and their family.

Updating Marketplace Account Information

Dominique stops to check in with Eda to see how she's doing.

Dominique: How are you, Eda?

Eda: I'm so glad you stopped by! Recently, someone I helped asked me how updates to their Marketplace account profile online might impact their eligibility. Can you help me understand what will and won't impact consumers' eligibility?

Dominique: Sure, small changes that don't affect consumers' eligibility are considered "account profile updates."

Some of these updates may include:

1. Updating an e-mail address
2. Changing a password
3. Changing an authorized representative, a person designated by a consumer to act on their behalf
4. Relocating within the same zip code
5. Security Questions
6. Phone Number

Eda: These changes seem like easy updates that consumers can make themselves on HealthCare.gov.

Dominique: Exactly.

Changes Affecting Eligibility & Enrollment

Dominique: Updating basic Marketplace account profile information is different from updating application data, which could affect consumers' eligibility for health coverage through the Marketplace or for advance payments of the premium tax credit or cost- sharing reductions. Consumers must revisit the online application to make changes if they want to update their application information after it has been submitted.

Eda: That makes sense. What if consumers need to change both their Marketplace account profile and their application data?

Dominique: That's also possible. For instance, if consumers want to change their e-mail address in their Marketplace account profile and update their communication preferences to get application notices electronically, they'll have to update their information on HealthCare.gov and in their application data, because the option to receive application notices electronically is on the application itself.

Changes Affecting Eligibility & Enrollment (continued)

Eda: Thanks, Dominique. What kinds of changes could have an effect on consumers' eligibility?

Dominique: Some examples of application changes that could impact consumers' eligibility at any time during the year include:

- A new state of residence
- A new job or a raise that changes a consumer's household income
- A loss of a job or household income
- A new job that offers different health coverage or doesn't offer any health coverage

Eda: So, if consumers move out of state or start a new job, it might mean changes to their health coverage options?

Dominique: Yes, once consumers inform the Marketplace of these changes, the Marketplace will verify the new information and re-determine their eligibility. A change could mean that a consumer may qualify for different health coverage, or for a different amount of help paying for coverage.

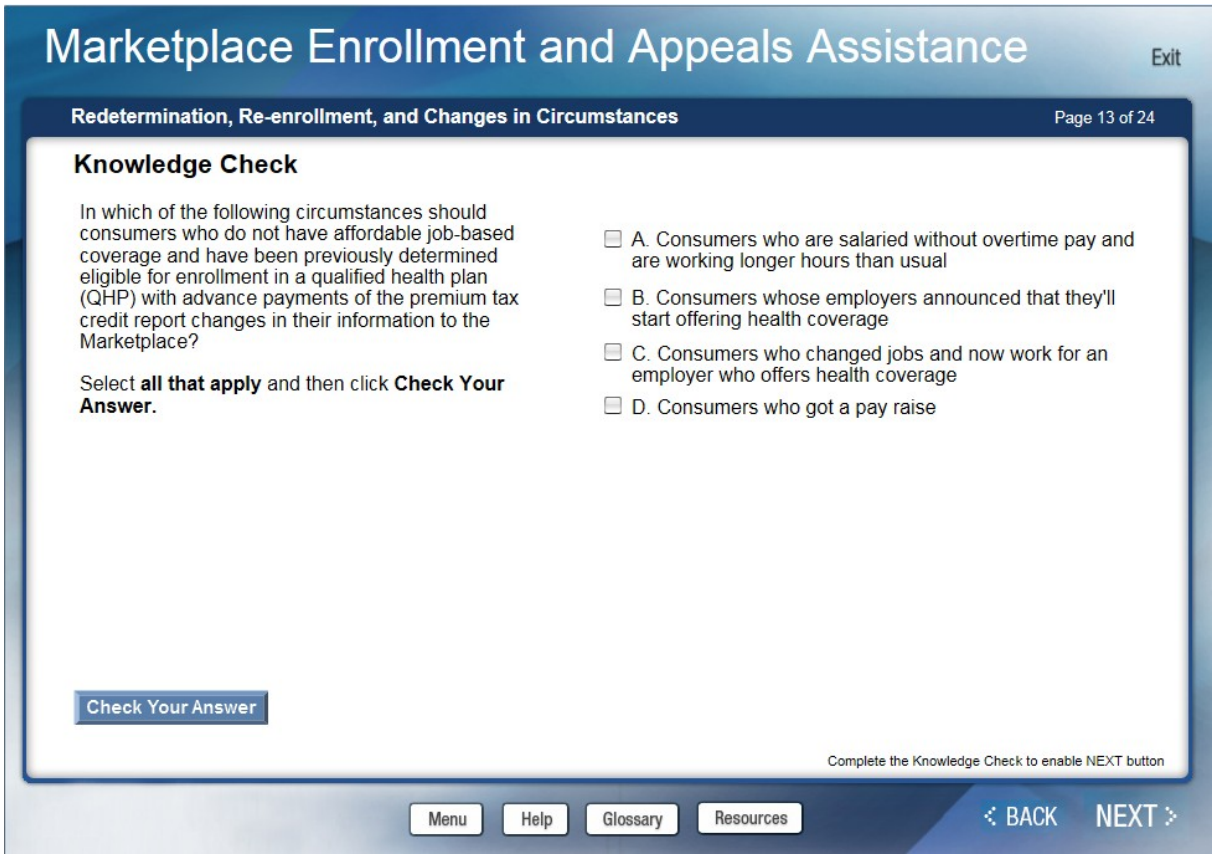
Dominique: For example:

- Consumers receiving advance payments of the premium tax credit and/or cost- sharing reductions who have a decrease in income (or an increase in household size) may be able to get more help paying their QHP premiums or may qualify for Medicaid or CHIP coverage.
- Consumers receiving advance payments of the premium tax credit who have an increase in income may be eligible for a lower amount of advance payments of the premium tax credit.

Eda: If consumers have an update that they want to make, is there a deadline for when they have to make the change?

Dominique: Consumers should report changes to the Marketplace within 30 days of the change occurring. Doing so will help make sure they are able to receive the maximum benefits for which they are eligible, and will help consumers who are receiving advance payments of the premium tax credit avoid having to pay more taxes when they file their federal income tax returns.

Eda: Thanks, Dominique. This is helpful.



Knowledge Check

In which of the following circumstances should consumers who do not have affordable job-based coverage and have been previously determined eligible for enrollment in a qualified health plan (QHP) with advance payments of the premium tax credit report changes in their information to the Marketplace?

Select **all that apply**.

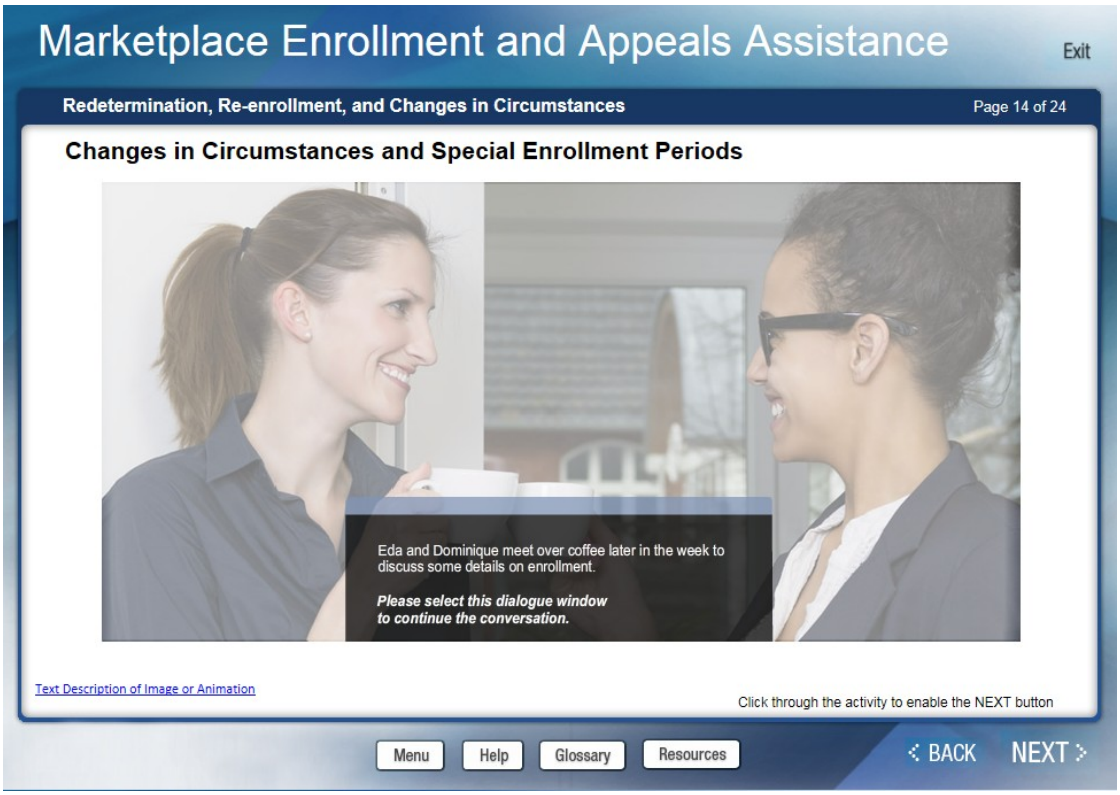
A. Consumers who are salaried without overtime pay and are working longer hours than usual

B. Consumers whose employers announced that they'll start offering health coverage

C. Consumers who changed jobs and now work for an employer who offers health coverage

D. Consumers who got a pay raise

Feedback: The correct answers are B, C, and D. If consumers' employers announced that they'll begin offering health coverage, consumers changed jobs and now work for employers who offer health coverage, or if consumers got a pay raise, then they should report this information to the Marketplace. Consumers don't need to report changes in their work schedules that don't affect their household income.



Changes in Circumstances and Special Enrollment Periods

Eda and Dominique meet over coffee later in the week to discuss some details on enrollment.

Eda: Hi Dominique. Thanks for meeting with me. I've been reading about “life events” and was hoping you could clarify what they are and how they affect enrollment.

Dominique: No problem! Certain circumstances, sometimes called “life events,” allow consumers to enroll in QHPs or change QHPs during a special enrollment period (SEP). SEPs are typically outside of the normal Open Enrollment period.

Eda: How do consumers know if they're eligible for an SEP?

Dominique: Consumers can either complete the Marketplace application or contact the Marketplace to see if they qualify for an SEP. Consumers' eligibility notices will indicate whether they qualify for an SEP. The SEP generally lasts for 60 days from the date of the qualifying event. If consumers don't have an SEP and the annual Open Enrollment period for the year has already passed, they must wait for the next Open Enrollment period or until they are eligible for an SEP to enroll in a Marketplace plan.

Dominique: Additionally, consumers may be eligible for certain SEPs if, for example, they experience exceptional circumstances, enrollment errors, or other defects in the eligibility and enrollment process. If you're assisting consumers who may be eligible for an SEP, they should contact the Marketplace Call Center to see if they're eligible.

Eda: Are we responsible for determining if consumers qualify for an SEP?

Dominique: No, you're not responsible for determining if consumers qualify for an SEP. Instead, you're responsible for educating consumers about the need to report all qualifying life events and other changes in circumstances that may affect their eligibility for or enrollment in a QHP through the Marketplace or may qualify them for an SEP as a result.

Special Enrollment Periods and Effective Dates of Coverage

Eda: Can you share some examples of life events and other circumstances that would allow a consumer to get an SEP?

Dominique shares her fact sheet with Eda that includes several examples of qualifying events for SEPs, including the effective date of coverage for each.

Eda: From your fact sheet, it seems as though the effective dates of coverage for SEPs generally follow the same timeline as effective dates for the initial Open Enrollment period.

