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2015
WV
Agents
Training

Tuesday, October 20, 2015

Holiday Inn & Suites

South Charleston, WV

9 am to 3:30 pm

Thursday, October 22, 2015

Hilton Garden Inn

Morgantown, WV

9 am to 3:30 pm

- *ACA Updates*
- *SHOP*
- *Group Health Insurance*
- *Consumer Assistance*
- *Carriers and Plans*
- *Financial Assistance & Cost Sharing*

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ACA Training Agenda



Introduction/Welcome

Assisters available for 2016 Enrollment

CMS Certified Training

ACA Basics

Qualified Health Plans & Dental Insurance

Group Health Insurance

Self-Funded Group Insurance

Medicaid Expansion

Medicare

*** Lunch ***

Health Literacy & Coverage to Care

Insurance Carrier Presentations

- Health Insurance Carriers
- Dental Insurance Carriers

Financial Assistance

Special Enrollment Periods (SEPs)

Questions & Answers

WV Offices of the Insurance Commissioner

Benefits Exchange WV website - bewv.com

Contains calendar of events, assisters, agents, ACA information and links

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Welcome

Today we will discuss:

- Consumer Assistance Programs in place
- Agents and why you are different
- The law and where we stand
- Results of the first two Open Enrollments
- 2016 Enrollment

THANK YOU FOR COMING!



Consumer Assistance



Help available in the Marketplace

- Marketplace Call Center 1-800-318-2596
- Marketplace Website www.healthcare.gov
- Certified Assisters
 - Navigator Program
 - Certified Application Counselors (CAC)
- Agents



Assisters Overview

- Assisters will be expected to:
 - Distribute fair, accurate, and impartial information about enrollment in Qualified Health Plans (QHP) and other health programs such as Medicaid and CHIP
 - Maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities.
 - Facilitate education of a QHP
 - Refer Consumers to other programs (Medicaid and CHIP)
 - Must be certified through the CMS web-based training
 - Cannot accept compensation from issuers for enrollment in QHP's or non-QHP's



Navigators



Navigators

- Navigator Grants are awarded directly from CMS
- In West Virginia, we have three Navigator Organizations for 2016:
 - First Choice Services
 - Appalachian Council on Aging
 - Healthy Start WVU



Certified Application Counselors



Certified Application Counselors (CAC)

- Every state is required to have a Certified Application Counselor program
- Interested organizations can submit a CAC application to CMS for approval
- An agreement is signed between CMS and the organization outlining the duties each organization will be required to fulfill
- Each person in the organization helping consumers with the marketplace must complete training through CMS to become certified



Insurance Agents



Insurance Agents

- The only licensed assisters
- Can look at life situations and suggest plans
- Experienced with health insurance
- Available to insureds year round
- Can compare plans on and off the Marketplace to give consumers a complete look at their choices



Insurance Agent Certification

- Complete the course on the new Marketplace Learning Management System (MLMS) on the CMS Enterprise Portal
- Must complete Individual training to sell individual products on the Marketplace
- For SHOP completion of offered training modules is encouraged, but not required
- Must sign SHOP Privacy and Security Agreement through MLMS to have access to SHOP Marketplace Agent Portal



Insurance Agent Certification

CMS approved vendors for agent training:

- Americans Health Insurance Plans
- Gorman Group
- National Association of Health Underwriters
 - Currently only AHIP and NAHU offer CEU credits in West Virginia (the course is offered for a fee)
 - Training offered by CMS does not offer CEU credits, however it is offered at no cost



ACA Law and Medicaid Expansion



West Virginia a Partnership State (SPM)

- Plan Management and Consumer Assistance
 - Ensuring CMS and NAIC IT systems work as intended
 - Assisting issuers with filing process
 - Interacting with Federal Exchange on plan certification
 - Guarding against fraud and scams
 - Sharing information on consumer complaints with CMS
 - Monitoring market stability and solvency
 - Market compliance strategies still unclear with HHS



How the Marketplace Works

- It uses one process to determine eligibility for
 - Qualified Health Plans(QHPs) through the Marketplace
 - Financial Assistance to lower monthly premiums
 - Reduced cost sharing
 - Medicaid
 - Children's Health Insurance Program (CHIP)
- It offers choice of plans and levels of coverage
- Insurance companies compete for business



Marketplace Basics

- Offers Qualified Health Plans that provide
 - Essential Health Benefits
 - Consumer Protections
- Allows you to compare costs and coverage among QHPs
- Exchange-eligible Individuals
 - State residents (all incomes)
 - Age 64 and under
 - Not incarcerated
 - Lawful resident
 - Medicaid and CHIP



Essential Health Benefits

Ambulatory patient services	Prescription drugs
Emergency services	Rehabilitative and habilitative services and devices
Hospitalization	Laboratory services
Maternity and newborn care	Preventive and wellness services and chronic disease management
Mental health and substance use disorder services, including behavioral health treatment	Pediatric services, including oral and vision care (pediatric oral services may be provided by stand-alone plan)



Preventive Benefits

- United States Prevention Services Task Force (USPSTF) grade all preventive medical services
- Any service with an A or B rating must be covered by a QHP with no cost sharing to the consumer
- The list can be found at:
 - <http://www.uspreventiveservicestaskforce.org/uspstf/uspabrecs.htm>



Key Market Reforms

- Essential Health Benefits – all plans include the same major medical benefits
 - EHB's derived from the state benchmark plan, Highmark's Super Blue Plus 2000 \$1000 Deductible Plan
 - In West Virginia, Minimum Essential Coverage (MEC) is equal to the EHB's in our state's Benchmark Plan
 - Benchmark plan changing for 2017 to Shared Cost \$1000
- Discriminatory practices banned



Key Market Reforms - continued

- Federal Subsidies for those at lower income levels to aid in their purchase
- Tax penalties for those that do not purchase insurance.
- Consumers receiving Advanced Premium Tax Credits (APTC) must be granted a 90 grace period to pay premiums by the carrier
 - Consumers not receiving APTC falls to the state mandated 30 days



Qualified Health Plans

- A Qualified Health Plan
 - Is offered through the Marketplace by an issuer that is licensed by the state and in good standing
 - Covers essential health benefits
 - Is offered by an issuer that offers at least one plan at the “Silver” level and one at the “Gold” level of cost sharing
 - Charges same premium whether offered through the Marketplace or outside the Marketplace



Health Plan Categories



Percent of Total Cost of Care Covered



Catastrophic Health Plans

- What is catastrophic coverage?
 - Federally mandated maximum OOP
 - Includes 3 primary care visits per year and preventive services with no out of pocket costs
 - Protects you from high out of pocket costs
- Who is eligible
 - Young adults under 30
 - Those who qualify for a hardship exemption



Individual Mandate

Exempt from the mandate if:

- Religious exemption exists
- Not lawfully present in the United States
- Incarcerated

No penalty assessed if:

- Individual cannot afford coverage
- Income below tax filing threshold
- Member of an Indian tribe
- Uninsured for short coverage gaps of less than 3 months
- Individual has received a hardship waiver from the Secretary

	2014	2015	2016 and beyond
	\$95 per adult and \$47.50 per child (up to \$285 for a family) or 1% of family income whichever is greater	\$325 per adult and \$162.50 per child (up to \$975 for a family) or 2.0% of family income whichever is greater	\$695 per adult and \$347.50 per child (up to \$2085 for a family) or 2.5% of family income whichever is greater
Penalty is pro-rated for the number of months without coverage, unless less than three months. The overall penalty is capped at the national average premium of a bronze level plan purchased through an Exchange. Penalties will be increased by COLA in 2017.			

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Federal Assistance for Individuals

Advanced Premium Tax Credits

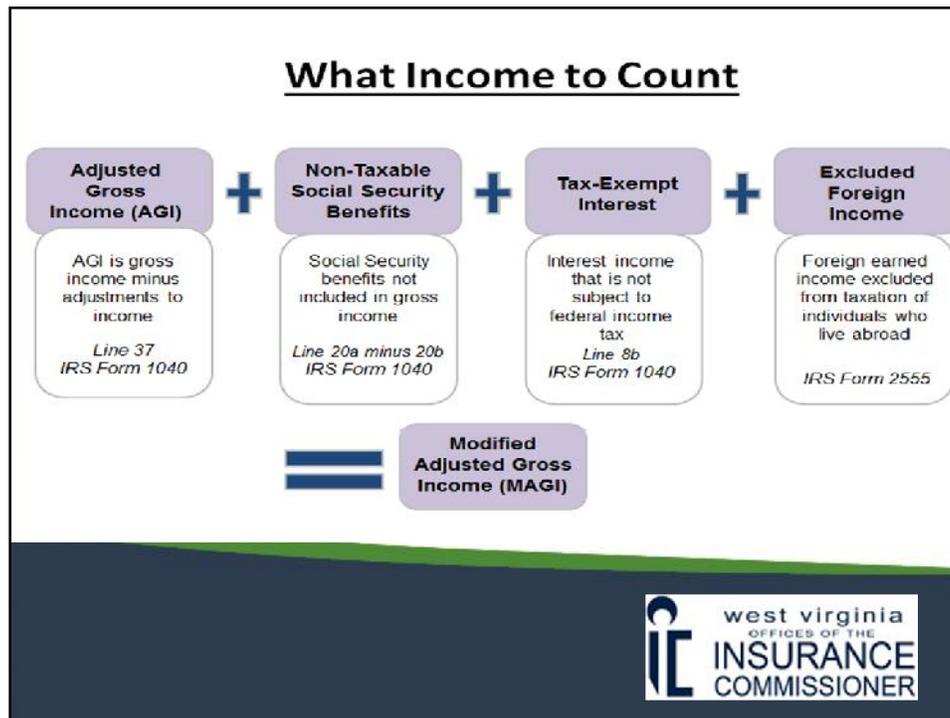
Modified Adjusted Gross Income (MAGI) as % of Federal Poverty Level	Consumer Premium Contribution Cannot Exceed
100-133% FPL	2% of income
>134-150% FPL	3 - 4% of income
>151%-200% FPL	4 - 6.3% of income
>201-250% FPL	6.3 – 8.05% of income
>251-300% FPL	8.05 – 9.5% of income
>301-400% FPL	9.5% of income

Cost Sharing Reductions

Cost-Sharing Subsidies

Household Income as % of FPL	Actuarial Value of Silver Plan
100-150%	94%
150-200%	87%
200-250%	73%
250-400%	70%

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Advance Premium Tax Credits

- APTC must be reconciled each year
- If you receive APTC, you must file federal taxes for the tax year the APTC is received
- All income changes must be reported to the Federal Call Center immediately (800-318-2596)
- If your APTC is too high during the year, you will be required to pay back the difference

Applicable Large Employers (ALE)

- ALEs must file Form [1095-C](#) and form [1094-C](#) annually
- Must provide a similar statement to each employee
 - A copy of the 1095-C will meet the requirement
- Self Insured ALEs must also report



Form W-2 Reporting

- Value of health care coverage should be reported in box 12 with the code DD
- Should be a total of employer and employee contributions
- [More](#) than just major medical is to be included



Enrollment in the Marketplace

- Open Enrollment begins November 1, 2015 and runs through January 31, 2016
- Utilizing same 15th of the month cut off

ALL MEDICAL PLANS WILL FOLLOW THE FEDERAL OPEN ENROLLMENT, ON AND OFF MARKETPLACE



West Virginia Enrollment

	<u>Open Enrollment 2014</u>	<u>Open Enrollment 2015</u>
Marketplace Enrollment*	19,856	31,106
WV Medicaid Expansion**	145,000	148,810
Financial Assistance		
Yes	86%	86%
No	14%	14%
<small>*Department of Health & Human Services ASPE Issue Brief May 1, 1994 & CMS June 30, 2015 Effectuated Enrollment Snapshot **West Virginia DHHR Expansion number as of September 2014 & August 2015</small>		



Redeterminations

- If the consumer allowed auto renewals in their initial application, the Federal Hub will automatically recalculate any APTC based on the previous year's income
- Consumers are HIGHLY encouraged to go into their online account to verify their income and other personal information
- Consumers have the right to change plans during each Open Enrollment Period



SHOP Marketplace

- Eligibility in the SHOP Marketplace
 - Business located in the state where you are buying coverage
 - At least one common law employee on payroll
 - 50 or fewer full time equivalent employees
 - PACE Act – [WV Informational Letter 196](#)



How to Count

- A full time employee is one working 30 hours per week
- 50 full time employees is determined by a combination of full and part time employees
- Seasonal staff counts if employed over 120 days a year

www.Healthcare.gov/FTE-calculator/



SHOP Marketplace

- Rating Methodology
 - Rates are derived from age and zip code
 - Any composite rates have tobacco load added after the composite to affected members only

- Estimated Rates

– www.Healthcare.gov/find-premium-estimates/



SHOP Market Reforms

- Non-profits are permitted a religious exemption for Contraceptive Coverage. CMS, through a third party vendor, will coordinate contraceptive coverage for any employee of such non-profit wishing coverage.
- Single Risk Pool Requirements for Insurers
 - Insurers must combine their risk pools of on and off Marketplace plans (both individual and small group) so that the rating maintains consistency
- Employer Tax Credits and Penalties
 - Tax Credits available 2014
 - Tax Penalties delayed until 2016



Affordability Provision

- When is a group plan considered affordable?
 - No employee can be required to pay more than 9.5% of his W-2 Income.

Hourly Rate	Hours/Week	Annual Comp	9.5% of Comp	Max Monthly EE Cost for EE Coverage
\$7.25	30	\$11,310	\$1,074.45	\$89.54
\$7.25	40	\$15,080	\$1,432.60	\$119.38
\$8	30	\$12,480	\$1185.60	\$98.80
\$8	40	\$16,640	\$1580.80	\$131.73
\$10	30	\$15,600	\$1300.00	\$123.50



Stand Alone Dental Plans (SADP)

- SADP are offered to individuals and small groups
- Plans are either on Marketplace or Off Marketplace Certified
- On Marketplace SADP Plans may only be purchased by a group purchasing medical through the SHOP
- Individual can purchase a SADP Plan with or without medical insurance



Pediatric Dental Coverage

- Pediatric Dental is a required EHB
 - All on and off certified SADP must offer at least one Pediatric Dental Plan
 - One child can have no more than \$350 out of pocket for dental expenses
- Off Marketplace Certified SADP can fulfill the requirement of pediatric dental for tax credit purposes
- Adult benefits remain the same as they have been in the past (waiting periods still apply)



Health Literacy

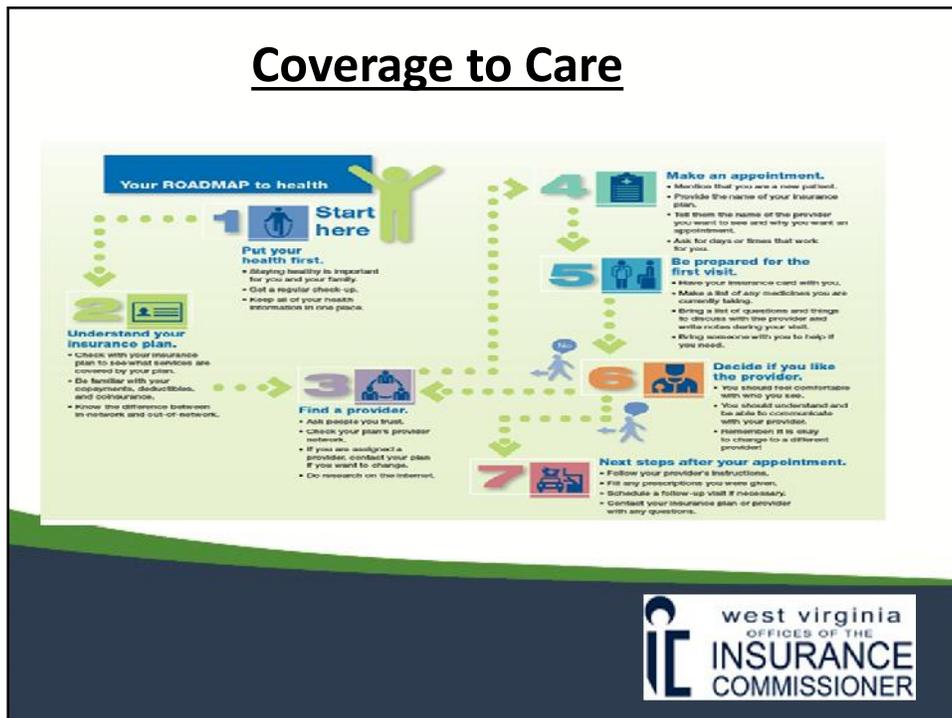


Health Literacy Education

- Consumers don't understand what they purchase
- Insurance as a Second Language
 - Deductible
 - Co-Insurance
 - Copays
 - Out of Pocket Maximum
- Coverage to Care
- Glossary of Health Insurance Terms



Coverage to Care



WVOIC Consumer Services

- Consumer Services is the liaison between the Consumer and the Insurance Company
- Unresolvable Issues should be brought to their attention for help and resolution
- Call the Life and Health Team (888-TRY-WVIC)

Resources

- HealthCare.gov
www.healthcare.gov
- CCIIO website:
www.cms.gov/CCIIO
- WVOIC Health Policy Unit:
www.bewv.com
- CMS Marketplace Call Center
1-800-318-2596



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Centers for Medicare & Medicaid Services News for Agents and Brokers

SEPTEMBER 2015 EDITION

An electronic source of information for Federally-facilitated Marketplace (FFM) Agents and Brokers

In This Issue:

- FFM Agent and Broker Training via CMS-approved Vendors
- CMS-approved Vendor Help Desks
 - America's Health Insurance Plans, Inc. (AHIP)
 - Gorman Health Group
 - The National Association of Health Underwriters (NAHU)
- Registration Tips for the New Marketplace Learning Management System (MLMS) Platform
- Supported Browsers for Plan Year 2016 Training
- Small Business Health Options Program (SHOP) Marketplace Corner
 - Establish Your SHOP Marketplace Profile Today
 - SHOP Marketplace Enrollment Videos Now Available
 - SHOP Marketplace Agent/Broker Frequently Asked Questions (FAQ) Document Now Available
- Spanish Training Now Live for FFM Agents and Brokers
- Registration and Training Resources for Plan Year 2016
- FFM Agent and Broker Registration Completion List
- *Did You Know?* Help Desk Information for Agents and Brokers
- Registration and Training Resources for Plan Year 2016
- Follow us on Twitter
- Contact Us

Agent/Broker Registration for Plan Year 2016 is Now Available on the [CMS Enterprise Portal](#)

FFM Agent and Broker Training via CMS-approved Vendors

New for plan year 2016, you may complete the required FFM agent and broker training through CMS-approved vendors in addition to the CMS-developed training offered on the Marketplace Learning Management System (MLMS). Completion of a training curriculum, including the associated exams, through one of the CMS-approved vendors will fulfill the FFM training requirement for agents and brokers registering to participate in the Individual Marketplace for plan year 2016. CMS highly recommends that agents and brokers participating in the SHOP Marketplace take the SHOP Marketplace training, but it is not required.

CMS is excited to announce that there are three CMS-approved vendors offering FFM training for agents and brokers in plan year 2016. They are [America's Health Insurance Plans, Inc.](#), [Gorman Health Group](#), and the [National Association of Health Underwriters](#).

Vendors are required to cover, at a minimum, the same topic areas as those covered in the FFM agent and broker training offered by CMS through the MLMS, and, pursuant to 45 CFR § 155.222, are required to offer continuing education unit (CEU) credits in a minimum of five states where the FFM is operating. The number



Centers for Medicare & Medicaid Services

News for Agents and Brokers

of CEU credits and the states where they are available may vary by vendor. Vendors may also charge a fee to agents and brokers that choose to take their FFM agent and broker trainings. For more information on the trainings each CMS-approved vendor offers, please visit their individual webpages, which are linked above.

If you choose to complete FFM agent and broker training through a CMS-approved vendor, you will still need to execute the applicable Agreements on the MLMS after completing training and prior to assisting consumers seeking to enroll in coverage through the FFM. You are also required to establish an account, select the agent/broker role, and complete identity proofing on the [CMS Enterprise Portal](#), if you have not already done so in a previous plan year. The vendors' trainings are accessible via the Agent Broker Registration Status page on the CMS Enterprise Portal.

As mentioned above, CMS also offers plan year 2016 FFM agent and broker training, as it has done for the past two years. The training offered by CMS through the MLMS does not offer CEU credits and is offered at no cost.

CMS-approved Vendor Help Desks

Each CMS-approved vendor has created a Help Desk to support agents and brokers with any issues they may experience in accessing the vendor's site as well as answer questions about its training options. Please note that the Help Desk hours vary by CMS-approved vendor. The Help Desk details are listed below:

America's Health Insurance Plans, Inc. (AHIP)

If you require assistance with AHIP's training option, you may contact the AHIP Help Desk at 800-984-8919. The Help Desk operators are available by phone from 8:00 AM – 12:00 AM Eastern Time (ET), Monday through Friday and from 8:30 AM – 5:30 PM ET, Saturday and Sunday. You may also contact the AHIP Help Desk via email at support@ahipinsuranceeducation.org.

Gorman Health Group

If you require assistance with Gorman Health Group's training option, you may contact the Gorman Health Group Help Desk at 877-207-0349. The Help Desk operators are available by phone from 8:00 AM – 7:00 PM ET, Monday through Friday and from 10:00 AM – 3:00 PM ET, Saturday and Sunday. Please note that these hours are subject to change after Open Enrollment. You may also contact Gorman Health Group's Help Desk via email at exchangetraining@gormanhealthgroup.com.

National Association of Health Underwriters (NAHU)

If you require assistance with NAHU's training option, you may contact the NAHU Help Desk at 844-257-0990. The Help Desk operators are available by phone from 9:00 AM – 6:00 PM ET, Monday through Friday. You may also contact the NAHU Help Desk via email at nahu-ffm@nahu.org.



Registration Tips for the New Marketplace Learning Management System (MLMS) Platform

Earlier this month, CMS launched the plan year 2016 FFM agent and broker training on the new MLMS training platform. The new MLMS has replaced the previously used Medicare Learning Network® (MLN) and is now accessible via the Agent Broker Registration Status page on the [CMS Enterprise Portal](#).

If you plan to participate in the FFM for plan year 2016, regardless of whether you participated in previous years, you need to complete an agent/broker profile on the MLMS, select a preferred training option via the CMS Enterprise Portal, complete the required Marketplace training and exams on the MLMS or through a CMS-approved vendor, and accept the applicable Marketplace Agreements on the MLMS. For agents and brokers who only plan to assist consumers in the SHOP Marketplace, completion of the recommended training modules is strongly encouraged, but not required.

There is a limit to the number of agents and brokers that can take the training at one time. If you attempt to begin training and there are no spots available, the MLMS will place you in a virtual waiting room. In order to avoid this, consider taking the training during an “off-peak” time, when you have a much better chance of accessing the system without waiting. Off-peak is any time prior to 11:00 AM or after 5:00 PM ET on a weekday and anytime on the weekend.

Supported Browsers for Plan Year 2016 Training

To ensure the best experience when completing the plan year 2016 FFM agent and broker training on the new MLMS training platform, please use Firefox or Google Chrome as your web browser.

- You can download the latest version of Mozilla Firefox at the following link:
<https://www.mozilla.org/en-US/firefox/new/>.
- You can download the latest version of Google Chrome at the following link:
<https://www.google.com/chrome/browser/desktop/>.

If you are using Mozilla Firefox or Google Chrome and are still experiencing any technical or system-specific issues, please contact the MLMS Help Desk at MLMSHelpDesk@cms.hhs.gov or the applicable vendor’s help desk.

Small Business Health Options Program (SHOP) Marketplace Corner

Establish Your SHOP Marketplace Profile Today

Agents and brokers who have signed the SHOP Privacy and Security Agreement through the MLMS have access to the SHOP Marketplace Agent/Broker Portal. On the portal, agents and brokers can create a searchable profile accessible by employers seeking assistance with their SHOP Marketplace application and enrollment. Through the SHOP Marketplace Agent/Broker Portal, agents and brokers can manage clients, create proposals for clients to review and approve, submit enrollment on behalf of clients, and satisfy the requirements to receive compensation for sales.

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To establish a searchable profile on the SHOP Marketplace Agent/Broker Portal, visit <https://healthcare.gov/marketplace/small-businesses/agent> and log in using your CMS Enterprise Portal username and password and confirm the accuracy of the information provided. Remember, the information provided there will be searchable by employers, so make sure the appropriate contact information is listed.

SHOP Marketplace Enrollment Videos Now Available

Step-by-step application and enrollment videos are now available online for agents, brokers, employers, and employees. Each video will walk you through the steps you need to take in order to assist your clients to apply, enroll, and respond to an offer of SHOP Marketplace coverage on HealthCare.gov.

Watch the videos here:

[How to Enroll in the SHOP Marketplace in 2015: For Agents and Brokers](#)

[How to Enroll in the SHOP Marketplace in 2015: For Employers](#)

[How to Enroll in the SHOP Marketplace in 2015: For Employees](#)

SHOP Marketplace Agent/Broker Frequently Asked Questions (FAQ) Document Now Available

The SHOP Marketplace makes it easy for agents and brokers to enroll their small business clients in health or dental coverage, online through HealthCare.gov.

A new FAQ document is now available for agents and brokers operating in the SHOP Marketplace and can be found [here](#).

Spanish Training Now Live for FFM Agents and Brokers

CMS is pleased to announce that the Spanish version of the CMS-developed plan year 2016 FFM training for agents and brokers is now live on the MLMS. Please note that completion of the Spanish version satisfies the FFM agent and broker training requirement. Look for additional details on the [Agents and Brokers Resources webpage](#) regarding how to complete the Spanish version of the FFM agent and broker training for plan year 2016 in the coming weeks.