Dominique: Mostly, although there are a few exceptions. Some of these exceptions include:

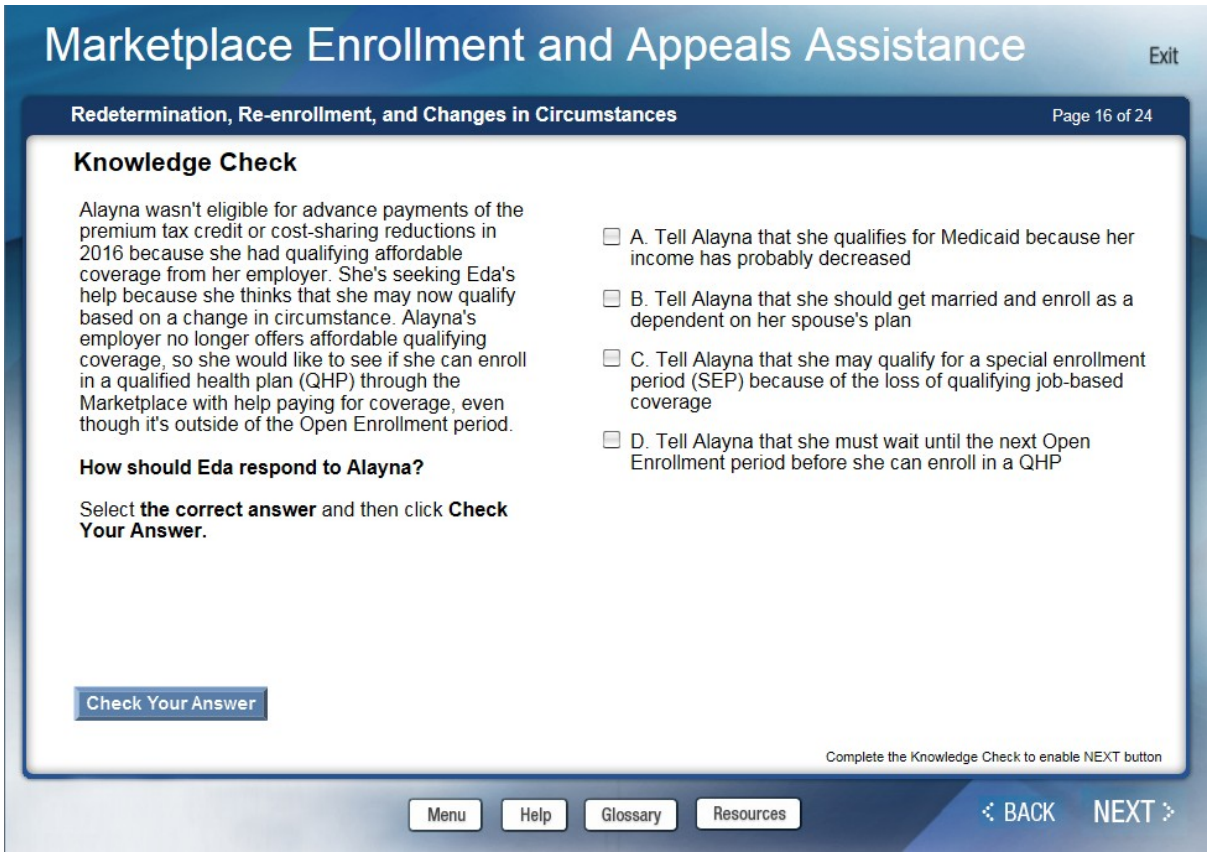
- In the case of marriage, coverage becomes effective on the first day of the month following plan selection.
- In the case of gaining or becoming a dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or due to a child support or other court order, coverage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

Here’s a key tip that you should remember if a consumer’s coverage is terminated.

Key Tip

If consumers' coverage is terminated because they didn't pay their premiums, this does NOT qualify them for an SEP.

For more information, reference the Fact Sheet on “SEPs and Effective Dates of QHP Coverage” which can be found in the “Resources” section.



Knowledge Check

Alayna wasn't eligible for advance payments of the premium tax credit or cost-sharing reductions in 2016 because she had qualifying affordable coverage from her employer. She's seeking Eda's help because she thinks that she may now qualify based on a change in circumstance. Alayna's employer no longer offers affordable qualifying coverage, so she would like to see if she can enroll in a qualified health plan (QHP) through the Marketplace with help paying for coverage, even though it's outside of the Open Enrollment period.

How should Eda respond to Alayna?

Select **the correct answer.**

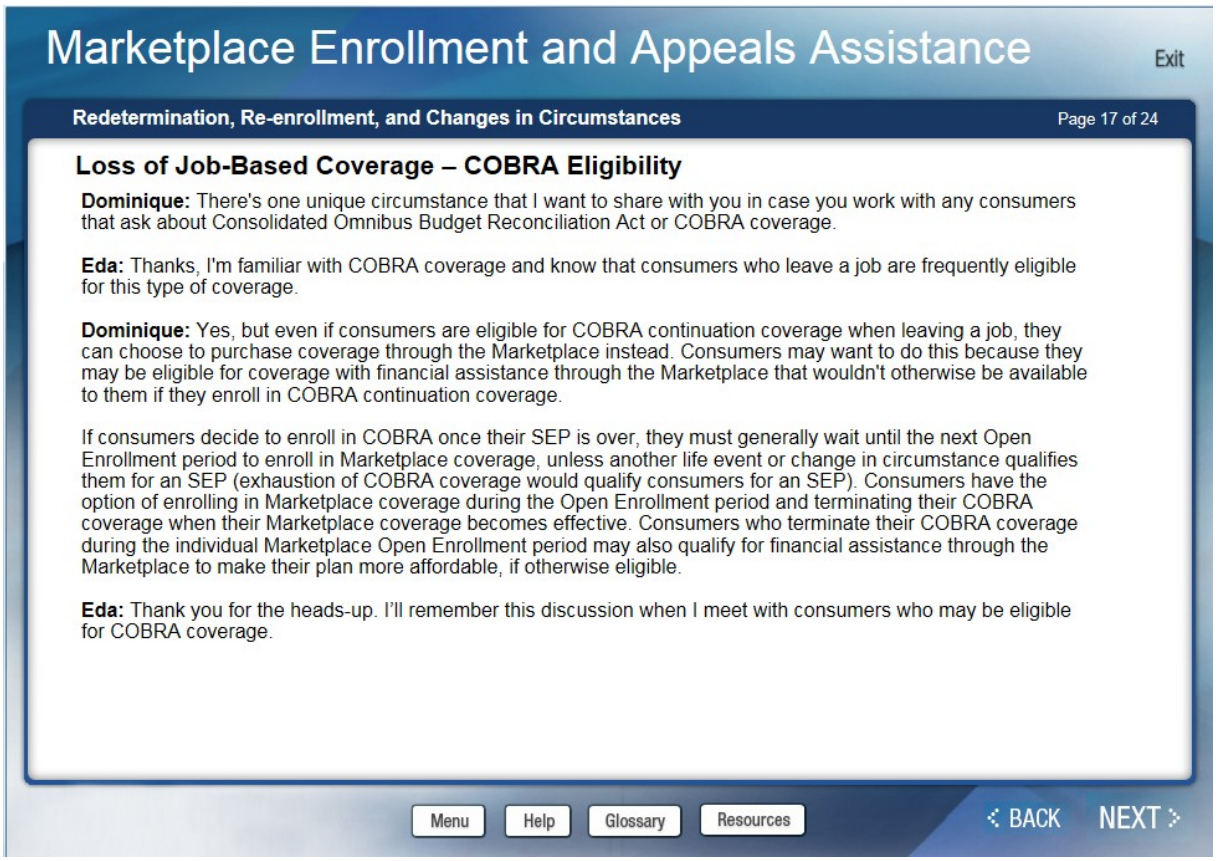
A. Tell Alayna that she qualifies for Medicaid because her income has probably decreased

B. Tell Alayna that she should get married and enroll as a dependent on her spouse's plan

C. Tell Alayna that she may qualify for a special enrollment period (SEP) because of the loss of qualifying job-based coverage

D. Tell Alayna that she must wait until the next Open Enrollment period before she can enroll in a QHP

Feedback: The correct answer is C. Alayna may qualify for an SEP due to the loss of affordable qualifying job-based coverage. Eda should give Alayna information, and if Alayna wants, help her apply for coverage through the Marketplace with help paying for coverage, so that she can continue to have health coverage.



Loss of Job-Based Coverage – COBRA Eligibility

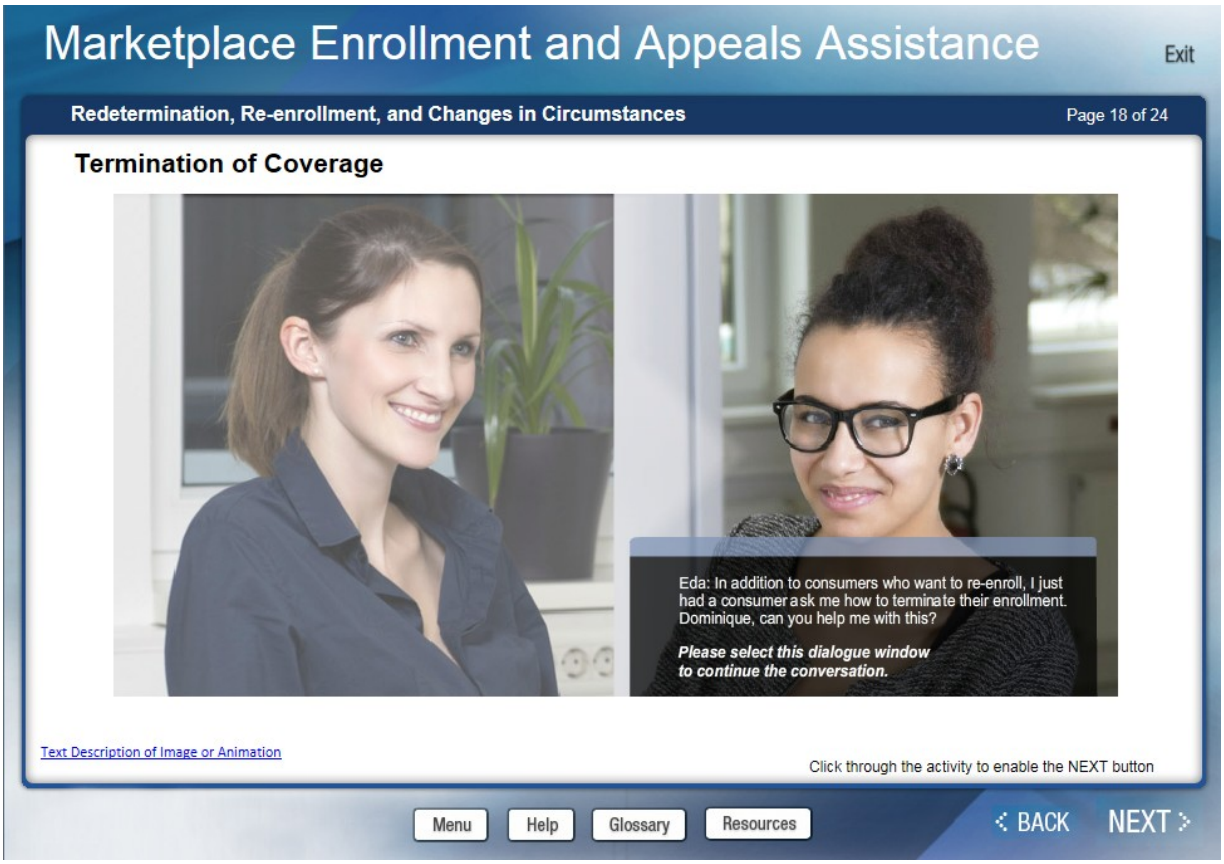
Dominique: There's one unique circumstance that I want to share with you in case you work with any consumers that ask about Consolidated Omnibus Budget Reconciliation Act or COBRA coverage.

Eda: Thanks, I'm familiar with COBRA coverage and know that consumers who leave a job are frequently eligible for this type of coverage.

Dominique: Yes, but even if consumers are eligible for COBRA continuation coverage when leaving a job, they can choose to purchase coverage through the Marketplace instead. Consumers may want to do this because they may be eligible for coverage with financial assistance through the Marketplace that wouldn't otherwise be available to them if they enroll in COBRA continuation coverage.

If consumers decide to enroll in COBRA once their SEP is over, they must generally wait until the next Open Enrollment period to enroll in Marketplace coverage, unless another life event or change in circumstance qualifies them for an SEP (exhaustion of COBRA coverage would qualify consumers for an SEP). Consumers have the option of enrolling in Marketplace coverage during the Open Enrollment period and terminating their COBRA coverage when their Marketplace coverage becomes effective. Consumers who terminate their COBRA coverage during the individual Marketplace Open Enrollment period may also qualify for financial assistance through the Marketplace to make their plan more affordable, if otherwise eligible.

Eda: Thank you for the heads-up. I'll remember this discussion when I meet with consumers who may be eligible for COBRA coverage.



Termination of Coverage

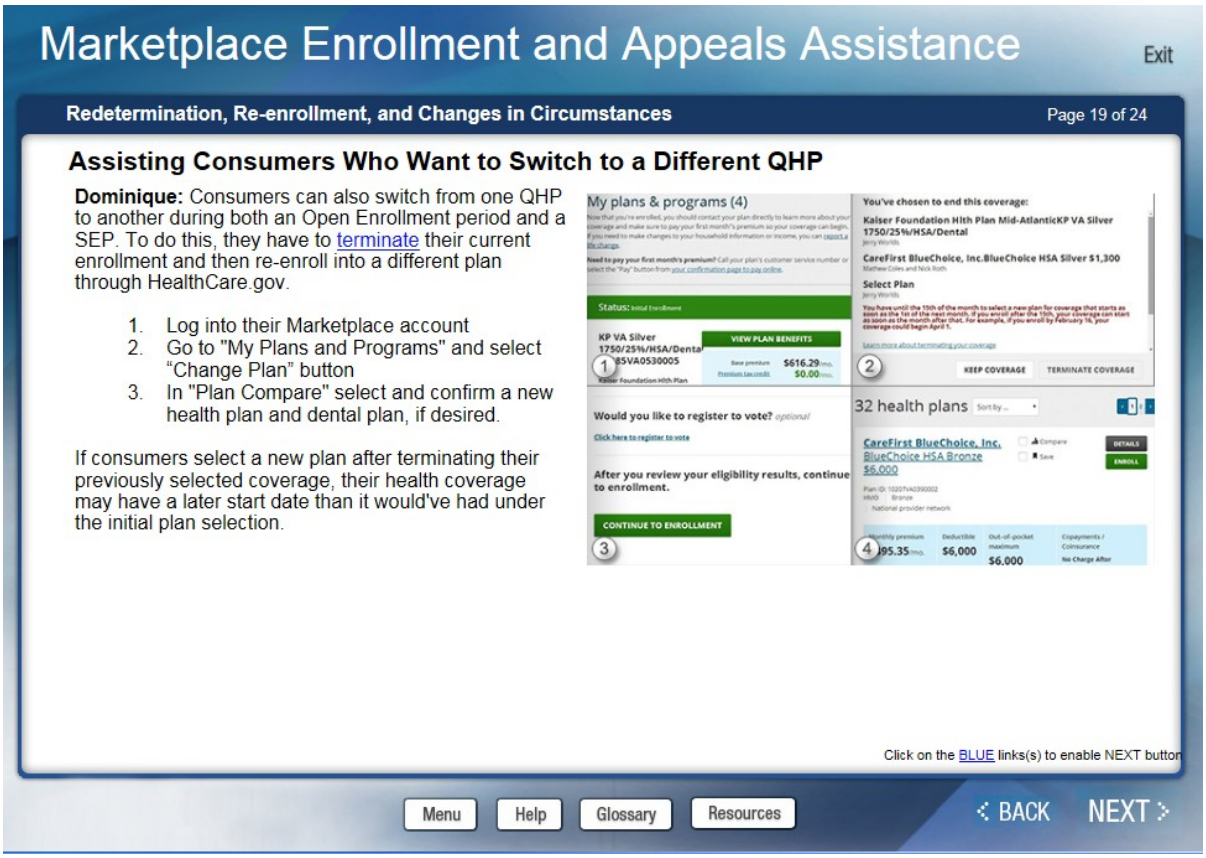
Eda: In addition to consumers who want to re-enroll, I just had a consumer ask me how to terminate their enrollment. Dominique, can you help me with this?

Dominique: Consumers can terminate their coverage at any time, but generally require a 14 day advance notice they don't need to wait for an Open Enrollment period or an SEP. Common reasons include getting other minimum essential coverage, such as Medicare, Medicaid, or job-based coverage; or newly qualifying for an exemption from the requirement to maintain minimum essential coverage.

If consumers want to terminate their Marketplace coverage, they can terminate their enrollment by logging into their Marketplace account, then going to "My Plans and Programs" and selecting "End (Terminate) All Coverage".

Dominique: Coverage generally can't be terminated with less than 14 days advance notice – that means consumers must select an effective date of termination that is 14 days or more in the future.

Dominique: Terminating coverage through the Federally-facilitated Marketplace will end consumers' health AND dental plans. Consumers can terminate their coverage at any time; they don't need to wait for an Open Enrollment period or an SEP.



Assisting Consumers Who Want to Switch to a Different QHP

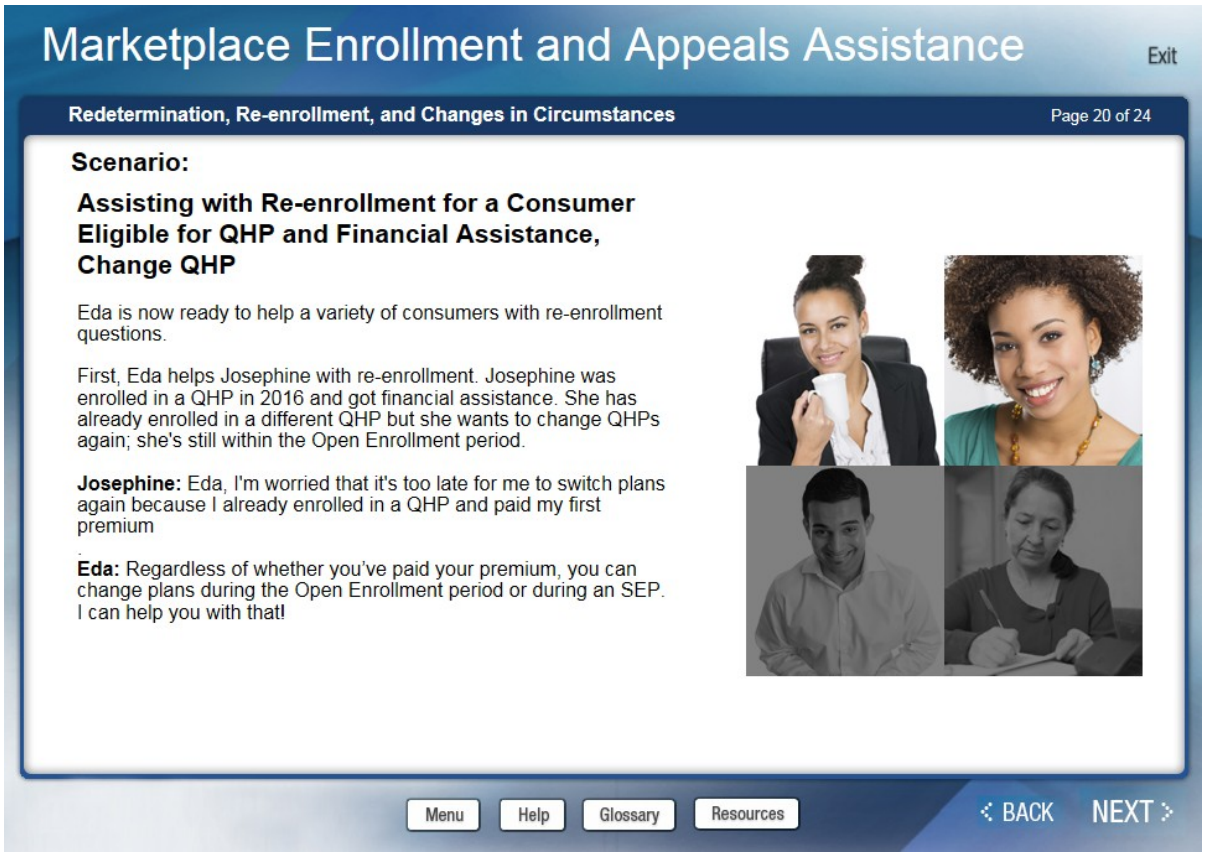
Dominique: Consumers can also switch from one QHP to another during both an Open Enrollment period and a SEP. To do this, they have to terminate their current enrollment and then re-enroll into a different plan through HealthCare.gov.

1. Log into their Marketplace account
2. Go to "My Plans and Programs" and select “Change Plan” button
3. In "Plan Compare" select and confirm a new health plan and dental plan, if desired.

If consumers select a new plan after terminating their previously selected coverage, their health coverage may have a later start date than it would've had under the initial plan selection.

More Information about Terminating Current Enrollment

If consumers select a new plan after canceling their previously selected coverage, their health coverage may have a later start date than it would've had under the initial plan selection.



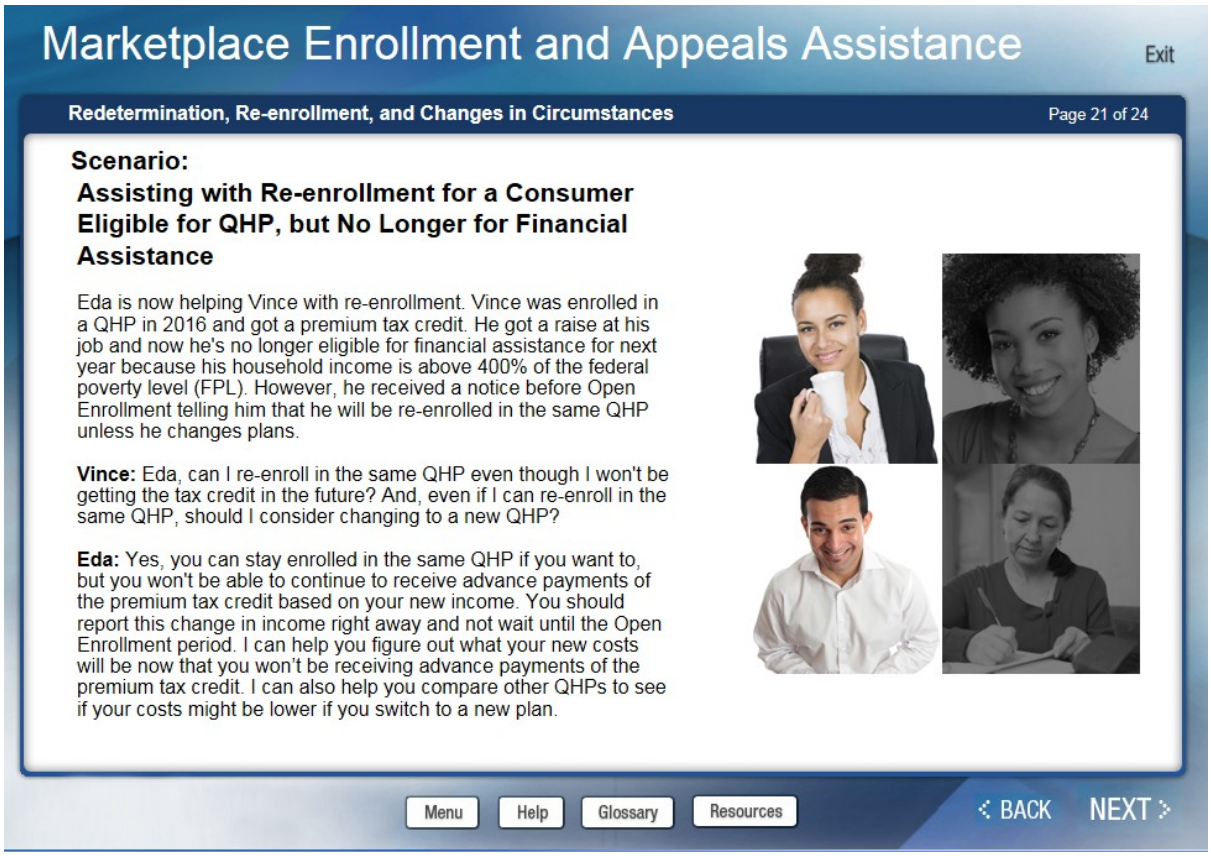
Scenario: Assisting with Re-enrollment for a Consumer Eligible for QHP and Financial Assistance, Change QHP

Eda is now ready to help a variety of consumers with re-enrollment questions.

First, Eda helps Josephine with re-enrollment. Josephine was enrolled in a QHP in 2016 and got financial assistance. She has already enrolled in a different QHP but she wants to change QHPs again; she's still within the Open Enrollment period.

Josephine: Eda, I'm worried that it's too late for me to switch plans again because I already enrolled in a QHP and paid my first premium.

Eda: Regardless of whether you've paid your premium, you can change plans during the Open Enrollment period or during an SEP. I can help you with that!

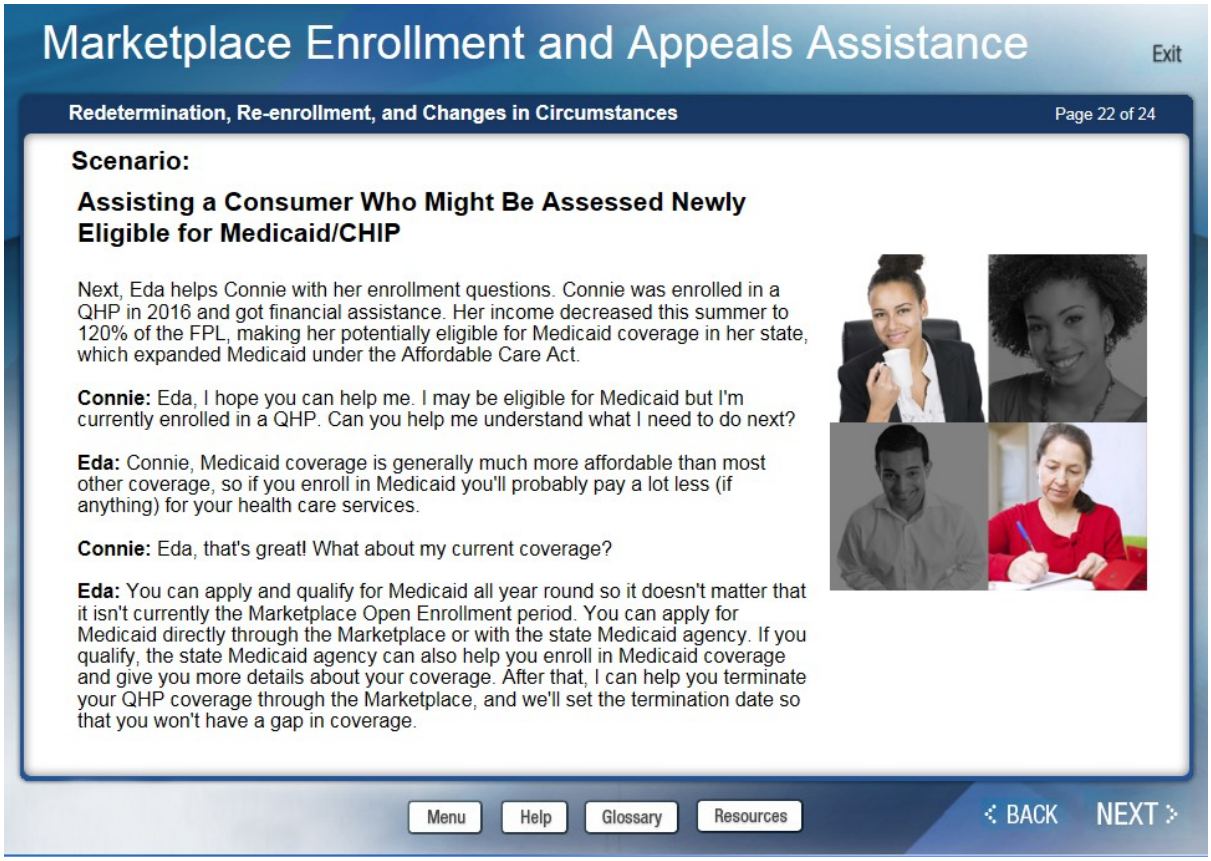


Scenario: Assisting with Re-enrollment for a Consumer Eligible for QHP, but No Longer for Financial Assistance

Eda is now helping Vince with re-enrollment. Vince was enrolled in a QHP in 2016 and got a premium tax credit. He got a raise at his job and now he's no longer eligible for financial assistance for next year because his household income is above 400% of the federal poverty level (FPL). However, he received a notice before Open Enrollment telling him that he will be re-enrolled in the same QHP unless he changes plans.