Registration and Training Resources for Plan Year 2016

Are you looking for additional help with the 2016 agent and broker training and registration process? CMS will be releasing FFM agent and broker registration and training resources, such as question and answer documents, quick reference guides, registration guided tour videos for different steps of the registration process, as well as other topics of importance to FFM agents and brokers. Look for additional details in future editions of the “News for Agents and Brokers” newsletter and on the [Agents and Brokers Resources webpage](#).



FFM Agent and Broker Registration Completion List

CMS maintains an FFM Agent and Broker Registration Completion List, which contains the National Producer Numbers (NPNs) for agents and brokers who have completed all the FFM registration and training requirements. For plan year 2016, CMS will continue to maintain a list that contains the NPNs of agents and brokers who have completed the FFM registration and training requirements for plan year 2016. CMS will post this list on the [Agents and Brokers Resources webpage](#) and will update it twice a month. It is important to confirm that your NPN appears on this list after you complete the plan year 2016 registration and training process. Issuers will review the FFM Agent and Broker Registration Completion List to confirm that agents and brokers with whom they have agreements are authorized to assist consumers in selecting plans through the FFM. Users can search NPNs by clicking the arrow in cell A1, or by using the “Ctrl + F” (or “Command + F”) keystroke. All NPNs are self-reported by the agent or broker during FFM registration, and should be validated against state and/or other National Association of Insurance Commissioners records to confirm state licensure.

Did You Know?

There are a number of Help Desks to assist you if you have questions about registration, training, or other topics.

- **FFM Producer and Assister Help Desk:** Contact the FFM Producer and Assister Help Desk at FFMProducer-AssisterHelpDesk@cms.hhs.gov for questions about agent or broker participation in the FFM, including general registration and training questions (not related to a specific training platform), even if they are SHOP related; identity proofing/Experian issues requiring manual verifications, and policy questions.
- **Marketplace Call Center:** For questions/comments about the FFM application and enrollment, contact 1-800-318-2596 (TTY: 1-855-889-4325). This Call Center is available 7 days a week, 24 hours a day.
- **Exchange Operations Support Center (XOSC):** Contact the XOSC at 1-855-CMS-1515 (855-267-1515) or CMS_FEPS@cms.hhs.gov for questions about password resets and account lockouts on the CMS Enterprise Portal; HealthCare.gov website issues; other CMS Enterprise Portal account issues, requests, or error messages. This Help Desk is available Monday through Saturday, 8:00 AM – 10:00 PM ET.
- **MLMS Help Desk:** For technical or system-specific issues related to the MLMS, user-specific questions about maneuvering the learning management system site, or accessing CMS training and exams on the MLMS, contact MLMSHelpDesk@CMS.HHS.gov.
- **SHOP Call Center:** For inquiries related to the SHOP Marketplace Agent/Broker Portal, contact the SHOP Call Center at 1-800-706-7893 (TTY: 711) Monday through Friday, 9:00 AM – 7:00 PM ET.
- **Web-broker Help Desk:** For questions about web-broker participation in the FFM, contact Webbroker@cms.hhs.gov.

Centers for Medicare & Medicaid Services News for Agents and Brokers

Follow us on Twitter

Agents and brokers can find important information and updates by following the CMS Twitter handle ([@CMSGov](https://twitter.com/CMSGov)) or by searching the hashtags #ABFFM or #ABFFSHOP on Twitter.

Contact Us

For questions pertaining to the FFM agent and broker program, including the FFM registration requirements, please contact the FFM Producer and Assister Help Desk via email at FFMProducer-AssisterHelpDesk@cms.hhs.gov.



Federally-facilitated Marketplace Agent and Broker Plan Year 2016 Registration and Training Requirements

An Overview for Agents and Brokers

July 22, 2015

July 29, 2015

August 19, 2015

*Centers for Medicare & Medicaid
Services (CMS)*

*Center for Consumer Information
& Insurance Oversight (CCIIO)*



Webinar Agenda

- Session Guidelines
- Webinar Objectives
- FFM Plan Year 2016 Agent and Broker Registration and Training Requirements Overview
- Resources
- Question & Answer (Q&A) Session
- Closing Remarks

Webinar Objectives

Topics to be covered:

- Role of Agents and Brokers in the Health Insurance Marketplaces
- Registration Overview
- Training Overview
- Training & Exams Requirements and Recommendations
- Agreement Requirements
- CMS-Approved Vendor Training Option
- Considerations for Business Entities
- Compensation/Credit for Agents and Brokers Operating in the FFM
- Additional Resources

Please note that the content in this presentation is limited to the Federally-facilitated Individual and Small Business Health Options Program (SHOP) Marketplaces.

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Federally-facilitated Marketplace Agent and Broker Plan Year 2016 Registration and Training Requirements



Role of Agents and Brokers in the Health Insurance Marketplaces

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Role of Agents and Brokers in the Health Insurance Marketplaces

- To the extent permitted by states, licensed agents and brokers can assist consumers in applying for insurance affordability programs (including the premium tax credit and cost-sharing reductions) and selecting qualified health plans (QHPs).
- Agents and brokers play a crucial role in educating consumers about the Health Insurance Marketplaces, both during annual Open Enrollment and throughout the coverage year.



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Federally-facilitated Marketplace Agent and Broker Plan Year 2016 Registration and Training Requirements



Registration Overview

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Registration Overview

- Registration for plan year 2016 will become available through the CMS Enterprise Portal starting in September.
- Agents and brokers who wish to participate in the FFM must complete the following actions on the CMS Enterprise Portal (<https://portal.cms.gov/>):
 - Create an account
 - Request the FFM agent/broker role
 - Complete remote identity proofing through the Enterprise Identity Management (EIDM) System

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Registration Overview

All agents and brokers must also complete the following actions:

- Complete an agent/broker profile on the new Marketplace Learning Management System (MLMS)
- Enroll in the desired Marketplace training (i.e. Individual and/or SHOP) on the MLMS or through a CMS-approved vendor via the CMS Enterprise Portal
- Complete assigned training courses and pass exams through the MLMS or through a CMS-approved vendor via the CMS Enterprise Portal
- Read and accept the applicable Marketplace Agreement(s) on the MLMS

The new MLMS will replace the previously-used MLN and can be accessed via the Agent Broker Registration Status page on the CMS Enterprise Portal.

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Registration Overview

Changes to Registration Since Plan Year 2015

While most of the registration process is the same as in plan year 2015, there are a few new features for plan year 2016:

Plan Year 2015	Plan Year 2016
Two accounts, a CMS Enterprise Portal account and a Medicare Learning Network® (MLN) account, were required.	Only one account (i.e., User ID and password), the CMS Enterprise Portal account, is required.
Agents and brokers could only view their registration status via the Agent and Broker FFM Registration Completion List on the Agents and Brokers Resources webpage at http://www.cms.gov/ccio/programs-and-initiatives/health-insurance-marketplaces/a-b-resources.html . This list is updated on a bi-weekly basis.	An Agent and Broker Registration Status page is available on the CMS Enterprise Portal to enable agents and brokers to check the status of their completion of each registration component in real time.

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Registration Overview

- All agents and brokers participating in the FFM are required to complete their profile information on the MLMS and electronically sign the Agreements that apply to the Marketplace(s) for which they complete training.
- Training courses and exams are only required for agents and brokers who wish to enroll consumers in the Individual Marketplace. However, CMS strongly encourages agents and brokers who wish to participate in the SHOP Marketplace to complete the optional training courses and exams that are provided.



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Registration Overview

- Upon successful completion of all registration requirements, agents or brokers will be able to generate a registration completion certificate specific to the Marketplace(s) for which they signed the Agreements.
 - The issuer(s) with which an agent or broker is affiliated may request to view his or her registration completion certificate(s).
 - However, issuers are instructed to review the Registration Completion list published by CMS to confirm the registration status of agents and brokers.



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Federally-facilitated Marketplace Agent and Broker Plan Year 2016 Registration and Training Requirements



FFM Agent and Broker Training Overview

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Training Overview

- Agents and brokers who plan to participate in the Individual Marketplace must:
 - Complete each of the training modules associated with Affordable Care Act and Marketplace Basics, Individual Marketplace, and Privacy and Security;
 - Successfully complete the three Exams for Affordable Care Act and Marketplace Basics, Individual Marketplace, and Privacy and Security;
 - Execute the Individual Marketplace General Agreement; and
 - Execute the Individual Marketplace Privacy & Security Agreement.
- Agents and brokers who plan to participate in the SHOP Marketplace must:
 - Execute the SHOP Privacy & Security Agreement.
 - Agents and brokers are strongly encouraged, but not required, to also complete the training modules and exams for Affordable Care act and Marketplace Basics, SHOP Marketplace, and Privacy and Security.
 - For agents and brokers who only intend to participate in the SHOP Marketplace, taking the SHOP Marketplace Exam will document their successful completion of the SHOP training material.

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Training Overview

Changes to Training Since Plan Year 2015

While most of the training content is the same as in plan year 2015, there are a few new features for plan year 2016:

Plan year 2015	Plan year 2016
The only approved training was offered by CMS.	The option to take training from CMS-approved vendors
CMS did not offer continuing education unit (CEU) credits to agents and brokers for completing training.	Agents and brokers may be able to receive CEU credits by completing training through a CMS-approved vendor, depending on the state in which they participate. CEU credits will not be offered through the MLMS training.
CMS offered four training modules.	Training has been streamlined into 11 focused modules and the content has been updated to reflect plan year 2016 policies.*
Agents and brokers accessed training through the MLN.	The new MLMS system replaces the previously-used MLN.

**The total time to complete all trainings will be the same as in plan year 2015, but the more specific modules will allow agents and brokers to review the different topics in smaller pieces.*

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Training Overview

For plan year 2016, CMS has eleven training modules available:

- Welcome
- Affordable Care Act Basics
- Marketplace Basics
- Individual Marketplace Eligibility for Enrolling in a QHP
- Individual Marketplace Eligibility for Enrolling in an Insurance Affordability Program (IAP)
- Individual Marketplace Enrollment
- Privacy Standards and Definitions
- Protecting and Handling Personally Identifiable Information (PII)
- Information Security
- FF-SHOP Marketplace Employer
- FF-SHOP Marketplace Qualified Employee

Depending on the Marketplace(s) in which an agent or broker is assisting consumers, the training requirements vary.

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Training Overview

CMS has four exams associated with the training modules:

- Affordable Care Act and Marketplace Basics
- Individual Marketplace
- Privacy and Security Standards
- SHOP Marketplace



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Training Overview

- Agents and brokers must complete the exam associated with required training modules in order for the training to be considered completed.
- For an exam to be considered complete, an agent or broker must pass with a minimum score of 70%.



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Federally-facilitated Marketplace Agent and Broker Plan Year 2016 Registration and Training Requirements



FFM Agent and Broker Training and Exams Requirements and Recommendations

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Training Requirements for Agents and Brokers Participating in the Individual Marketplace

		Required	Strongly Encouraged
Training Modules	Welcome	✓	
	Affordable Care Act Basics	✓	
	Marketplace Basics	✓	
	Individual Marketplace Eligibility for Enrolling in a QHP	✓	
	Individual Marketplace Eligibility for Enrolling in an IAP	✓	
	Individual Marketplace Enrollment	✓	
	Privacy Standards and Definitions	✓	
	Protecting and Handling PII	✓	
	Information Security	✓	
	FF-SHOP Marketplace Employer		
	FF-SHOP Marketplace Qualified Employee		
Exams	Affordable Care Act and Marketplace Basics	✓	
	Individual Marketplace	✓	
	Privacy and Security Standards	✓	
	SHOP Marketplace		

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Training Requirements for Agents and Brokers Participating in the SHOP Marketplace

		Required	Strongly Encouraged
Training Modules	Welcome		✓
	Affordable Care Act Basics		✓
	Marketplace Basics		✓
	Individual Marketplace Eligibility for Enrolling in a QHP		
	Individual Marketplace Eligibility for Enrolling in an IAP		
	Individual Marketplace Enrollment		
	Privacy Standards and Definitions		✓
	Protecting and Handling PII		✓
	Information Security		✓
	FF-SHOP Marketplace Employer		✓
	FF-SHOP Marketplace Qualified Employee		✓
Exams	Affordable Care Act and Marketplace Basics		✓
	Individual Marketplace		
	Privacy and Security Standards		✓
	SHOP Marketplace		✓

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Training Requirements for Agents and Brokers Participating in the Individual and SHOP Marketplaces

		Required	Strongly Encouraged
Training Modules	Welcome	✓	
	Affordable Care Act Basics	✓	
	Marketplace Basics	✓	
	Individual Marketplace Eligibility for Enrolling in a QHP	✓	
	Individual Marketplace Eligibility for Enrolling in an IAP	✓	
	Individual Marketplace Enrollment	✓	
	Privacy Standards and Definitions	✓	
	Protecting and Handling PII	✓	
	Information Security	✓	
	FF-SHOP Marketplace Employer		✓
	FF-SHOP Marketplace Qualified Employee		✓
Exams	Affordable Care Act and Marketplace Basics	✓	
	Individual Marketplace	✓	
	Privacy and Security Standards	✓	
	SHOP Marketplace		✓

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Ensuring an Agent’s or Broker’s National Producer Number is Associated with Profile

Agents and brokers must enter a correct National Producer Number (NPN) in their MLMS profiles and should verify it is correct to receive credit for completing training.

- The NPN can be up to 10 digits long and must not begin with a zero.
- The NPN must not include any special characters or letters.
- The NPN is not the same as the agent’s or broker’s state license number. The agent or broker should be sure to use his or her NPN, not a state license number.
- To update the NPN, agents and brokers can click on the “Complete Agent Broker Training” hyperlink and update the information in their MLMS profiles.
- Agent and broker NPNs can be found at: <https://pdb.nipr.com/html/PacNpnSearch.html>.

Entering an inaccurate NPN could result in denial of compensation/credit by an issuer.

Federally-facilitated Marketplace Agent and Broker Plan Year 2016 Registration and Training Requirements



FFM Agent and Broker CMS-approved Vendor Training Option

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CMS-approved Vendor Training Option

In addition to the plan year 2016 training provided by CMS, training will be offered by a limited number of CMS-approved vendors.

- CMS-approved vendors may charge a fee to agents and brokers that choose to take their training.
- Agents and brokers who complete FFM training through a CMS-approved vendor will still need to execute the applicable Agreements on the MLMS prior to assisting consumers seeking to enroll in coverage through the FFM.
- CMS will provide additional information to agents and brokers regarding the final list of approved vendors, the process for the completion of training using the CMS-approved vendor options, and the go-live date(s) via the Agents and Brokers Resources webpage (<http://www.cms.gov/ccio/programs-and-initiatives/health-insurance-marketplaces/a-b-resources.html>), CMS's twitter account (@CMSgov), the News for Agents and Brokers newsletter and emails distributed through GovDelivery.

The CMS-approved vendor training option is planned to go live starting in September.

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CMS-approved Vendor Training Option

The benefits of completing training through a CMS-approved vendor include:

- CMS-approved vendors are required to offer CEU credits in a minimum of five states where the FFM is operating (45 CFR 155.222). The states where CEUs are offered may vary by vendor.
- Completion of a training curriculum, including the associated exams, through one of the CMS-approved vendors will fulfill the FFM training requirements for agents and brokers registering to participate in the Individual and/or SHOP Marketplaces.
- CMS-approved vendors are required to cover, at a minimum, the same topic areas as are covered in the CMS training.

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Federally-facilitated Marketplace Agent and Broker Plan Year 2016 Registration and Training Requirements



FFM Agent and Broker Agreement Requirements

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Agreements Overview

- **Individual Marketplace General Agreement:** includes terms for complying with federal and state laws, rules, standards, and policies.
- **Individual Marketplace Privacy and Security Agreement:** includes privacy and security policies for protecting consumers' PII. The FFM privacy standards are consistent with the eight principles outlined in 45 CFR 155.260(a).
- **SHOP Marketplace Agreement:** includes privacy and security policies for protecting consumers' PII. The FFM privacy standards are consistent with the eight principles outlined in 45 CFR 155.260(a).

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Agreement Requirements

Agents and brokers participating in the...	Must execute the following Agreement(s):
Individual Marketplace and SHOP	<ul style="list-style-type: none"> • Individual Marketplace General Agreement • Individual Marketplace Privacy and Security Agreement • SHOP Marketplace Agreement
Individual Marketplace	<ul style="list-style-type: none"> • Individual Marketplace General Agreement • Individual Marketplace Privacy and Security Agreement
SHOP	<ul style="list-style-type: none"> • SHOP Marketplace Agreement

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Agreement Requirements

- Agents and brokers who complete Individual Marketplace training will only be able to execute the associated Agreements on the MLMS after completing the required training modules and exams.
- Agents and brokers must read and accept the terms of the required Agreements in order to become a registered FFM agent or broker.



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Federally-facilitated Marketplace Agent and Broker Plan Year 2016 Registration and Training Requirements



Considerations for Business Entities

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Considerations for Business Entities

	Execute Web-broker Agreement	Register on CMS Enterprise Portal	Complete Individual Marketplace Training Modules	Execute the Individual Marketplace Agreements
Web-broker Senior Official*	✓			
Web-broker Authorized Representative		✓	✓	✓
Other Business Entities Authorized Representative		✓	✓	✓
Agents/Brokers Affiliated with Web-broker or Other Business Entity		✓	✓	✓

**The senior official and authorized representative may be the same individual.*

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Federally-facilitated Marketplace Agent and Broker Plan Year 2016 Registration and Training Requirements



***Compensation/
Credit for
Agents and
Brokers
Operating in
the FFM***

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Compensation/Credit for Agents and Brokers Operating in the FFM

- The FFM does not directly appoint agents or brokers and does not set compensation/credit levels.
- Agents and brokers in the FFM are credited in accordance with their agreements with QHP issuers and any state-specific requirements.
- To the extent permitted by a state, agents and brokers may receive compensation/credit from QHP issuers in the form of commissions as a result of assisting qualified individuals in selecting QHPs through the Marketplace.
- A QHP issuer must pay the same compensation/credit for QHPs offered through the FFM as it does for similar health plans offered in the state but outside of the FFM.
- Agents and brokers should ensure they enter a correct NPN in their MLMS profiles to ensure issuers are able to credit them appropriately.

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Summary

The topics presented during this webinar included:

- Role of Agents and Brokers in the Health Insurance Marketplaces
- Registration Overview
- Training Overview
- Training & Exams Requirements and Recommendations
- Agreement Requirements
- CMS-approved Vendor Training Option
- Considerations for Business Entities
- Compensation/Credit for Agents and Brokers Operating in the FFM

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Agent and Broker Resources

- *Additional resources can be found on CMS's Agents and Brokers Resources webpage: <http://www.cms.gov/CCIIO/programs-and-initiatives/health-insurance-marketplaces/a-b-resources.html>.*
- *Additional information agents and brokers can use to educate consumers can be found at [HealthCare.gov](http://www.healthcare.gov).*
- *For more information about technical assistance training and support, please visit <http://www.regtap.info>.*
- *For information on eligibility and enrollment, please visit <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Eligibility-and-Enrollment-in-the-FFM-Tips.pdf>*
- *Information on special enrollment periods can be found at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/SEP_Webinar_Slides_042915.pdf*
- *Agent and Broker NPNs can be found at: <https://pdb.nipr.com/html/PacNpnSearch.html>.*

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Agent and Broker Resources

- *The CMS Enterprise Portal can be accessed at: <https://portal.cms.gov/>.*
- *The Find Local Help tool can be accessed at <https://localhelp.healthcare.gov/>.*
- *For the regulations outlining the CMS-approved vendor training option, review 45 CFR 155.222.*
- *For the regulations outlining CMS's eight privacy principals, review 45 CFR 155.260(a).*
- *The News for Agents and Brokers monthly newsletter is distributed through GovDelivery. For agents and brokers who not receive the newsletter via email, CMS posts on the Agents and Brokers Resources webpage at: <http://www.cms.gov/CCIIO/programs-and-initiatives/health-insurance-marketplaces/a-b-resources.html>.*
- *Current news and updates are distributed via email through GovDelivery and CMS's twitter handle, @CMSSGov.*

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Upcoming Activities

- Plan year 2016 Open Enrollment begins on November 1, 2015 and ends on January 31, 2016.
- The first date when plan year 2016 coverage can start is January 1, 2016.
- As a reminder, plan year 2016 registration, MLMS training and CMS-approved vendor training will be available starting in September.
- Additional outreach will continue through the remainder of 2015 on topics relevant to agents and brokers to help prepare for the 2016 Open Enrollment period.

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Upcoming Activities

CMS will be providing a number of opportunities in the coming months to learn more about plan year 2016, including:

- Email blasts and tweets informing agents and brokers of when the new MLMS goes live and when the CMS-approved vendor training option becomes available
- In-depth webinars and videos on the process for completing registration. If you wish to register for a session, please log in to <https://www.regtap.info/> and complete the following steps:
 - Select "Training Events" from "My Dashboard."
 - Select the "View" icon next to event Title "Guidance on Plan Year 2016 FFM Registration and Training for Agents and Brokers."
 - Select "Register Me."
- A special edition of the News for Agents and Brokers newsletter focused on plan year 2016 registration
- A kick-off call once the MLMS and CMS-approved vendor training options go live

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Questions?



For questions/comments about agent/broker participation in the FFM: FFMProducer-AssisterHelpDesk@cms.hhs.gov

For questions/comments about the FFM application and enrollment:
1-800-318-2596 (TTY: 1-855-889-4325) available 7 days a week, 24 hours a day

For questions/comments about the FF-SHOP:
1-800-706-7893 (TTY: 711) available M-F 9:00am-7:00pm ET

For questions/comments about web-broker participation in the FFM: Webbroker@cms.hhs.gov

Visit the Agents and Brokers Resources webpage (<http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/a-b-resources.html>) and Marketplace.cms.gov for additional resources and helpful information.

Market Place Plans Filed for 2016

2016 Medical Plans On/Off Marketplace effective January 1, 2016

Issuer	Highmark				CareSource		All Issuers
Type	PPO				HMO		All Type
Plan/Tier	Individual		Small Group		Individual		All Plan/Tier
Exchange	ON	OFF	ON	OFF	ON	OFF	Total Metal Levels
Platinum	0	0	2	2	0	0	4
Gold	5	5	4	4	2	2	22
Silver	5	5	6	6	2	2	26
Bronze	4	4	3	3	2	2	18
Catastrophic	1	1	N/A	N/A	0	0	2
Total	15	15	15	15	6	6	72

Notes: Data created from Rate and Form filings submitted to WVOIC for 2016

N/A - Catastrophic plans are not applicable for Small Group

- Total of 36 Marketplace plans for 2 Issuers which include 21 Individual Plans, 15 Small Group Plans by metal level.

2016 Medical Plans Off Marketplace effective January 1, 2016

Issuer	Aetna Health		Celtic Insurance	Federated Mutual	Optimum Choice	Freedom Life	The Health Plan of the Upper Ohio Valley, Inc.		¹ THP	United Healthcare	All Issuers
Type ²	HMO/POS		PPO	PPO	HMO	PPO	HMO		PPO	EPO/POS	All Type
Plan/Tier	Individual	Small Group	Individual Only	Small Group Only	Small Group Only	Individual Only	Individual	Small Group	Small Group Only	Small Group Only	All Plan/Tier
Metal Level											Total Metal Levels
Platinum	0	0	0	3	6	0	0	1	1	14	25
Gold	0	5	0	11	11	0	0	1	1	25	54
Silver	0	6	0	13	10	2	0	1	1	19	52
Bronze	1	4	1	7	3	3	1	1	1	3	25
Catastrophic	0	N/A	0	N/A	N/A	N/A	1	N/A	N/A	N/A	1
Total	1	15	1	34	30	5	2	4	4	61	157

Source: Data created from Rate and Form filings submitted to WVOIC for 2016.

¹ THP is a sister company of The Health Plan of the Upper Ohio Valley, Inc.

²Type: HMO - Health Maintenance Organization; POS - Point of Service; EPO - Exclusive Provider Organization; PPO - Preferred Provider Organization

N/A - Catastrophic plans are not applicable for Small Group

- Both charts together show a total of 193 Off Marketplace plans for 10 Issuers which include 30 Individual Plans and 142 Small Group Plans by metal level.

Definitions:

Marketplace QHP or a Qualified Health Plan medical plan is a plan that is eligible for Advance Premium Tax Credit (APTC).

Off Marketplace medical plans comply with Essential Health Benefit (EHB) mandates but are not eligible for APTC.

SHOP or Small Business Health Options Program plans are Marketplace medical plans that are eligible for tax credits. West Virginia offers both SHOP and Small Group medical plans.