Vince: Eda, can I re-enroll in the same QHP even though I won't be getting the tax credit in the future? And, even if I can re-enroll in the same QHP, should I consider changing to a new QHP?

Eda: Yes, you can stay enrolled in the same QHP if you want to, but you won't be able to continue to receive advance payments of the premium tax credit based on your new income. You should report this change in income right away and not wait until the Open Enrollment period. I can help you figure out what your new costs will be now that you won't be receiving advance payments of the premium tax credit. I can also help you compare other QHPs to see if your costs might be lower if you switch to a new plan.



Scenario: Assisting a Consumer Newly Assessed Eligible for Medicaid/CHIP

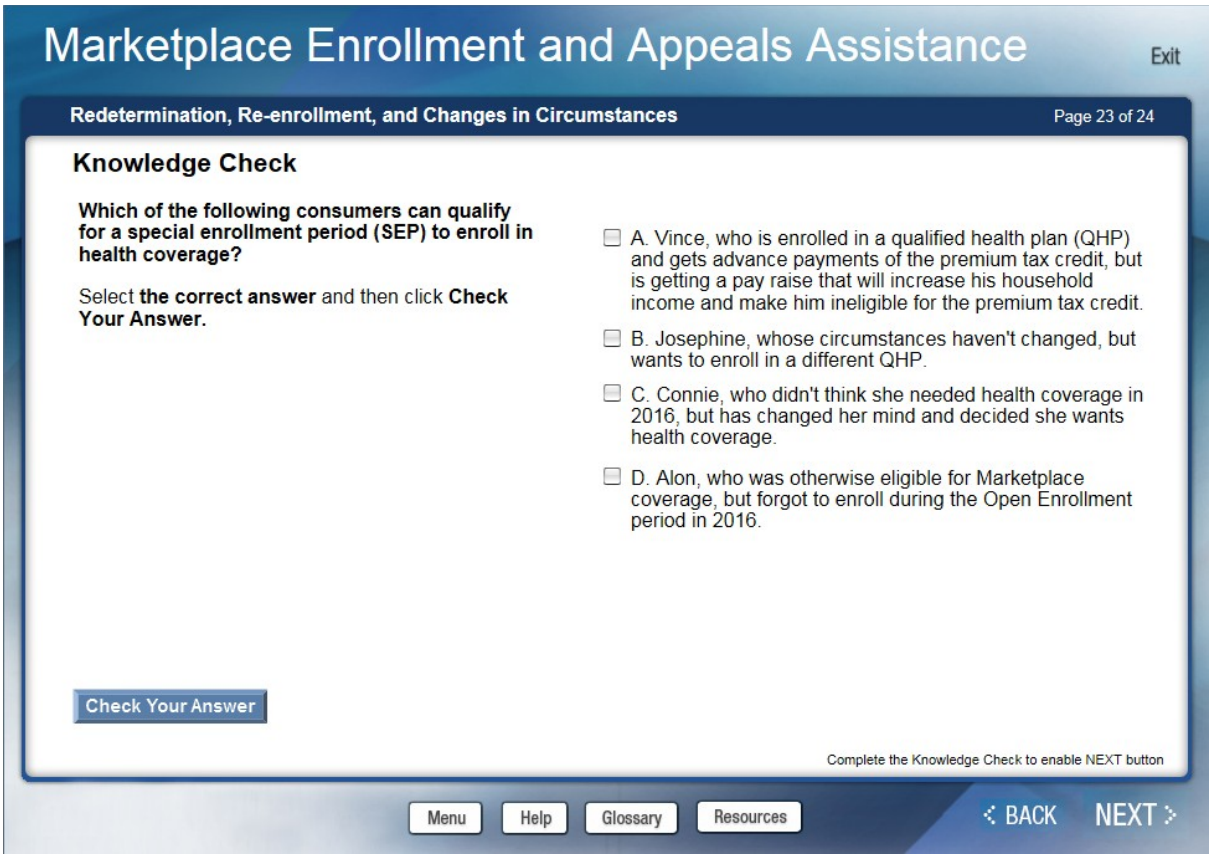
Next, Eda helps Connie with her enrollment questions. Connie was enrolled in a QHP in 2016 and got financial assistance. Her income decreased this summer to 120% of the FPL, making her potentially eligible for Medicaid coverage in her state, which expanded Medicaid under the Affordable Care Act.

Connie: Eda, I hope you can help me. I may be eligible for Medicaid but I'm currently enrolled in a QHP. Can you help me understand what I need to do next?

Eda: Connie, Medicaid coverage is generally much more affordable than most other coverage, so if you enroll in Medicaid you'll probably pay a lot less (if anything) for your health care services.

Connie: Eda, that's great! What about my current coverage?

Eda: You can apply and qualify for Medicaid all year round so it doesn't matter that it isn't currently the Marketplace Open Enrollment period. You can apply for Medicaid directly through the Marketplace or with the state Medicaid agency. If you qualify, the state Medicaid agency can also help you enroll in Medicaid coverage and give you more details about your coverage. After that, I can help you terminate your QHP coverage through the Marketplace, and we'll set the termination date so that you won't have a gap in coverage.



Knowledge Check

Which of the following consumers can qualify for a special enrollment period (SEP) to enroll in health coverage?

Select **the correct answer.**

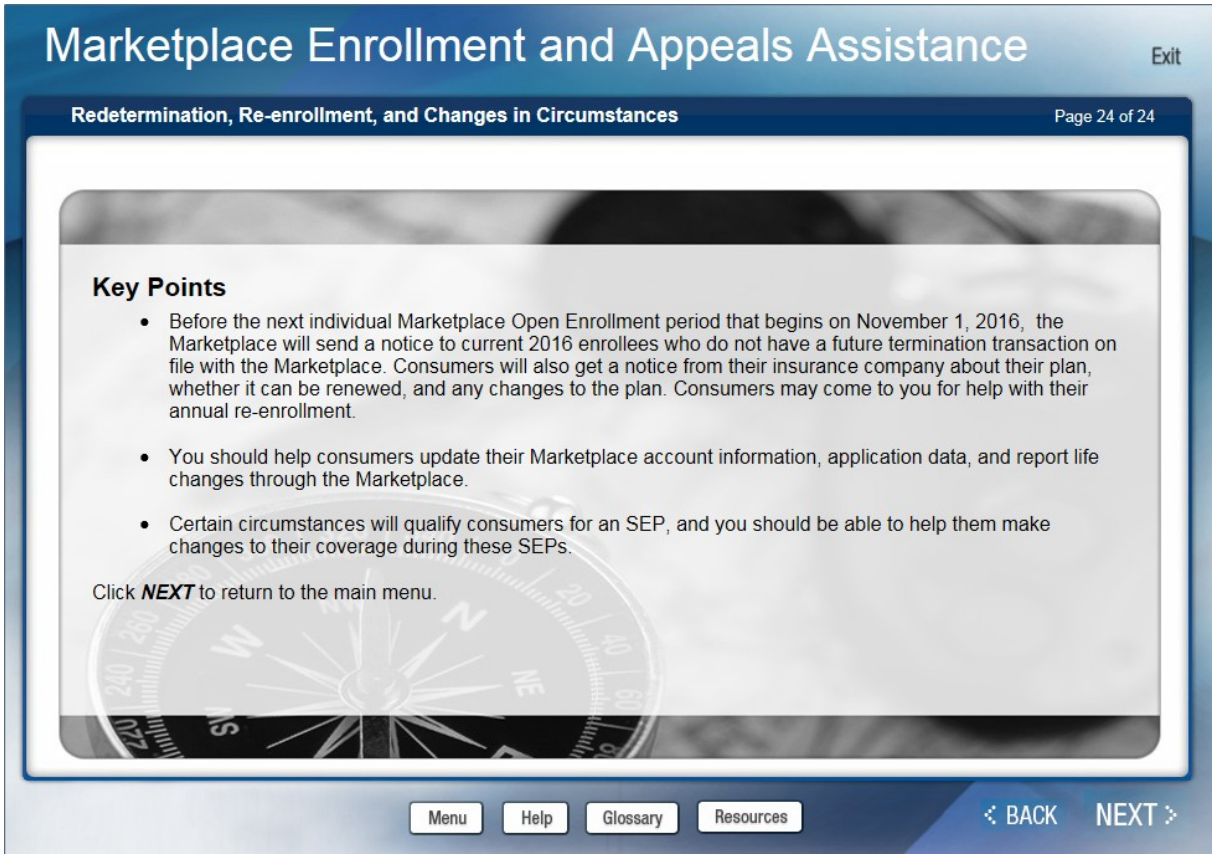
A. Vince, who is enrolled in a qualified health plan (QHP) and gets advance payments of the premium tax credit, but is getting a pay raise that will increase his income and make him ineligible for the premium tax credit.

B. Josephine, whose circumstances haven't changed, but wants to enroll in a different QHP.

C. Connie, who didn't think she needed health coverage in 2016, but has changed her mind and decided she wants health coverage.

D. Alon, who was otherwise eligible for Marketplace coverage, but forgot to enroll during the Open Enrollment period in 2016.

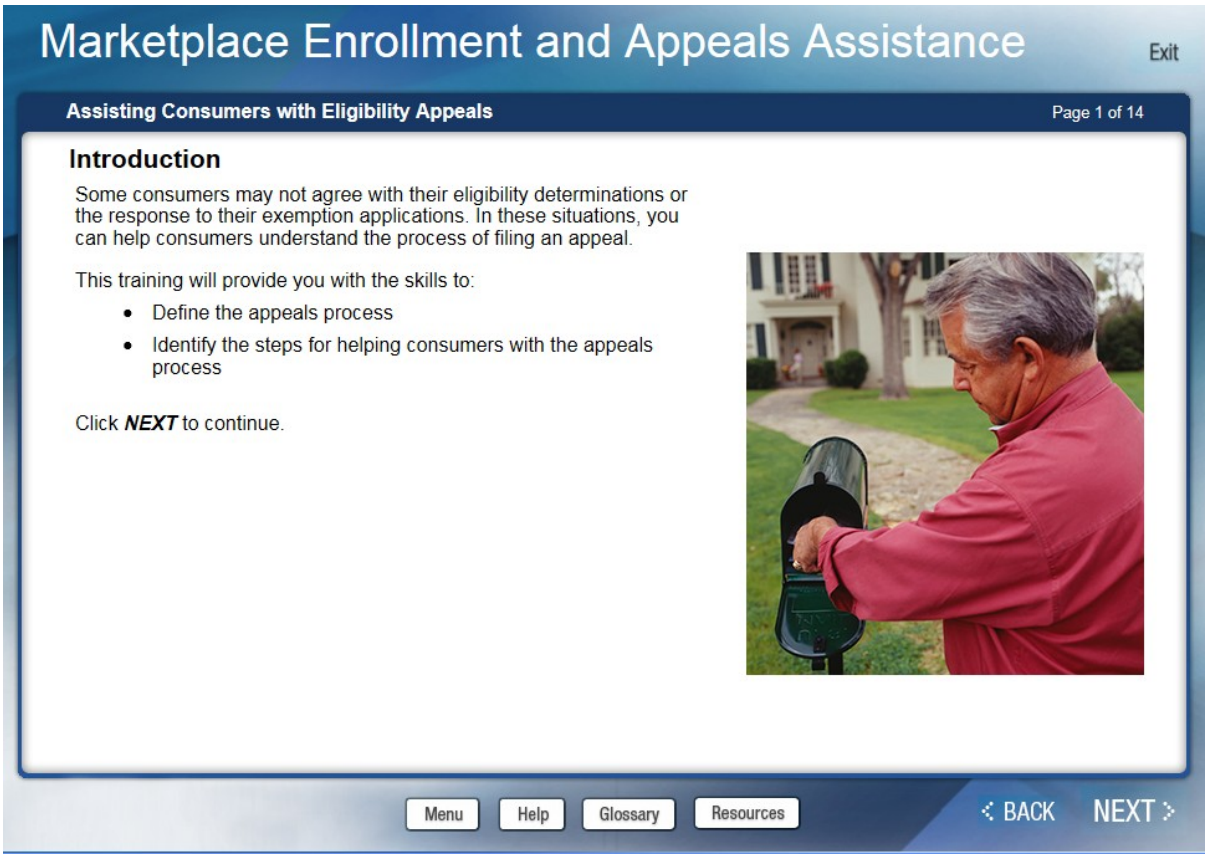
Feedback: The correct answer is A. Vince qualifies for an SEP because his new income changes his eligibility for the premium tax credit. The others have not qualified for an SEP and must wait for the Open Enrollment period or to qualify for an SEP.