Adult and Pediatric Stand Alone Dental Plans (SADP)

2016 Stand Alone Dental Plans *On/Off the Marketplace* effective January 1, 2016

Issuer	Delta				Dentegra				Guardian		TruAssure				All Issuers
Plan/Tier	Individual		Small Group		Individual		Small Group		Small Group		Individual		Small Group		All Plan/Tier
Exchange	ON	OFF	ON	OFF	ON	OFF	ON	OFF	ON	OFF	ON	OFF	ON	OFF	All Levels
Low ¹	1	2	1	2	1	2	1	2	1	2	1	1	0	1	18
High ²	1	2	1	2	1	1	1	1	1	2	1	1	0	1	16
Total	2	4	2	4	2	3	2	3	2	4	2	2	0	2	34

Notes: Data created from Rate and Form filings submitted to WVOIC for 2016

¹ Low - dental plan meeting an Actuarial Value (AV) of 70% (+/-2%)

² High - dental plan meeting an Actuarial Value (AV) of 85% (+/-2%)

Stand Alone Dental Plans (SADP Continued)

2016 Stand Alone Dental Plans Off the Exchange effective January 1, 2016

Issuer	Ameritas	Companion	Metropolitan	Principal	Reliance Standard
Plan/Tier	Small Group Only				
Level					
Low ¹	2	0	1	1	2
High ²	2	1	0	1	2
Total	4	1	1	2	4
Issuer	Renaissance		Standard		All Issuers
Plan/Tier	Individual	Small Group	Small Group Only		All Plan/Tier
Level					All Levels
Low ¹	2	1	2		11
High ²	2	1	2		11
Total	4	2	4		22
Total All Plans and Levels					22

Notes: Data created from Rate and Form filings submitted to WVOIC for 2016. All Plans are Off Exchange Certified

¹ Low - dental plan meeting an Actuarial Value (AV) of 70% (+/-2%)

² High - dental plan meeting an Actuarial Value (AV) of 85% (+/-2%)

**Exhibit 4: 2016 CCIIO Mandated West Virginia Insurance Ratings Area
for All Plans On/Off Exchange - Individual and Small Group**

Ratings Area	County	CareSource (see note)	Highmark WV
1	Braxton, Calhoun, Clay, Fayette, Greenbrier, Nicholas, Roane	N/A	Individual and Group
2	Kanawha	Kanawha	Individual and Group
3	Boone, Lincoln, Logan, McDowell, Mingo, Wyoming	Lincoln	Individual and Group
4	Mercer, Monroe, Raleigh, Summers	N/A	Individual and Group
5	Cabell, Mason, Putnam, Wayne	All Counties	Individual and Group
6	Berkeley, Jefferson	N/A	Individual and Group
7	Grant, Hampshire, Hardy, Mineral, Morgan, Pendleton	N/A	Individual and Group
8	Doddridge, Gilmer, Lewis, Marion, Monongalia, Wetzell	N/A	Individual and Group
9	Barbour, Harrison, Pocahontas, Preston, Randolph, Taylor, Tucker, Upshur, Webster	N/A	Individual and Group
10	Jackson, Pleasants, Ritchie, Tyler, Wirt, Wood	N/A	Individual and Group
11	Brooke, Hancock, Marshall, Ohio	All Counties	Individual and Group

Note: Care Source is offering individual plans in parts of Regions 1,2,3,5,10 and 11. CareSource is not offering a group plan in any region.

Definition: CCIIO is the Center for Consumer Information and Insurance Oversight of CMS which oversees the implementation of the provisions related to private health insurance. In particular, CCIIO is working with states to establish new Health Insurance Marketplaces.



October 2015

WEST VIRGINIA INFORMATIONAL LETTER

NO. 196

TO: All Insurance Companies Doing Business in the State of West Virginia, Insurance Trade Associations, Insurance Media Publications and Other Interested Persons

RE: Protecting Affordable Coverage for Employees Act

On October 7, 2015, President Obama signed into law the Protecting Affordable Coverage for Employees (PACE) Act. The PACE Act amends the provision of the Patient Protection and Affordable Care Act (ACA) which provided that, as of January 1, 2016, all employers with one hundred or fewer employees must be regarded as small employers for the purpose of small group health insurance plans.

Under current law in West Virginia, employers with two to fifty employees are considered small employers.¹ The PACE Act enables West Virginia to retain the current definition of small employer at fifty or fewer employees. However, the ACA will continue to preempt West Virginia's requirement that a small employer have at least two employees considering the ACA's definition of small employer includes those employers having only one employee.

In light of the PACE Act's passage, health plan issuers should file amended forms to correct any designation indicating that a small group may consist of more than fifty employees. The Rates and Forms Division will expeditiously review such forms upon filing.

Please e-mail any questions concerning this Informational Letter to Informational.Letters@wvinsurance.gov or call (304) 558-0401.

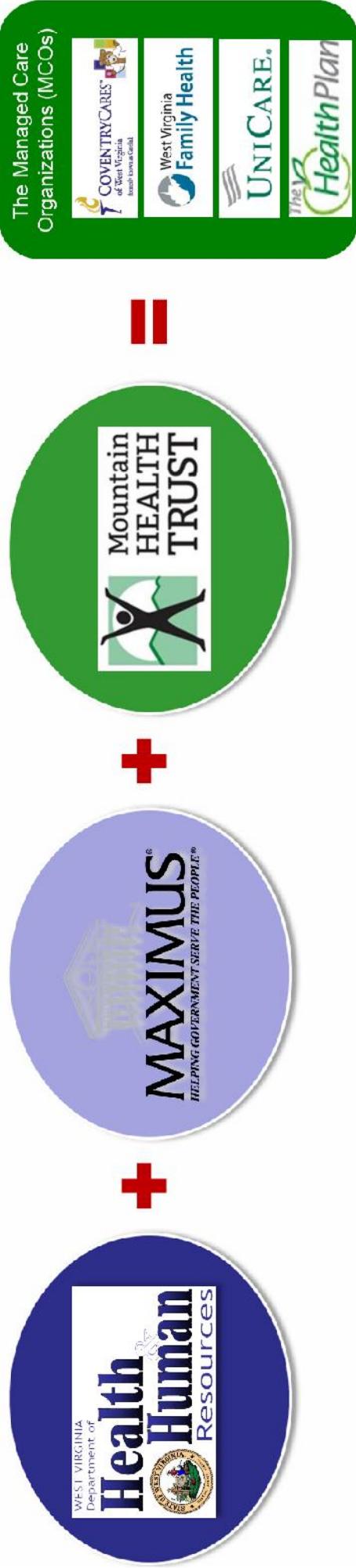
Michael D. Riley
Insurance Commissioner

¹ See W. Va. Code § 33-16D-2(r).



What is Mountain Health Trust?

- Mountain Health Trust is the Medicaid managed care program for West Virginia.
- With Mountain Health Trust, you choose a managed care organization (MCO) and a primary care provider (PCP).



Member enrollment: Medicaid Expansion

- As of August, 2015, approximately 148,810 expanded Medicaid members were transitioned from Fee-for-Service to a Managed Care Organization.
- Approximately 28% (513,680) of West Virginia's population is now covered by Medicaid utilizing either:
 - Fee-for-Service (126,236)
 - Managed Care (387,444)
- About 75% of the Medicaid population receives services through Mountain Health Trust.

Medicaid benefit: Managed Care and Fee-for-Service

Medicaid Managed Care

- MCO members will utilize their health plan benefits when receiving healthcare services.
- MCO members should have their annual Medicaid medical card and their MCO membership ID card.
- Providers will bill the members MCO health plan for services provided.

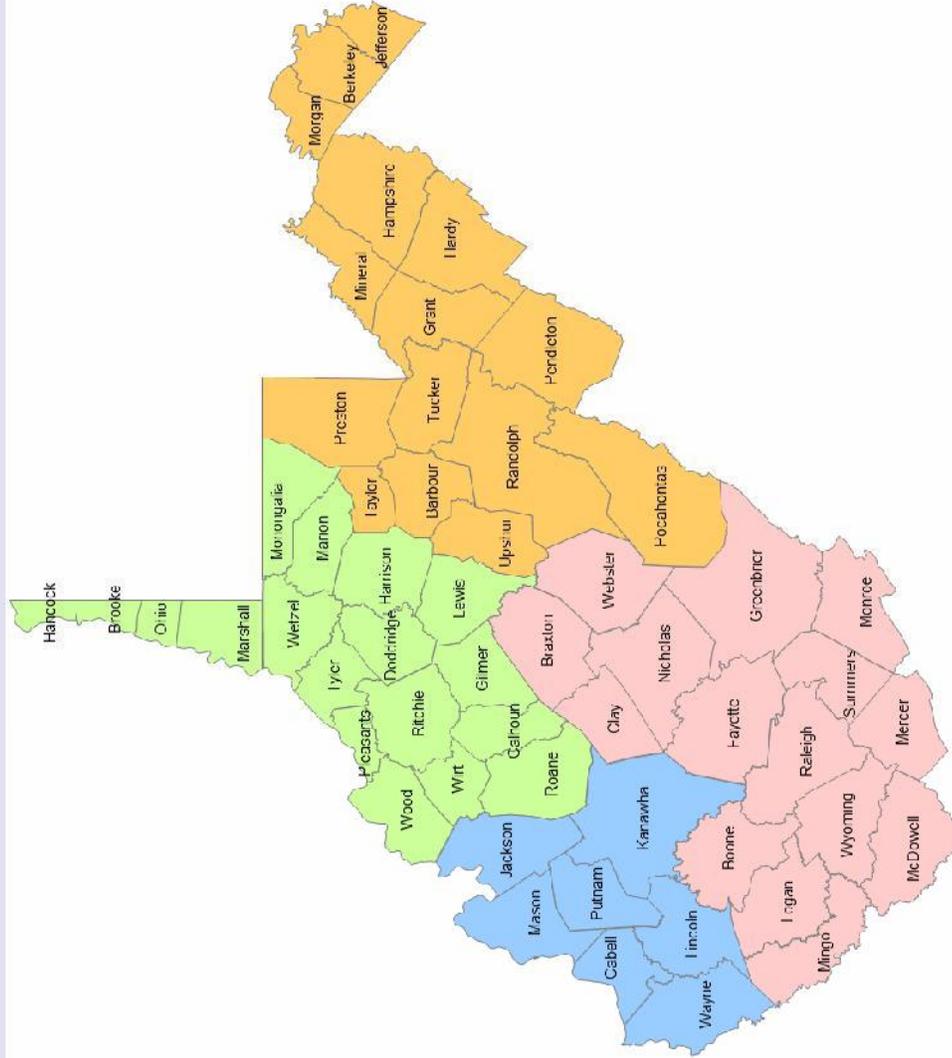
Medicaid Fee-for-Service

- Individuals who are exempt from an MCO will utilize Fee-for-Service benefit when receiving healthcare services.
- Medicaid Fee-for-Service members should have their annual Medicaid medical card.
- Providers will bill Fee-for-Service for services provided.

Have Questions or Need Help?



**Mountain
HEALTH
TRUST**



MAXIMUS

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	<p>Region I - OES Steven Richardson StevenRichardson@Maximus.com (304) 844-6148</p>
	<p>Region II - Ronnie Smith Jr. RonnieSmith@Maximus.com (304) 741-8776</p>
	<p>Region III - OES Heather Ray HeatherRay@Maximus.com (304) 707-8501</p>
	<p>Region IV - OES Teresa Long TeresaLong@Maximus.com (304) 550-1744</p>

MAXIMUS

Reference Guide for Medicaid Managed Care

Department of Health and Human Resources (DHHR)

Apply and Change Medicaid Benefits

- First Time Applicants
- Report Changes and Updates – (*Income, Address, and Newborn Children*)

Customer Service Center: 1-877-716-1212
Apply online for Medicaid Website: www.wvinroads.org

- Third Party Liability (TPL) Customer Service Center: 1-877-598-5820

Mountain Health Trust (MHT)

Enroll in a Medicaid Managed Care Organization (MCO)

- Enroll in an MCO or transfer MCOs
- You can enroll in PAAS in Wayne or Cabell county

Customer Service Center Phone: 1-800-449-8466
Website: www.MountainHealthTrust.com

Managed Care Organizations (MCOs)

- This is your Health Plan
- Member Claims and Benefits
- Member Appeals



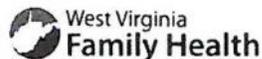
Member Services: 1-888-348-2922
Provider Services: 1-800-348-2922
Website: www.chcwv.com



Member Services: 1-888-613-8385
Provider Services: 1-877-847-7901
Website: www.healthplan.org



Member Services: 1-800-782-0095
Provider Services: 1-800-782-0095
Website: www.unicare.com/Medicaid



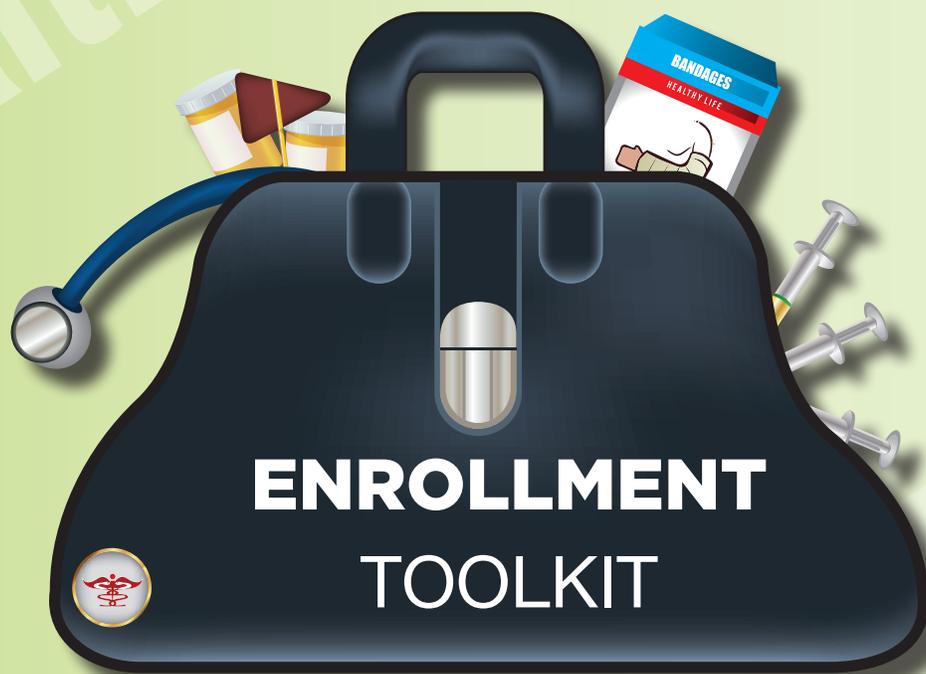
Member Services: 1-855-412-8001
Provider Services: 1-855-412-8002
Website: www.wvfh.com

Molina Medicaid Solutions

For questions about covered services and billing:

Member Customer Service Center Phone: 1-888-483-0797
Provider Helpline: 1-888-483-0793
Website: www.wvmmis.com

FROM COVERAGE TO CARE



**Helping Consumers Choose
the Health Plan
That's Right for Them**

Quick Start Guide to This Toolkit

Every year, consumers can enroll in health insurance coverage (coverage) or change their health insurance plan (plan). People may be overwhelmed by their choices. They may not know **how to choose the plan that meets their needs or how to use their coverage to get the care they need.**

This Toolkit is for community partners, assisters, and other people who help consumers enroll in coverage or change their plan. Sections start with a few questions consumers might have. There are key messages for you to emphasize at the top of each page. At the end of the section there are links to more resources for you and consumers on each topic.

You may be helping someone get covered for the first time, helping them re-enroll, or explaining coverage options so consumers can enroll on their own. You can use the information and resources here and in the **From Coverage to Care Roadmap to Better Care and a Healthier You** to help consumers get the coverage that's right for them and help them move **From Coverage to Care.**

The Roadmap and other **From Coverage to Care (C2C)** resources are available at:

<https://marketplace.cms.gov/c2c>.



▶ LET'S BEGIN

Personalize It.

To make the most of your time with consumers, look for ways to personalize this information to each person. Before you begin, ask if consumers have questions. Their answers will help you navigate this Toolkit to meet their needs.

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- Exemptions or fee for not having coverage

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- Costs of coverage
- How to get help paying for coverage
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1



WHY CONSUMERS SHOULD SIGN UP FOR HEALTH COVERAGE

If the consumer you're working with isn't sure why he or she should get coverage, talk about the points below, and make it personal. For example, you could ask if there was a time when they thought they should go to a doctor but didn't, or if this happened to a family member. Was it because they couldn't afford the visit? Were they afraid of finding a problem and how much it would cost to treat it? Let consumers know that having coverage means they can get the care they need, and that there is a limit to the amount they will have to pay towards the cost of their care. Tell them that together you can find a plan that meets their health care needs and budget.

When we say "coverage"... we mean a legal entitlement consumers have to payment or reimbursement for their health care costs. It is generally offered through:

Health Insurance Company

Group health plan offered in connection with employment

OR

A government program like Medicare, Medicaid, or the Children's Health Insurance Program (CHIP)

ARE THERE QUESTIONS ABOUT ...

BENEFITS OF COVERAGE?

GO TO 3

AFFORDABILITY?

GO TO 4

EXEMPTIONS OR FEE FOR NOT HAVING COVERAGE?

GO TO 5

1. Coverage Is Security.

Even if they're uninsured, most consumers use health care when they are sick. This may involve waiting until a health condition is unbearable, then going to an emergency department or clinic for care. **Explain that coverage can relieve some of the stress about using health care** by providing a set of health care services they know will be covered, including mental health and substance use disorder services (known as Essential Health Benefits, explained more on page 10).

Having coverage can also help relieve the stress of not knowing how much health care will cost if you get sick and get a high bill. With coverage, consumers know the portion of health care costs they're responsible for, and what their plan will pay. They also get access to free or low cost preventive care, which can keep people healthy and help them avoid more expensive medical problems in the future.

PERSONALIZE THE CONVERSATIONS FOR ...

- **Someone with a chronic condition (like diabetes, hypertension, depression, or cancer):** Ask consumers to think about their health and their family's health. For example, high blood pressure, diabetes or heart disease may run in their family. Explain that they can use their coverage to find out if they have a condition, then get treatment to manage it if they do. You could provide an example of the cost of a vial of a prescription drug like insulin. Without insurance, it could cost them \$300 but with coverage they would only pay a copayment – like \$10 or \$20.

To explain more about how total costs are different from what they'll pay when they're covered, refer to the Cost Tables in the

From Coverage to Care Roadmap. There is an example Cost Table for “Costs of Type 2 Diabetes” on page 15.

- **A young adult:** Young adults are sometimes called “young invincibles” because they think they can't get sick or injured. They might not see the value of coverage right away. Ask consumers if they've been to the emergency department recently – and if they know how much the visit cost. You can explain to them that without coverage, treating a broken arm can cost nearly \$7,700.

They may be thinking about starting a family. If so, let them know that having a baby can cost thousands of dollars. You can use the “Costs of Having a Baby” Cost Table in the **Roadmap** (on page 15) to show them an example of how having coverage could affect how much they'll pay.

Remind young consumers that they have options. They may be able to stay on their parents' plan until they're 26, get covered through their school's health plan, or enroll in Medicaid or a Marketplace plan with financial help. Having coverage will protect them from large health care costs if they get sick. Plus, using coverage for preventive services can reduce their health care costs over time by keeping them healthy.

Share information about preventive services and screenings that may be covered without cost-sharing. There's a link to the **Roadmap** and other resources to help you work with young adults at the end of this section on page 8.

2. Coverage May Be More Affordable Than You Think.

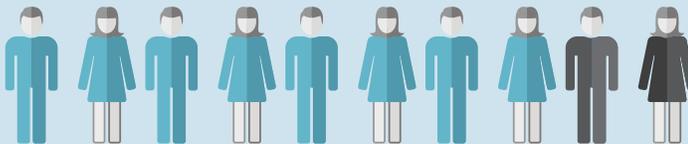
Eighty-five percent of individuals who selected a Marketplace plan last year qualified for financial help to lower their out-of-pocket costs. But many people didn't apply for coverage because they thought they couldn't afford it. Remind consumers that they will only find out whether they qualify for help paying for coverage if they apply to the Marketplace or their state Medicaid agency.

Consumers can select "See plans & prices" on **HealthCare.gov** and enter some basic information to get an estimate of their costs to use as a guide. If you can, show consumers an estimate of their costs by window shopping on the site with them, but let them know their costs and the exact amount of financial help they'll get is only available once they apply. Applying is free and it may save the consumer out-of-pocket costs.

Section 2 has more information on how to see plans and prices on **HealthCare.gov** and there's a cheat sheet on page 14 so you can quickly tell whether a consumer might qualify for help based on their income. Remind consumers these are only estimates and the Marketplace and state Medicaid agencies will make final determinations when they apply for health coverage.

SEE PLANS & PRICES AT:
<https://www.healthcare.gov/see-plans/>

80% Or 8 out of 10 Consumers



can get coverage for **\$100** or less
per month after any applicable tax credits in 2015.



3. Avoid The Fee For Not Having Coverage.

Minimum Essential Coverage is what consumers must have to avoid paying the Individual Shared Responsibility Payment – a fee for going without coverage for part or all of the year. Qualified Health Plans in the Marketplace plans meet this standard. So does TRICARE, the Veteran’s health care program, Medicare Part A, Medicaid, coverage for Peace Corps Volunteers, and job-based coverage.

Minimum Essential Coverage doesn’t include coverage that only provides limited benefits. For example, coverage for just vision or dental care, and Medicaid just for certain benefits like family planning, workers’ compensation or disability, don’t meet this standard.

For more information or to find out what coverage qualifies, visit: <https://www.healthcare.gov/fees-exemptions/plans-that-count-as-coverage/>

Consumers who don’t enroll in coverage may have to pay a fee when they file taxes (also called the Individual Shared Responsibility Payment). Make sure consumers know the fee for not enrolling in coverage goes up every year. Some consumers are exempt from this requirement if any of these apply them:

- Uninsured for less than 3 months of the year
- Lowest-priced coverage available would cost more than 8% of their household income

- Don't have to file a tax return because their income is too low
- Member of a federally recognized tribe or eligible for services through an Indian Health Services provider
- Member of a recognized health care sharing ministry
- Member of a recognized religious sect with religious objections to insurance, including Social Security and Medicare
- Incarcerated (either detained or jailed), and not being held pending disposition of charges
- Not lawfully present in the U.S.
- Qualify for a hardship exemption

Encourage consumers to apply for coverage even if they are going to apply for an exemption. Once they see that they can get affordable coverage, they may decide they want the peace of mind and access to affordable health care services that they get when they’re covered. There are more resources at the end of this section on page 8 to help you explain what qualifies for an exemption and how consumers can apply.

//////

FIND OUT WHAT QUALIFIES AS MINIMUM ESSENTIAL COVERAGE:
[www.irs.gov/AffordableCare-Act/
 Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Minimum-Essential-Coverage](http://www.irs.gov/AffordableCare-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Minimum-Essential-Coverage)

//////

3. Avoid The Fee For Not Having Coverage (Continued).

If you don't enroll in Minimum Essential Coverage for 2015 (or have an exemption), the applicable taxpayer will pay whichever cost is higher when they file their 2015 income taxes:

- **Method 1:** Percentage of yearly income. 2% of their yearly household income (above the minimum tax threshold of \$10,150)

OR

- **Method 2:** Flat fee per person, \$325 for each adult and \$162.50 per child under 18 (up to a total maximum of \$975 per family for 2015)

For a single person living alone, earning \$35,000 per year that's...

METHOD 1: Percentage of yearly income

STEP 1

$$\$35,000 - \$10,150 = \$24,850$$

Annual Income	Minimum Filing Threshold	Fee Income
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STEP 2

$$\$24,850 \times 2\% = \$497$$

Fee	%	What the taxpayer owes
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METHOD 2: Flat fee per Person

\$325 for 1 person

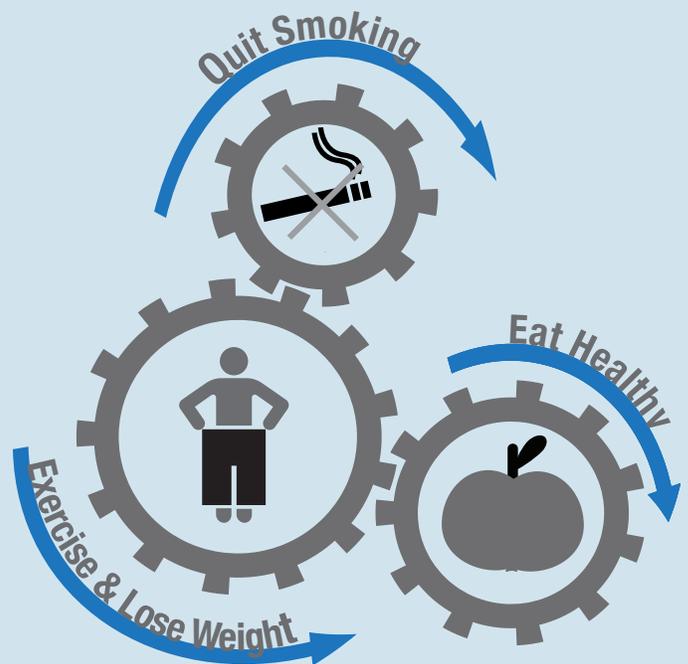
The consumer will pay \$497 in 2015 since that is the higher amount.

4. Your Coverage Pays For Preventive Care That Can Keep You Healthy.

Consumers may have had a provider recommend vaccines, screenings, or tests to them or a family member, but they may not have known why they needed it, or the value of knowing the results. Explain that screenings and test results help providers monitor patients' health and make sure they're on the right track. And most preventive services, like screenings, tests and vaccines, are available at no cost to the enrollee (no copayments or deductibles). Explain to consumers that if they're diagnosed with a health condition or illness, catching it early could be life-saving. Many serious health conditions can be treated or managed.

Consumers may have also heard statistics, like: 1 in 8 women will develop breast cancer in their lifetime, or 1/3 of all people have heart disease. People with a family history of a certain illness or health condition may have heard that they're more likely to get sick. They may even think that they can't avoid it, and may be afraid to see a provider. Talk about how consumers can be proactive and get regular health care to prevent illness or to catch it early.

ONCE CONSUMERS HAVE COVERAGE,
THEY CAN TALK WITH A PROVIDER
ABOUT HOW TO USE IT TO STAY
HEALTHY.



Do Consumers Need Help Enrolling?