Key Points

- Before the next individual Marketplace Open Enrollment period that begins on November 1, 2016, the Marketplace will send a notice to current 2016 enrollees who do not have a future termination transaction on file with the Marketplace. Consumers will also get a notice from their insurance company about their plan, whether it can be renewed, and any changes to the plan. Consumers may come to you for help with their annual re-enrollment.
- You should help consumers update their Marketplace account information, application data, and report life changes through the Marketplace.
- Certain circumstances will qualify consumers for an SEP, and you should be able to help them make changes to their coverage during these SEPs.

Assisting Consumers with Eligibility Appeals Module



Introduction

Some consumers may not agree with their eligibility determinations or the response to their exemption applications. In these situations, you can help consumers understand the process of filing an appeal.

This training will provide you with the skills to:

- Define the appeals process
- Identify the steps for helping consumers with the appeals process

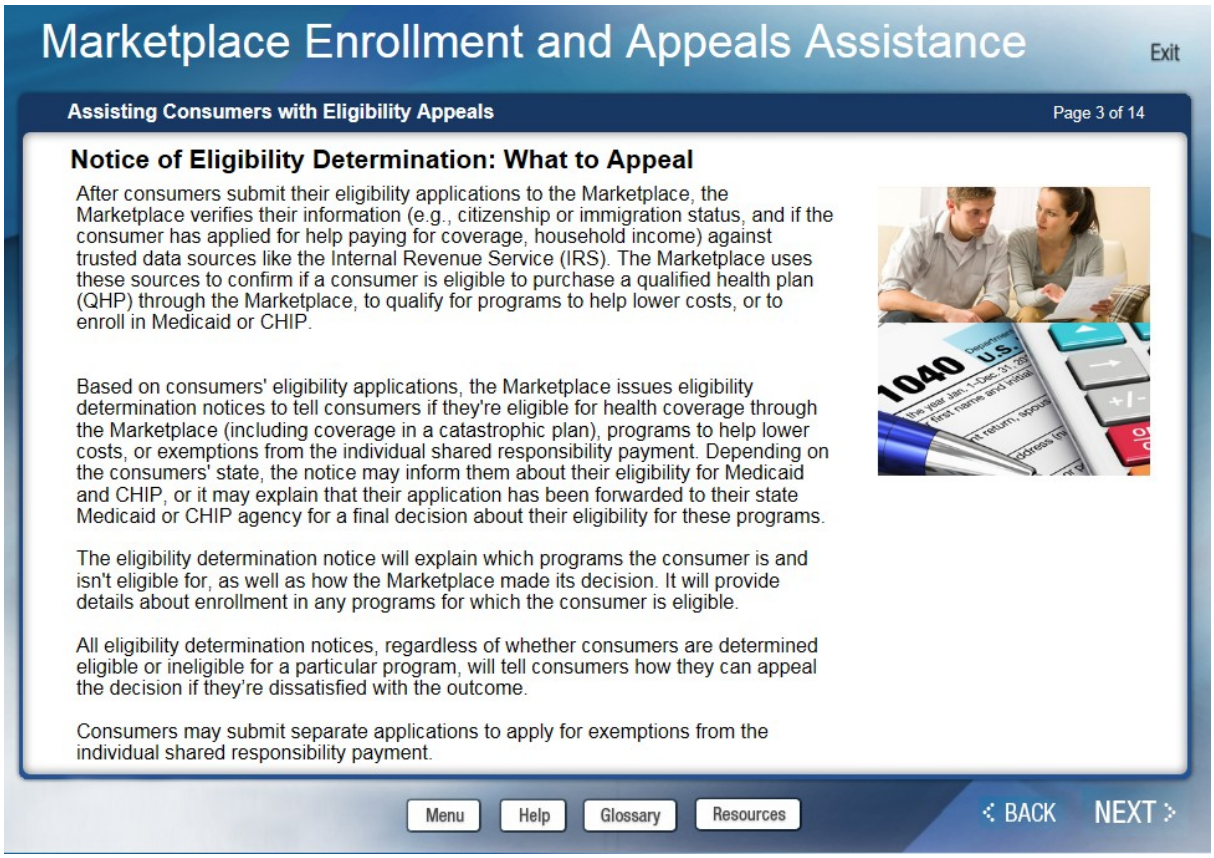
Appeal Rights

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

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

- Whether they're eligible to buy a Marketplace plan
- Whether they can enroll in a Marketplace plan outside the regular Open Enrollment period (i.e., have special enrollment period [SEP] eligibility)
- Whether they're eligible for lower costs based on income and other eligibility criteria
- Whether they've been determined eligible for the appropriate amount of savings (i.e., advance payments of the premium tax credit and cost-sharing reductions)
- Whether they're eligible for Medicaid or the Children's Health Insurance Program (CHIP)
- Whether they're eligible for an exemption from the individual shared responsibility payment
- Whether they're eligible to enroll in a catastrophic plan through the Marketplace

- Whether the Marketplace is taking an unreasonably long time to provide notice of eligibility determination
- A denial of a request to reconsider certain decisions of a state-based appeals entity.



Notice of Eligibility Determination: What to Appeal

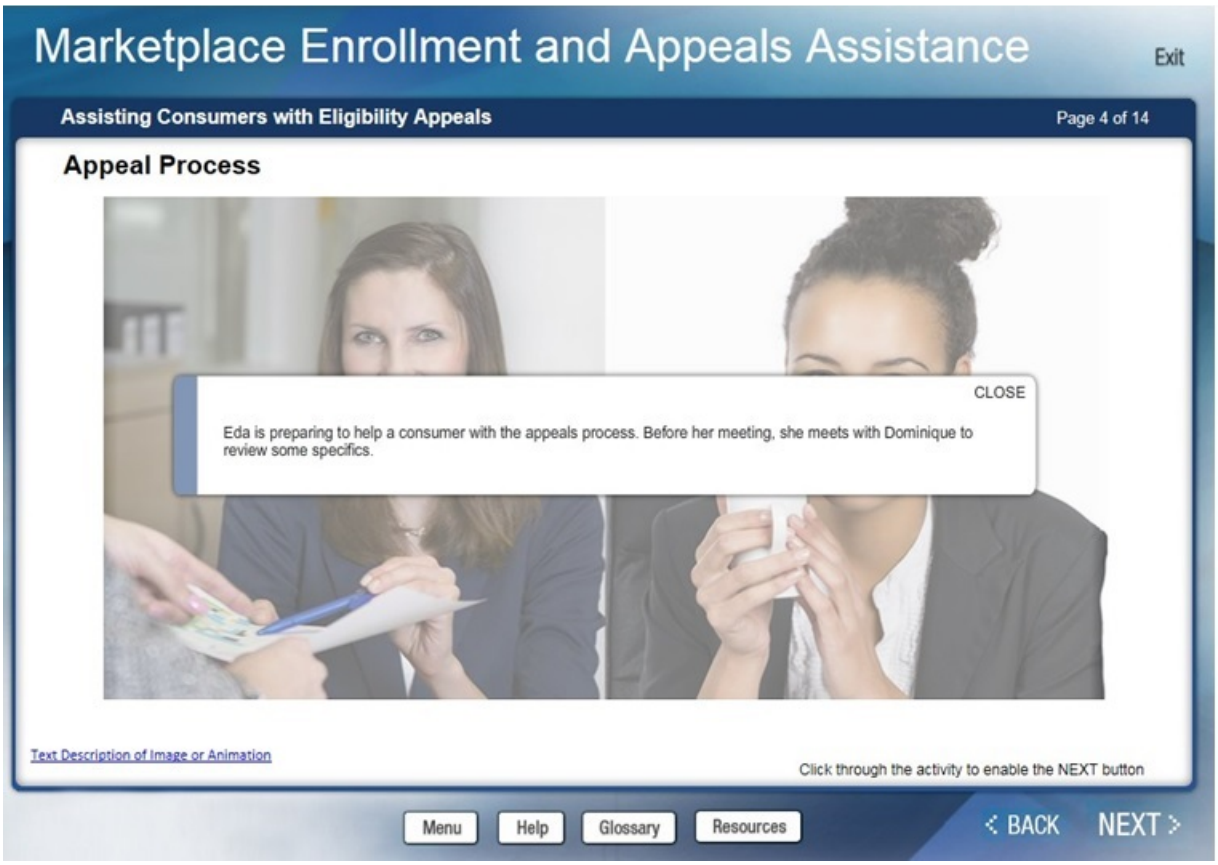
After consumers submit their eligibility applications to the Marketplace, the Marketplace verifies their information (e.g., citizenship or immigration status, and if the consumer has applied for help paying for coverage, household income) against trusted data sources like the Internal Revenue Service (IRS). The Marketplace uses these sources to confirm if a consumer is eligible to purchase a qualified health plan (QHP) through the Marketplace, to qualify for programs to help lower costs, or to enroll in Medicaid or CHIP.

Based on consumers' eligibility applications, the Marketplace issues eligibility determination notices to tell consumers if they're eligible for health coverage through the Marketplace (including coverage in a catastrophic plan), programs to help lower costs, or exemptions from the individual shared responsibility payment. Depending on the consumers' state, the notice may inform them about their eligibility for Medicaid and CHIP, or it may explain that their application has been forwarded to their state Medicaid or CHIP agency for a final decision about their eligibility for these programs.

The eligibility determination notice will explain which programs the consumer is and isn't eligible for, as well as how the Marketplace made its decision. It will provide details about enrollment in any programs for which the consumer is eligible.

All eligibility determination notices, regardless of whether consumers are determined eligible or ineligible for a particular program, will tell consumers how they can appeal the decision if they're dissatisfied with the outcome.

Consumers may submit separate applications to apply for exemptions from the individual shared responsibility payment.



Appeal Process

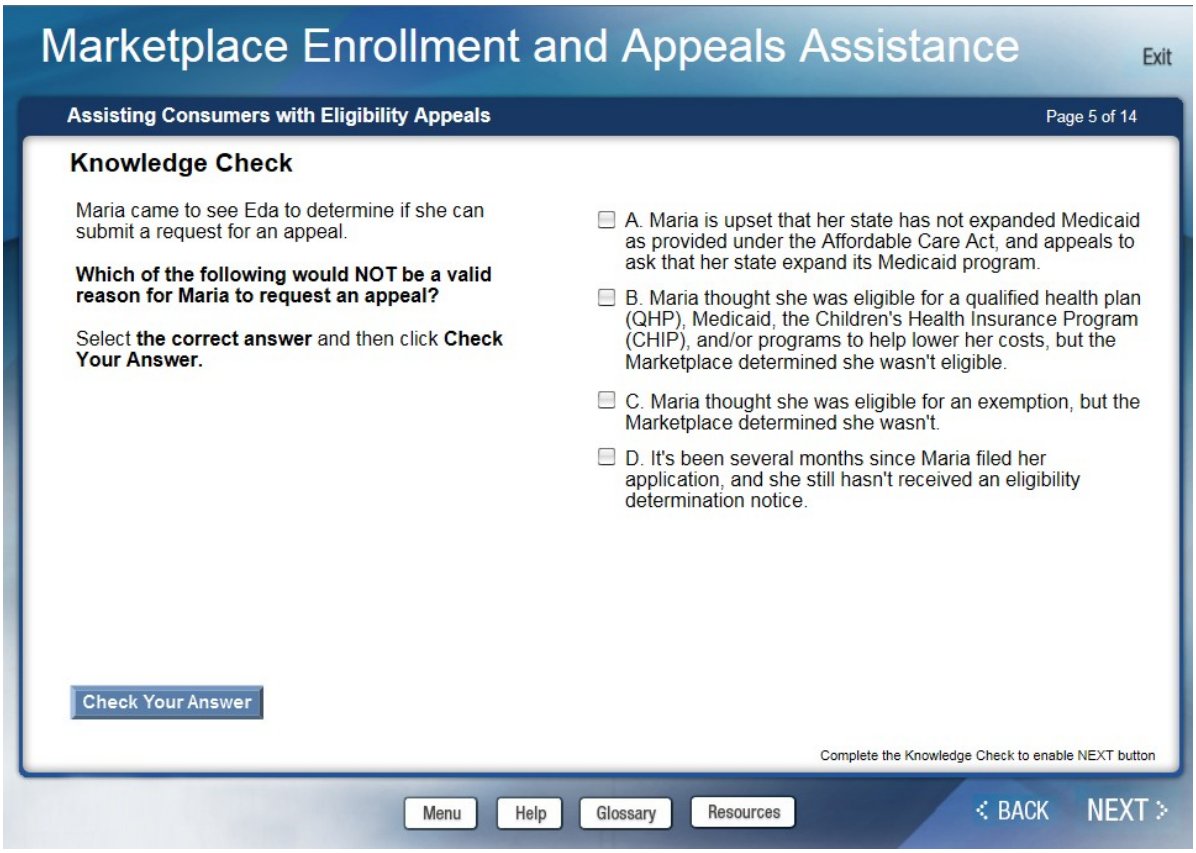
Eda is preparing to help a consumer with the appeals process. Before her meeting, she meets with Dominique to review some specifics.