Call the Marketplace Call Center:

- 1-800-318-2596
- TTY: 1-855-889-4325
- Available 24 hours a day, 7 days a week in more than 150 languages

Find local in-person help, visit:
<https://localhelp.healthcare.gov/>

RESOURCES

From Coverage to Care resources (Partner/Consumer)

<https://marketplace.cms.gov/c2c>

Incomes that qualify for lower costs (Partner/Consumer)

<https://www.healthcare.gov/qualifying-for-lower-costs-chart/>

How to estimate income for the Marketplace (Partner/Consumer)

<https://www.healthcare.gov/income-and-household-information/>

How health coverage affects 2014 taxes (Partner/Consumer)

<https://www.healthcare.gov/taxes/marketplace-health-plan/>

Where and how to get an exemption (Partner/Consumer)

<http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Exemptions>

Qualifying for a hardship exemption (Partner/Consumer)

<https://www.healthcare.gov/fees-exemptions/hardship-exemptions/>

Questions & answers on the Individual Shared Responsibility Payment and exemptions (Partner/Consumer)

<http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision - Exemptions>

Health coverage for young adults (Partner/Consumer)

<https://www.healthcare.gov/young-adults/>

Myhealthfinder web app for personalized preventive care recommendations (Consumer)

healthfinder.gov/myhealthfinder/

Mental health and substance use disorder services treatment locator and resources (Consumer)

<http://www.mentalhealth.gov/>



2



WHAT CONSUMERS SHOULD KNOW BEFORE ENROLLING IN A PLAN

People enrolling in health coverage for the first time may not understand common health insurance coverage terms. Misconceptions and knowledge gaps can make shopping for coverage difficult. Use this section and the **From Coverage to Care Roadmap, Step 2** to discuss key coverage terms and consumers' concerns about costs.

Emphasize the four topics below, and get the **Roadmap** at:

<https://marketplace.cms.gov/c2c>

ARE THERE QUESTIONS ABOUT ...

WHAT SERVICES ARE COVERED? GO TO 10

COSTS OF COVERAGE? GO TO 11

HOW TO GET HELP PAYING FOR COVERAGE? GO TO 14

RE-ENROLLMENT REMINDERS? GO TO 18

1. All Marketplace Plans Must Cover Doctor Visits, Preventive Services, Prescription Drugs, Mental Health Care, Hospitalization, And More.

Consumers may be hesitant to enroll in coverage because they are unclear on what is covered and afraid to pick the wrong plan. They may have had a bad experience in the past, been denied coverage, had their coverage cancelled, or thought a treatment was covered when it wasn't, which may contribute to their hesitation. Reassure consumers that although each plan is different, Marketplace plans must meet certain minimum standards, including covering the ten Essential Health Benefits listed to the right. Plans also cover many preventive services like screenings and vaccines without out-of-pocket costs to the consumer, like copayments, coinsurance, or deductibles.

Talk to consumers about which services they may need. Ask if there are other things that they don't see listed in the box to the right. Write them down and refer back to the list when comparing available plans.

WHAT ARE ESSENTIAL HEALTH BENEFITS?

A set of health care service categories that Marketplace plans must be covered by plans sold through the Marketplace.

- 1** **Outpatient care** is care a person gets without being admitted to the hospital as an inpatient
- 2** **Emergency services**
- 3** **Treatment in the hospital for inpatient care**
- 4** **Care before and after a baby is born**
- 5** **Mental health and substance use disorder services**
- 6** **Prescription drugs**
- 7** **Services and devices** to help you a person recover if they're injured or have a disability or chronic condition, or that help you gain function (called habilitative and rehabilitative services)
- 8** **Lab tests and services**
- 9** **Preventive services** including counseling, screenings, and vaccines to keep people healthy and manage a chronic disease
- 10** **Pediatric Services** - services tailored to the needs of children to ensure they grow up and develop properly, including dental and vision care for kids

//////
**ONE IN THREE CONSUMERS DON'T UNDERSTAND
WHAT A PREMIUM IS.**
//////

2. Once You Understand Key Terms, You Can Compare Costs For Plans.

Consumers may not understand common health care terms, including deductible, premium, copayments, and coinsurance.

Below are some key pieces of information to point out:

Premiums are payments generally made every month to maintain coverage. Explain that consumers will pay their premium to their insurance plan, regardless of whether they use any health care services. Remind them that it's important to pay their premiums in order to keep their coverage.

Copayment (or Copay) is the fixed amount a consumer pays for a covered health care service or supply. Copayments are usually a set amount, for example \$15 for primary care visits and \$35 for specialty care visits. Point out the copayment amounts for each service. With some types of coverage (like Medicaid) there may not be a copayment. Mention that copayments could differ based on the type of care or service they receive (for example, primary care, specialist, emergency department, and brand-name and generic prescription drugs may have different copayments).

Go to **Section 3** for more information about talking with consumers about the costs of prescription drug coverage.

Coinsurance is the consumer's share of the costs of a covered health care service. It's different from a copayment because it is a percent of the total allowed amount for the service, not a set dollar amount. For example: if the cost of a visit to a specialist is \$180, and the consumer is responsible for paying 20% coinsurance, he or she would pay \$36.

SAMPLE: WHAT YOU PAY WITH COINSURANCE

$$\mathbf{\$180 \times .20 = \$36}$$

Specialist cost x 20% coinsurance = Patient cost

Deductible is the dollar amount consumers have to pay for health care services before their plan will start paying for their care. The deductible may not apply to all health care services. For example, in all Marketplace plans, coverage for preventive services is not subject to the deductible. Other plans may not have a deductible for primary care or prescription drugs. Different plans may have different deductibles for specific services, so consumers should know the deductibles before they pick a plan. Let them know their insurance company will keep track of how much they've paid toward their deductible, but they should keep track as well.

2. Once You Understand Key Terms, You Can Compare Costs For Plans (Continued).

Out-of-pocket limit is the maximum amount consumers will have to pay for covered health care services for the year. One of the benefits of having coverage is that consumers are protected from paying very high costs because of the out-of-pocket limit. Once they reach this limit, their plan will pay for 100% of the rest of the covered health care they need. Each plan sets its own out-of-pocket limit, but it can't be more than **\$6,600 for an individual** (or **\$13,200 for 2 or more people**) in 2015. This may still be unaffordable for some consumers.

Remind consumers they may qualify to get a cost-sharing reduction that lowers their maximum out-of-pocket expenses even more. There's more information about how to apply in this section.

Have consumers go to **www.healthcare.gov/see-plans/** and answer a few basic questions. They will see a display like this one for the available plans with estimated costs and some of the financial help they may get. Write down the costs for the plans they're considering, then select a few on the website and print.

ESTIMATED MONTHLY PREMIUM	ESTIMATED DEDUCTIBLE	ESTIMATED OUT-OF-POCKET MAXIMUM
\$304 <small>Number of people covered: 1</small>	\$2,250 <small>Estimated individual total</small>	\$6,350 <small>Estimated individual total</small>

COPAYMENTS / COINSURANCE

Primary doctor: \$35
Specialist doctor: 20% Coinsurance after deductible
Emergency room care: 30% Coinsurance after deductible
Generic drugs: \$15

- Summary of Benefits
- Plan brochure
- Provider directory
- List of covered drugs

[LEARN MORE ABOUT THIS PLAN](#)

CMS.gov Health Insurance Marketplace
Centers for Medicare & Medicaid Services

Search

Get email updates

Health Insurance Marketplace

Welcome to the official Marketplace information source for assisters and outreach partners.

On this site, you'll find information about assister programs and tools to help existing and new Health Insurance Marketplace consumers.

[Applications & Forms](#) > [Technical Assistance Resources](#) > [Outreach & Education](#) >

Talk about the different costs to get a sense of the consumer’s preferences. Some people may prefer to pay a smaller amount each month, even if their copayments when they get care are a little higher. Consumers can filter plans by plan category, premiums, or out-of-pocket costs to find one that meets their needs. For example, if a low premium is the most important thing, consumers can see plans sorted from lowest premium prices to the highest.

Discuss monthly budget or spending and which options are affordable. If consumers aren’t sure which plan to enroll in, encourage them to take the information home and to talk with trusted family and friends, if needed, about which plan meets their health care needs and budget. Remind consumers that the information in the “window shopping” feature may not reflect their specific costs or savings – it will only provide an estimate of the premium tax credit, but not other help. Consumers need to apply to know exactly what their costs and financial assistance will be.

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TALK TO CONSUMERS ABOUT THEIR MONTHLY BUDGET AND WHICH COVERAGE OPTIONS ARE AFFORDABLE.

////



09/2014
Form Approved OMB No. 0938-1191

Application for Health Coverage & Help Paying Costs (Short Form)



Apply faster online

Apply faster online at HealthCare.gov.



Use this application to see what coverage you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well.
- A tax credit that can immediately help pay your premiums for health coverage.
- Free or low-cost coverage from Medicaid or the Children’s Health Insurance Program (CHIP).



Who can use this application?

Single adults who:

- Aren’t offered health coverage from their employer
- Don’t have any dependents and can’t be claimed as a dependent on someone else’s tax return

NOTE: If any of the following apply, you need to fill out a different form to make sure you get the most benefits possible:

- You’re married or have dependent children.
- You were in the foster care system, and you’re under age 26.
- You have items that can be deducted from your income. If your only deduction is student loan interest, you can use this form.
- You’re American Indian or Alaska Native.



What you may need to apply

- Your Social Security number (or document number if you’re an eligible immigrant)
- Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements)



Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it.

We’ll keep all the information you provide private and secure, as required by law. To view the Privacy Act Statement, go to HealthCare.gov.

What happens

Send your complete, signed application to the address on page 3. **If you don’t have all the information we ask for, sign and submit your application anyway.** We’ll contact you within 1-2 weeks and you may receive a call from us if we need more information. You’ll get an eligibility determination after your application is processed. Filling out this application does not guarantee you will buy health coverage.

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3. Financial Assistance May Be Available, But You Must Apply To Learn What You Qualify For.

Many people don't think they can afford coverage, and don't realize that financial assistance may be available. Talk to consumers about tax credits, cost-sharing reductions, Medicaid and the Children's Health Insurance Program (CHIP), and protections for American Indian and Alaska Natives and members of federally recognized tribes and ANCSA shareholders. Let people know that help is available for eligible people and families with lower household incomes. See below for a cheat sheet from **HealthCare.gov** to match up their income to the federal poverty level (FPL). The amounts below are 2014 numbers and used for calculating eligibility for Medicaid and the Children's Health Insurance Program (CHIP). 2014 numbers are used to calculate eligibility for savings on private insurance plans for 2015.

PRIVATE MARKETPLACE HEALTH PLANS

Number of people in household..	1	2	3	4	5	6
You may qualify for lower premiums AND lower out-of-pocket costs for Marketplace insurance if your yearly income is between...	\$11,670 - \$46,680	\$15,730 - \$62,920	\$19,790 - \$79,260	\$23,850 - \$95,400	\$27,910 - \$111,640	\$31,910 - \$127,880
You may qualify for lower premiums AND lower out-of-pocket costs for Marketplace insurance if your yearly income is between...	\$11,670 - \$29,175	\$15,730 - \$39,325	\$19,790 - \$49,475	\$23,850 - \$59,625	\$27,910 - \$69,775	\$31,970 - \$79,925

PREMIUM TAX CREDIT-ELIGIBLE:
This is 100% - 400% FPL in 2014

MEDICAID ELIGIBLE:
This is 138% FPL in 2014

COST SHARING ELIGIBLE:
This is 100% - 250% FPL in 2014

MEDICAID COVERAGE

Number of people in household..	1	2	3	4	5	6
If your state is expanding Medicaid: You may qualify for Medicaid coverage if your yearly income is below...	\$16,101	\$21,707	\$27,310	\$32,930	\$38,516	\$44,119
If your state isn't expanding Medicaid: You may not qualify for any Marketplace savings programs if your yearly income is below....	\$11,670	\$15,730	\$19,790	\$23,850	\$27,910	\$31,970

This is 100% FPL in 2014

NOTE: INCOMES THAT QUALIFY FOR LOWER COSTS ARE HIGHER IN ALASKA & HAWAII.

Persons in Household	2014 FPL	Alaska 2014 FPL	Hawaii 2014 FPL
	1	\$11,670	\$14,580
2	\$15,730	\$19,660	\$18,090
3	\$19,790	\$24,740	\$22,760
4	\$23,850	\$29,820	\$27,430
5	\$27,910	\$34,900	\$32,100
6	\$31,970	\$39,980	\$36,770
7	\$36,030	\$45,060	\$41,440
8	\$40,090	\$50,140	\$46,110

Types of Financial Assistance

Premium tax credit is for people with household incomes between 100% - 400% FPL who are not eligible for certain other coverage. Lower incomes are eligible for a larger credit. The credit reduces monthly premium payments. Consumers can apply the credit before they pay their premium so they pay less per month, or when they file taxes to get money back at the end of the year.

Cost-sharing reductions provide additional financial assistance for eligible consumers with incomes between 100% - 250% FPL who also qualify for premium tax credits. Let consumers know that this reduction lowers the amount they will have to pay for out-of-pocket for deductibles, coinsurance, and copayments, but they must enroll in a specific category of plan (Silver, and we'll talk about the categories in **Section 3**).