Eda: Hi Dominique. Thank you so much for meeting with me today. I have a few questions about the appeals process. When can consumers request an appeal? Can you give me some examples?

Dominique: No problem, Eda. Consumers can request an appeal when they're dissatisfied with an eligibility determination. For example, consumers can request an appeal if they disagree with an initial eligibility determination or redetermination, or if they were denied an exemption. Consumers can also request an appeal if they didn't receive their eligibility determination notice in a timely manner. Consumers have 90 days from the date they receive their eligibility determination notice to start an appeal.

Eda: Thanks! Those examples are helpful. What information will consumers need to provide with their appeal requests?

Dominique: Consumers must submit specific information to complete appeal requests. At a minimum, they should provide their first and last name, address, and the reason for their appeal.



Knowledge Check

Maria came to see Eda to determine if she can submit a request for an appeal.

Which of the following would NOT be a valid reason for Maria to request an appeal?

Select **the correct answer.**

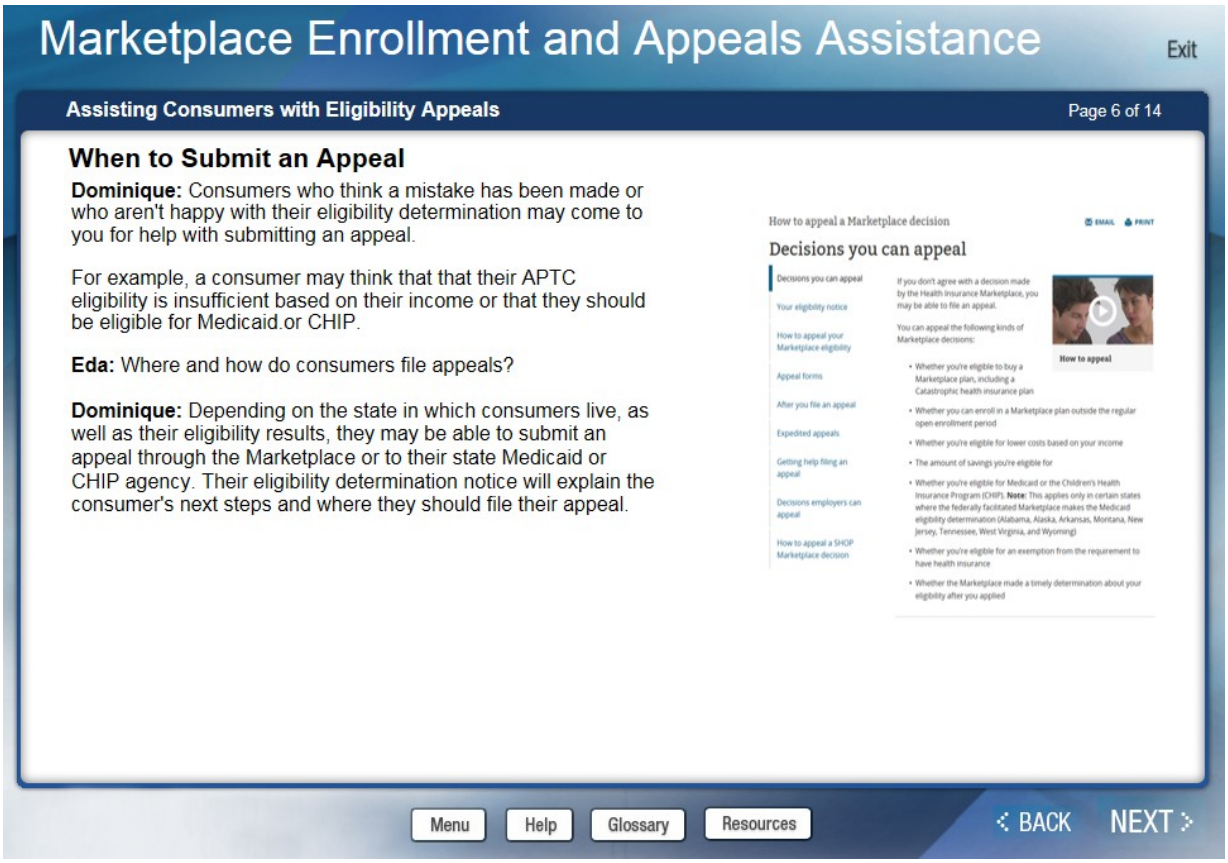
A. Maria is upset that her state has not expanded Medicaid as provided under the Affordable Care Act, and appeals to ask that her state expand its Medicaid program.

B. Maria thought she was eligible for a qualified health plan (QHP), Medicaid, the Children's Health Insurance Program (CHIP), and/or programs to help lower her costs, but the Marketplace determined she wasn't eligible.

C. Maria thought she was eligible for an exemption, but the Marketplace determined she wasn't.

D. It's been several months since Maria filed her application, and she still hasn't received an eligibility determination notice.

Feedback: The correct answer is A. Consumers can submit an appeal request for any of the reasons listed, except if the appeal is to ask for the consumers' state to expand its Medicaid program.



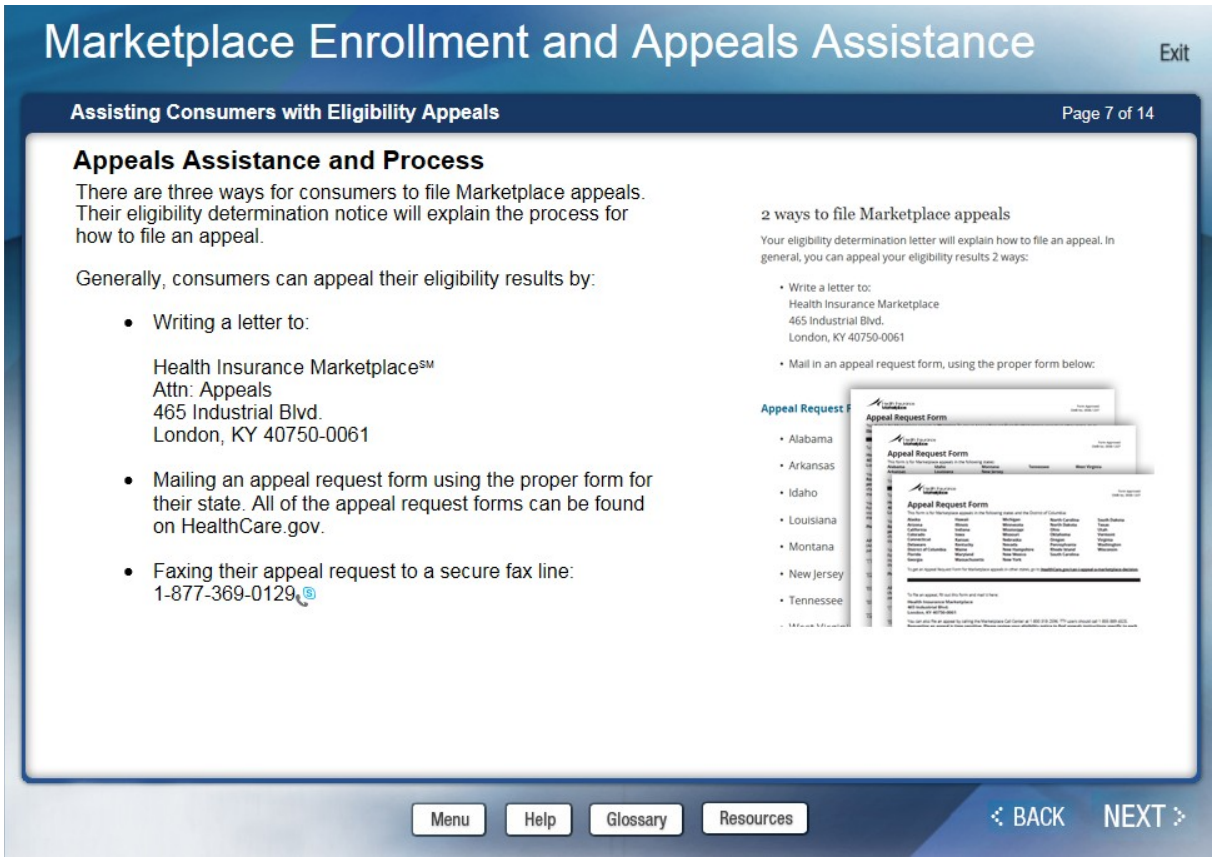
When to Submit an Appeal

Dominique: Consumers who think a mistake has been made or who aren't happy with their eligibility determination may come to you for help with submitting an appeal.

For example, a consumer may think that that their APTC eligibility is insufficient based on their income or that they should be eligible for Medicaid or CHIP.

Eda: Where and how do consumers file appeals?

Dominique: Depending on the state in which consumers live, as well as their eligibility results, they may be able to submit an appeal through the Marketplace or to their state Medicaid or CHIP agency. Their eligibility determination notice will explain the consumer's next steps and where they should file their appeal.



Appeals Assistance and Process

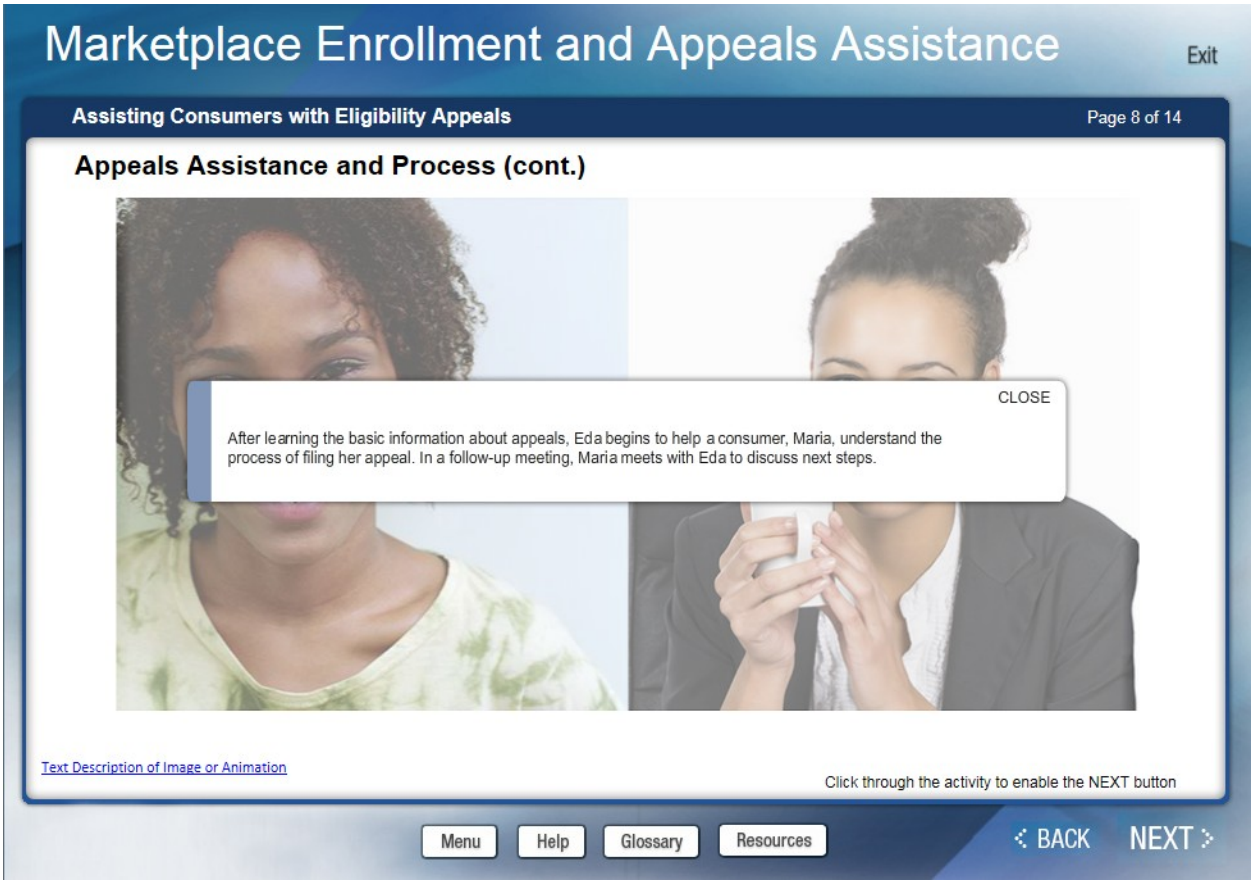
There are three ways for consumers to file Marketplace appeals. Their eligibility determination notice will explain the process for how to file an appeal.

Generally, consumers can appeal their eligibility results by:

- Writing a letter to:

  Health Insurance Marketplace℠
  Attn: Appeals
  465 Industrial Blvd.
  London, KY 40750-0061

- Mailing an appeal request form using the proper form for their state. All of the appeal request forms can be found on HealthCare.gov.
- Faxing their appeal request to a secure fax line: 1-877-369-0129



Appeals Assistance and Process (cont.)

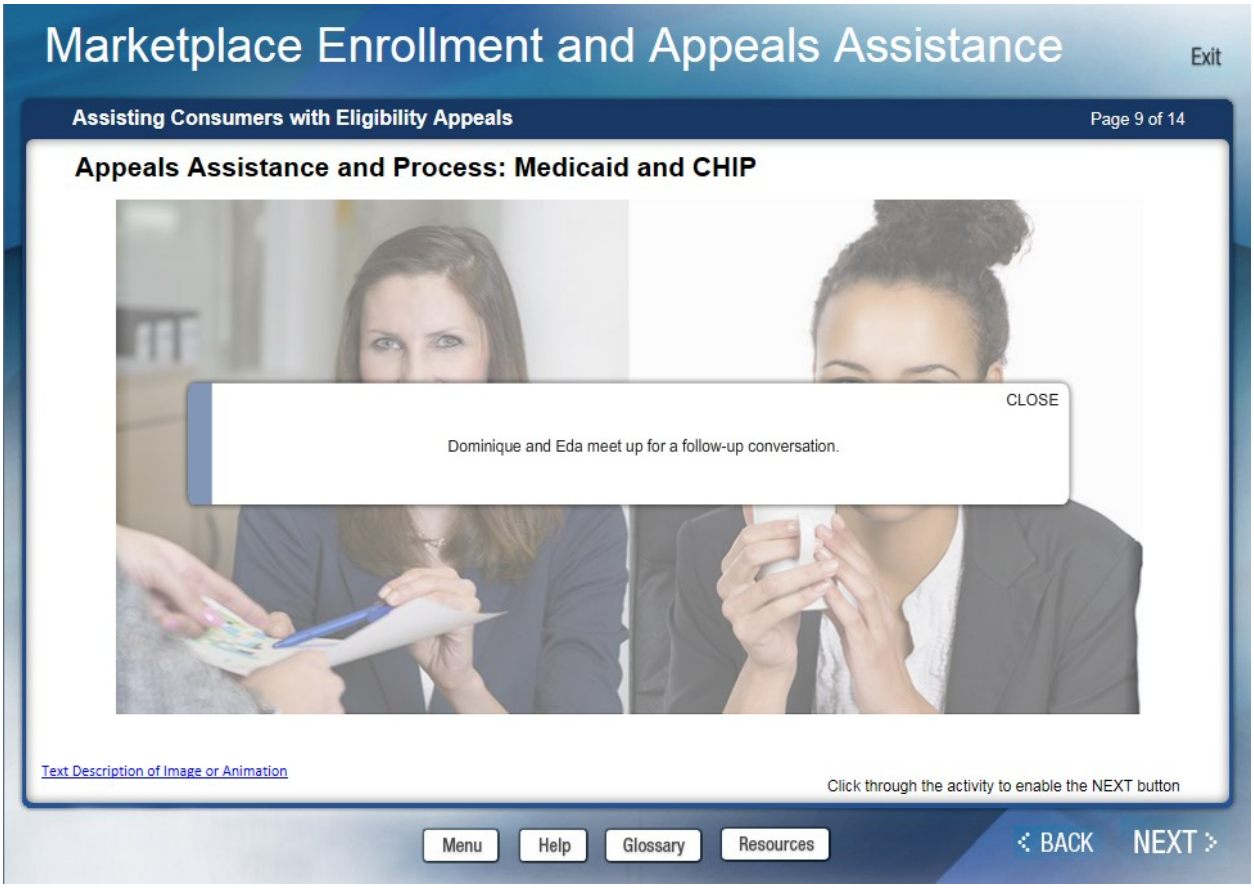
After learning the basic information about appeals, Eda begins to help a consumer, Maria, with her appeal. In a follow-up meeting, Maria meets with Eda to discuss next steps.

Maria: Eda, I know my appeal is in process, but I got a letter from the Marketplace asking for more information or documentation. What should I do?

Eda: You can submit supporting documents by mail any time during the appeals process leading up to the hearing.

Maria: Is there anything else I should know?

Eda: You can always keep the eligibility in your current eligibility determination notice while you're appealing. If you're appealing a redetermination, you may be able to maintain your previous eligibility while the appeal is in process, as long as you meet certain qualifications specified by the Marketplace. You can accept or waive these benefits while the appeal is pending. If you accept the benefits during the appeals process, you may need to pay back the benefits if the appeal decision states that you weren't eligible for the benefits you accepted.



Appeals Assistance and Process: Medicaid and CHIP

Dominique and Eda meet up for a follow-up conversation.

Dominique: That's great that you were able to help Maria understand the process of filing an appeal. I want to share some additional information with you about special appeals situations, as well as what happens once consumers file their appeals.

Dominique: A consumer may have received an eligibility determination notice that indicates they're eligible to enroll in a Marketplace plan but not eligible to enroll in Medicaid or CHIP. The consumer may think they should have qualified for Medicaid or CHIP and may want to file an appeal. Some states don't allow the Marketplace to make final eligibility determinations for Medicaid and CHIP.

Dominique: Consumers in these states who want to appeal determinations that they are not eligible for Medicaid or CHIP should submit their appeals to the state Medicaid or CHIP agency, instead of the Marketplace. However, if they do submit the appeal request to the Marketplace, the Marketplace will send it to the proper state agency anyway.

Eda: What happens if the consumer is still found to be ineligible after the Medicaid or CHIP hearing?

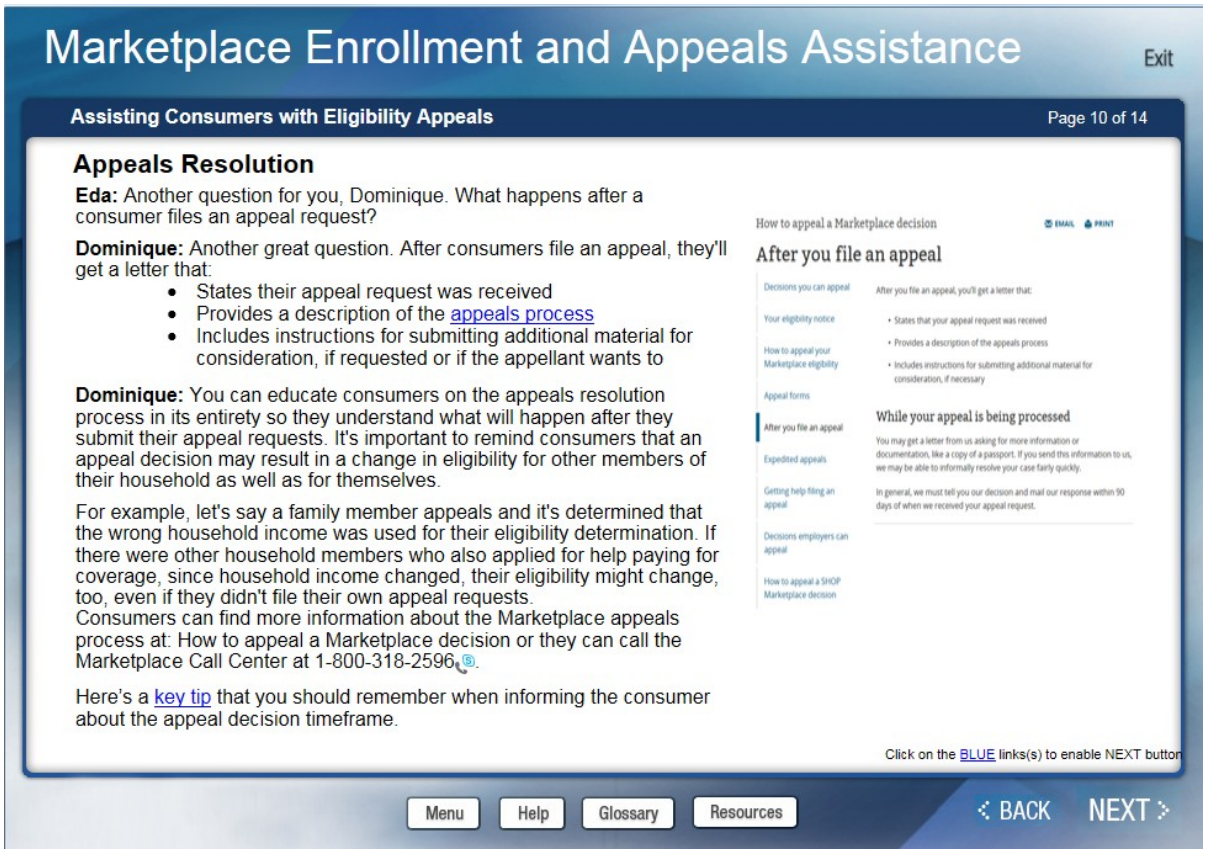
Dominique: If the appeal process results in a decision that the initial eligibility determination was correct, then that determination will stand and the consumer will not be eligible for Medicaid or CHIP. That is the end of the administrative process, but the appeal decision explaining this will also include information about available judicial review. But, if the appeal process results in a decision that the initial eligibility determination was wrong and the consumer actually should have been determined eligible for Medicaid or CHIP, then the consumer's appeal will be successful and they will be enrolled in the appropriate public program.

Dominique: If a consumer's appeal for Medicaid or CHIP coverage is unsuccessful, as long as they are a qualified individual, they can still enroll in a Marketplace plan through a special enrollment period. Additionally, if originally determined eligible for premium tax credits and/or cost sharing reductions through the Marketplace, the consumer is also still eligible for those programs.

Dominique: Remember, consumers can appeal their eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions, too. Sometimes, consumers may appeal because they think they should have been determined eligible for a larger advance payments of the premium tax credit, and don't want to pay the premium for coverage through the Marketplace until they get the larger amount.

Dominique: If it turns out the initial eligibility determination was wrong and the consumers didn't already enroll in a plan, they will get a special enrollment period (SEP) to enroll in coverage through the Marketplace.

But if the initial eligibility determination was correct, the consumer won’t be allowed to enroll in or change plans through the Marketplace if the original enrollment period during which he or she applied has ended.



Appeals Resolution

Eda: Another question for you, Dominique. What happens after a consumer files an appeal request?

Dominique: Another great question. After consumers file an appeal, they'll get a letter that:

- States their appeal request was received
- Provides a description of the appeals process
- Includes instructions for submitting additional material for consideration, if requested or if the appellant wants to

Dominique: You can educate consumers on the appeals resolution process in its entirety so they understand what will happen after they submit their appeal requests. 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.

For example, let's say a family member appeals and it's determined that the wrong household income was used for their eligibility determination. If there were other household members who also applied for help paying for coverage, since household income changed, their eligibility might change, too, even if they didn't file their own appeal requests.

Consumers can find more information about the Marketplace appeals process at: How to appeal a Marketplace decision or they can call the Marketplace Call Center at 1-800-318-2596.

Here's a key tip that you should remember when informing the consumer about the appeal decision timeframe.

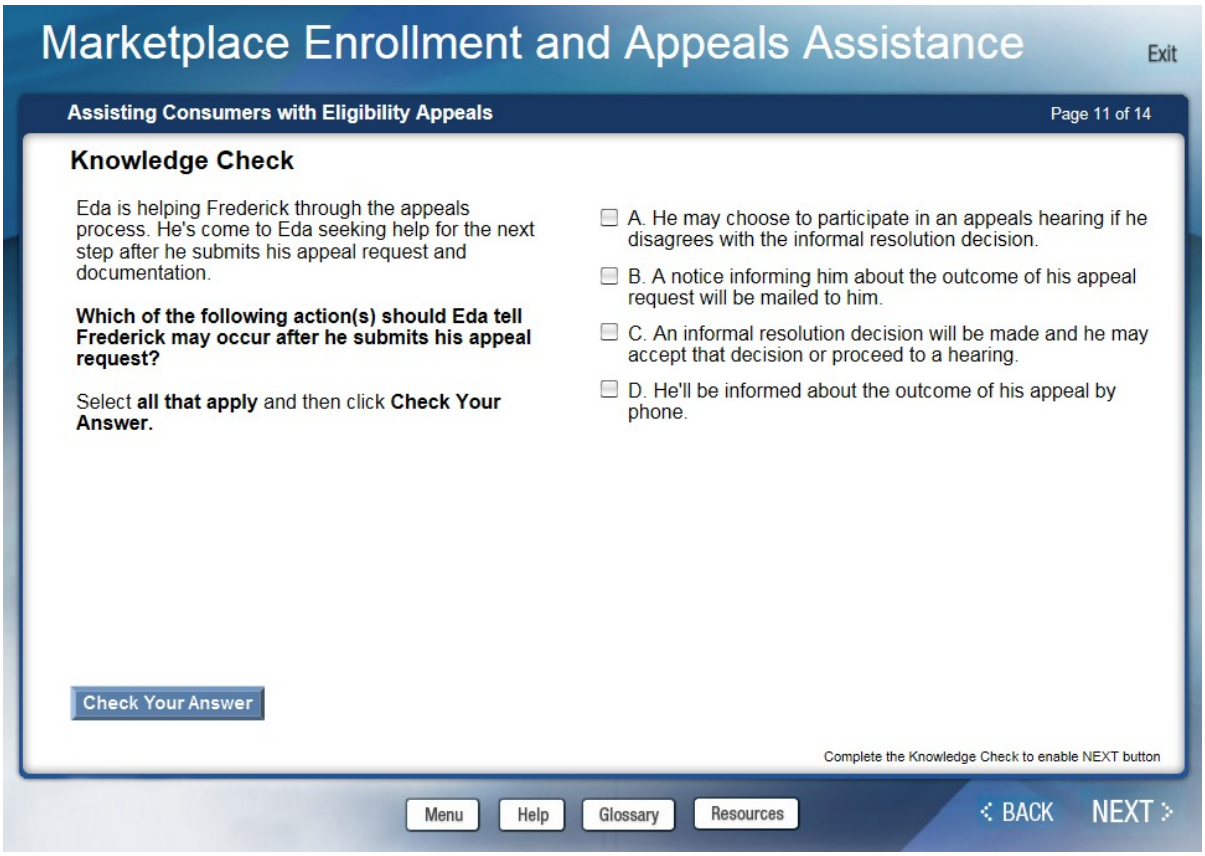
More Information about the Appeals Process

The process for resolving eligibility appeals in the Marketplace is as follows:

1. The consumer disagrees with an eligibility determination.
2. The complete appeal request is submitted.
3. An informal resolution is attempted.
4. The consumer decides whether or not to accept the informal resolution decision.
    a. If they accept, the appeal is closed and the decision is communicated through a notice.
    b. If they don'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 still dissatisfied, they can seek review in court to the extent it's available by law.

Key Tip

In general, the Marketplace will send consumers an appeal decision within 90 days of the date the Marketplace got the appeal request. However, sometimes it takes longer than this for the Marketplace to finish processing the appeal.



Knowledge Check

Eda is helping Frederick through the appeals process. He's come to Eda seeking help for the next step after he submits his appeal request and documentation.

Which of the following action(s) should Eda tell Frederick may occur after he submits his appeal request?

Select **all that apply.**

A. He may choose to participate in an appeals hearing if he disagrees with the informal resolution decision.

B. A notice informing him about the outcome of his appeal request will be mailed to him.

C. An informal resolution decision will be made and he may accept that decision or proceed to a hearing.

D. He'll be informed about the outcome of his appeal by phone.

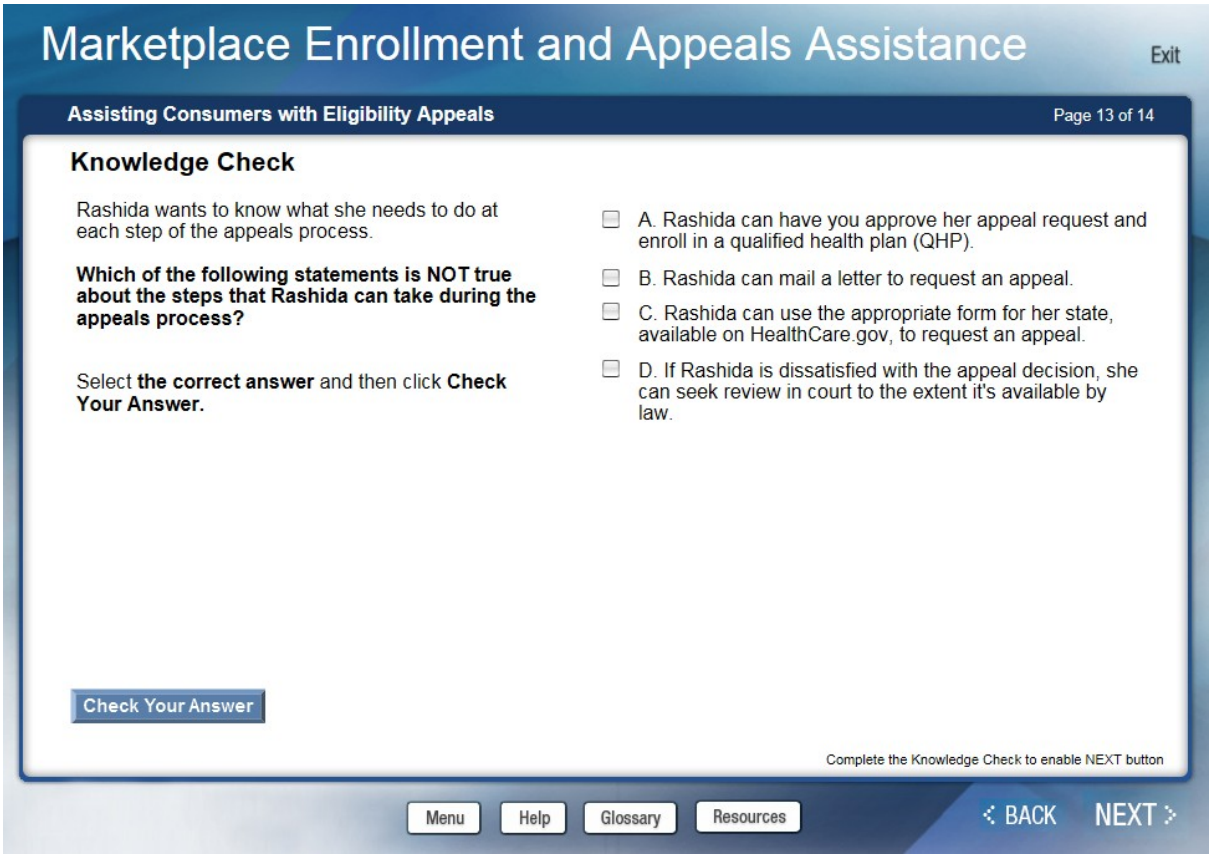
Feedback: The correct answers are A, B, and C. Once a request for an appeal has been submitted, Frederick's appeal may be resolved through an informal resolution process or a hearing. The outcome will be mailed to him.

Scenario: Helping a Consumer Understand the Eligibility Determination Notice

Rashida, a consumer Eda helped previously, comes back in to see Eda for help understanding her eligibility determination notice.

Rashida: I completed the application a few weeks ago and got a notice from the Marketplace saying that I'm eligible to enroll in a QHP, but I'm not eligible for any programs to help lower my costs. I don't understand what happened. I thought my annual income would make me eligible for a program that will help lower my costs. I don't think I can afford a health plan without any help. What should I do?

Eda: Do you have your eligibility determination notice with you? Let's take a look and see why the Marketplace determined you ineligible for premium tax credits or cost-sharing reductions. This determination should be explained clearly in your eligibility determination notice. Once we know the reason, we can determine your next steps.



Knowledge Check

Rashida wants to know what she needs to do at each step of the appeals process.

Which of the following statements is NOT true about the steps that Rashida can take during the appeals process?

Select **the correct answer**.

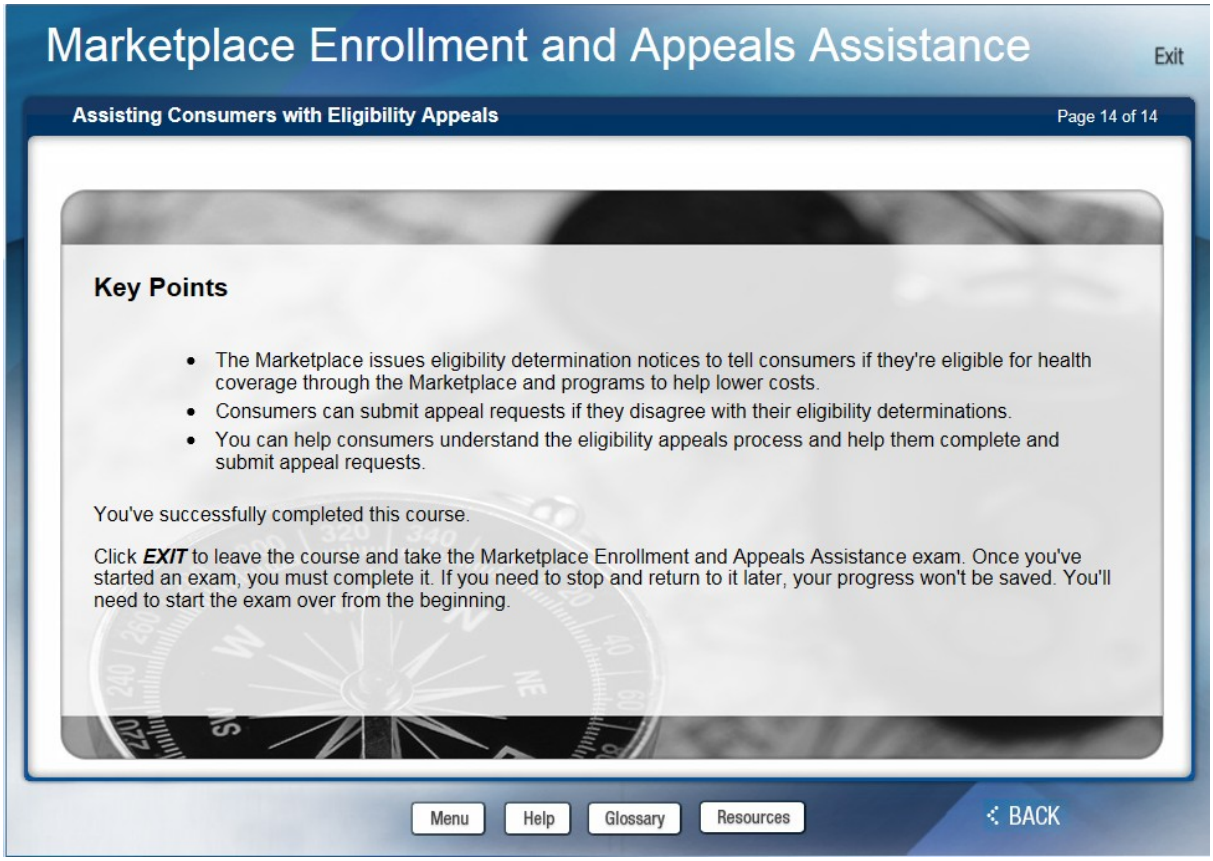
A. Rashida can have you approve her appeal request and enroll in a qualified health plan (QHP).

B. Rashida can mail a letter to request an appeal.

C. Rashida can use the appropriate form for her state, available on HealthCare.gov, to request an appeal.

D. If Rashida is dissatisfied with the appeal resolution, she can seek review in court to the extent it's available by law.

Feedback: The correct answer is A. You can't approve Rashida's appeal request. She can write a letter or use the appropriate appeal request form for her state, available on HealthCare.gov. If she's dissatisfied with the appeal resolution, she can seek review in court to the extent it's available by law.



Key Points

- The Marketplace issues eligibility determination notices to tell consumers if they're eligible for health coverage through the Marketplace and programs to help lower costs.
- Consumers can submit appeal requests if they disagree with their eligibility determinations.
- You can help consumers understand the eligibility appeals process and help them complete and submit appeal requests.

You've successfully completed this course.

Marketplace Enrollment and Appeals Assistance Resources

See Health Plans and Prices Before You Apply

A resource that provides sample health plans and prices for consumers to view before submitting a Marketplace application and enrolling in coverage.

https://www.healthcare.gov/see-plans/

Appealing a Marketplace Decision

An explanation of the appeals process for consumers who would like to appeal an eligibility decision issued by the Marketplace

https://www.healthcare.gov/marketplace-appeals/

Find Legal Aid

A locator tool that identifies legal aid offices in a specified geographic area

http://www.lsc.gov/find-legal-aid

National Disability Rights Network (NDRN), Find Help in Your State

A resource page and locator tool that identifies NDRN agencies by state

http://www.ndrn.org/en/ndrn-member-agencies.html

HealthCare.gov

A resource where consumers can create a Marketplace account and access information about health coverage and the Health Insurance Marketplace℠

https://www.healthcare.gov/

Premium Estimation Tool

A calculation tool that estimates premium costs for a health plan based on a consumer's needs, location, and desired benefits.

https://www.healthcare.gov/find-premium-estimates/