American Indians and Alaska Natives (AI/AN) and members of federally recognized tribes and ANCSA shareholders have special protections and cost-sharing. **Section 5** has more information.

3. Financial Assistance May Be Available, But You Must Apply To Learn What You Qualify For (Continued).

Premium tax credits: Talk to consumers about how coverage will affect their income taxes when they file their federal income tax returns. People may not realize they could get a premium tax credit, even if they earn more than \$40,000 a year. Advance payments of the premium tax credit can lower monthly premium costs. If they qualify for a tax credit, consumers can decide how much of the credit to apply to their premium each month up to their maximum credit amount. They can apply the credit when their coverage starts and pay less per month or claim the credit when they file their taxes.

Let consumers know they must file their federal taxes to get this subsidy, whether they apply it up front as advance payment of the premium tax credit or when they file their taxes. When the individual files their annual federal income tax return, the amount of premium tax credit they received during the year will be reconciled with their eligibility for the premium tax credit based on their actual household income for the year. If the individual received excess premium tax credit than what they are eligible for, they may have to repay the excess amount.

Cost-sharing reductions: In addition to the premium tax credit, eligible consumers enrolling in Marketplace plans with incomes whose household income is between 100% - 250% of FLP and who don't qualify for Medicaid can get cost-sharing reductions if they enroll in a Silver plan. This subsidy is different from the premium tax credit in these ways: it is only for Silver plans, it reduces the consumer's out-of-pocket costs when they use health care services, and it applies to their deductibles, copayments and coinsurance.

- **Without the cost-sharing subsidy,** a consumer's total out-of-pocket maximum can be no higher than \$6,600 for an individual and \$13,200 for 2 or more people.
- **With the cost-sharing subsidy,** a consumer's out-of-pocket maximum can be no higher than \$2,250-\$5,200 for an individual or \$4,500-\$10,400 for a family depending on where their household income falls between 100% - 250% FPL.

A plan can change how it combines its charges for copayments, coinsurance, and deductibles, but consumers will never pay more than these out-of-pocket maximum amounts for covered health care services. If you're serving consumers who are members of a federally recognized tribe, are ANCSA shareholders, or are American Indian or Alaska Native, let them know they could be eligible for additional cost-sharing reductions. Go to **Section 5** for more information.



Paying for coverage and care may seem expensive, but having coverage actually makes using health care more affordable. Explain that coverage can be like having a coupon – plans negotiate a lower payment rate with health care providers who participate with their plan so consumers pay a reduced rate for services. Coverage is also like having a gift card – when consumers use their coverage, their plan generally pays part of the covered services, so consumers’ payments (or out-of-pocket costs) are lower. If consumers are uninsured they might be billed a higher amount for the same services **and** have to pay the full cost of their care.

Medicaid and the Children’s Health Insurance Program (CHIP)

Medicaid and CHIP provide comprehensive benefits for people at no cost or low cost so talk with eligible consumers about enrolling. In states that have expanded eligibility, more adults qualify than ever before – but children and adults may qualify even if your state has not expanded eligibility. People also may not know they can enroll any time of the year if they qualify. Let them know that if they’re eligible for Medicaid but choose to enroll in a Marketplace or other private plan, they can’t get the premium tax credits and cost-sharing reductions.

If your state chose not to expand its Medicaid program and consumers are not eligible for Medicaid, adults below 100% FPL may not have access to cost-sharing reductions or premium tax credits. Medicaid expansion is a state choice and some states did not increase the eligibility threshold. If you are working with low-income consumers who are not eligible for Medicaid, they also may not be able to afford Marketplace coverage. Be sensitive to their circumstances

and let them know they can’t get federal help paying for coverage for a Marketplace plan. If possible, connect them to any local or state resources that might help cover the costs of their care. Additionally, notify these individuals that they may qualify for a hardship exemption. Go to **Section 1** for more information on exemptions and use resources on page 8 to help eligible consumers apply.

Job-Based Coverage & Financial Assistance

In general, if an employer offers a consumer a plan that’s affordable and meets the minimum value standard for plans in the Marketplace, the consumer won’t qualify for financial help if they purchase Marketplace coverage – even if they meet the income threshold. If the employer plan doesn’t meet these two standards, consumers can qualify for premium tax credits in the Marketplace.

- The health plan has to be affordable: cost of coverage for one person is less than 9.5% of the individual’s household income.
- The health plan has to meet minimum value standards.

Most job-based coverage will meet the minimum standards. If a consumer thinks their coverage doesn’t qualify, have them bring the **Employer Coverage Tool** to their employer to fill out. You can help them apply for a determination to see whether they’re eligible for help paying for coverage.

Employer Coverage Tool: <https://www.healthcare.gov/downloads/employer-coverage-tool.pdf>

4. If You're Already Enrolled In A Marketplace Plan, Review Current Plan Options To Make Sure Your Coverage Still Meets Your Needs And Update Your Information.

Encourage consumers to log in to **HealthCare.gov** to review and update their income and report life changes, including information about changes like a birth, adoption, marriage, divorce, or change of address. This information will be used to determine eligibility for premium tax credits and cost-sharing reductions.

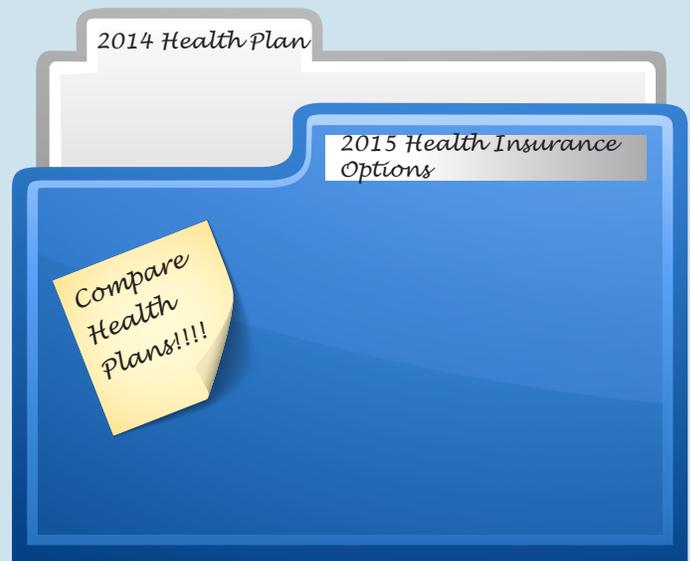
Reporting changes will help consumers avoid getting a smaller refund or owing money they didn't expect to owe on their federal tax return. If you're working with consumers who are claiming the premium tax credit for 2014, you may want to remind them that they must file a federal tax return in order to get it. If they are married, they generally must file taxes jointly with their spouse.

When consumers file their annual federal income taxes, the IRS will match up the information they report with the premium tax credit they received. The IRS may adjust the amounts consumers owe or are due if:

- The amount of advance payments of the premium tax credit that consumer got is less than the premium tax credit due. **Consumers will receive the difference as a refund.**

OR

- A consumer's advance payment of the premium tax credit for the year is more than the amount of the premium tax credit due. **Consumers will have to repay the excess with their tax return, subject to statutory repayment limits.**



Health plans will be different this year.

Let consumers know that every year health insurance plans may change benefits and how they cover certain services, prescription drugs, or include particular providers in their networks. Teach them how to review their coverage this year – and every year. Let them know they could find a more affordable plan, or one with better choices and value, if they go back to the Marketplace and look at their options during open enrollment.



RESOURCES

Helping consumers compare and select a plan (Partner)

<http://marketplace.cms.gov/technical-assistance-resources/plan-compare-walk-through.pdf>

Essential Health Benefits covered in the Marketplace (Consumer)

<https://www.healthcare.gov/blog/10-health-care-benefits-covered-in-the-health-insurance-marketplace/>

How to estimate your income for the Marketplace (Consumer)

<https://www.healthcare.gov/income-and-household-information/>

Videos with facts about the Premium Tax Credit (Consumer)

<http://www.irs.gov/uac/The-Premium-Tax-Credit>

Qualifying for Marketplace cost-sharing reductions (Consumer)

<https://www.healthcare.gov/lower-costs/save-on-out-of-pocket-costs/>

Find and compare plans in your area (Consumer)

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

HealthCare.gov employer-provided coverage tool (Consumer)

<https://www.healthcare.gov/downloads/employer-coverage-tool.pdf>

MEDICAID & CHIP

To find out information about specific State Medicaid programs (Partner)

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State>

Information on Medicaid programs (Partner/Consumer)

<http://www.medicaid.gov/>

Information on Children's Health Insurance Programs (Partner/Consumer)

<http://www.insurekidsnow.gov/>

3



WHAT CONSUMERS SHOULD KNOW BEFORE ENROLLING IN A PLAN

ARE THERE QUESTIONS ABOUT ...

PLAN
CATEGORIES?

GO TO
21

PROVIDER
NETWORKS?

GO TO
23

PRESCRIPTION
DRUGS &
FORMULARIES?

GO TO
26

DENTAL & VISION
COVERAGE?

GO TO
28

Once consumers have a basic understanding of health coverage and cost-sharing, they're ready to find the health plan that best meets their health care needs and budget. Explain that different plans and provider networks have different costs and benefits. For example: some plans may have very low premiums, but limited provider and hospital networks and high out-of-pocket costs. Other plans may have higher premiums but a bigger selection of providers and hospital facilities, and lower out-of-pocket costs like deductibles, copayments, and coinsurance.

This section has discussion-starters and diagrams to help you explain the benefits of different plans. If you haven't already, ask which things are most important to each individual you're helping so you can personalize your assistance.

1. Choosing Your Plan Category Generally Means Balancing Monthly Premium Costs With Costs When You Get Health Care Services.

Plans sold in the Marketplace are divided into four different categories: Bronze, Silver, Gold, and Platinum. The main difference between metals, or plan categories, is the proportion of a consumer's health care costs that their plan will pay. Another difference will be how much cost-sharing the consumer will be responsible for. In general, there is a trade-off between premiums and costs at the time of care: **lower premiums usually come with higher out-of-pocket costs.** Make sure consumers understand this. Consumers should also be aware that no matter which category they choose, all plans cover the 10 Essential Health Benefits discussed in **Section 2.** Let consumers know that the plan categories only apply to certain health insurance plans, and not Medicaid, CHIP, or other coverage types.

Consumers under 30 (and certain individuals who qualify for an exemption from the individual shared responsibility fee) may want to consider a Catastrophic plan. These plans have low premiums and require consumers to meet a high deductible before their coverage starts, except for coverage for certain preventive services and a

limited number of primary care visits (three visits, generally). Consumers who do not plan on using much health care during the year and who only want protection against very high costs in case of a serious accident or illness may want to consider this type of plan.

As with all Marketplace plans, the maximum amount consumers with a Catastrophic plan will pay during a policy year is \$6,600 for an individual plan and \$13,200 for a family plan in 2015. After that, the plan covers 100% of the cost of the covered Essential Health Benefits. Without any coverage, a serious accident or illness could cost a consumer thousands of dollars in health care bills. Let consumers know that premium tax credits can't be used to discount premiums on Catastrophic plans.

BRONZE

SILVER

GOLD

PLATINUM



1. Choosing Your Plan Category Generally Means Balancing Monthly Premium Costs With Costs When You Get Health Care Services (Continued).

Cost-sharing reductions are available for **Silver Plans** if you are eligible.

	BRONZE	SILVER	GOLD	PLATINUM
What You Pay Each Month (Premium*)	\$	\$\$	\$\$\$	\$\$\$\$
What You Pay When You Go For Care (Out of Pocket Costs, including Deductible, Copays & Coinsurance)	\$\$\$\$	\$\$\$	\$\$	\$
Percent of Total Average Costs of Care Your Plan Will Cover (Actuarial Value)	60% Your Plan 40% You	70% Your Plan 30% You	80% Your Plan 20% You	90% Your Plan 10% You
Might Be Good For You If You...	don't plan to need a lot of health care services for the year.	need to balance your monthly premium with your out of pocket costs.	want to keep your out of pocket costs low, but can afford a higher monthly premium.	plan to use a lot of health care services.

The **actuarial value** of your plan is the percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actual value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total cost of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.

* Note: These numbers are not real and give an idea of different premium costs. Check the plans in your area for exact costs. You may find a lower premium on a higher metal level plan.

2. Aside From Choosing A Plan Category, Decide What Type of Provider Network Helps You Balance the Providers You Can See With How Much You'll Pay For A Visit.

A plan's provider network is the list of providers, facilities, and suppliers a health insurer or plan has contracted with to provide health care services. The **From Coverage to Care Roadmap, Step 2** introduces the provider network concept to consumers. Explain that plans negotiate lower rates for consumers with providers who are "in-network" for a plan. These providers can be called "preferred providers" or "participating providers." So, in-network providers will usually cost consumers less than out-of-network providers. With some plans, out-of-network care will not be covered, meaning the consumer will pay the full cost.

Each consumer has different priorities, so as you talk about provider network types, **discuss whether they would be willing to pay more to have a larger pool of providers.** Some plans keep premiums low by contracting with a smaller, "tighter" network of providers. Emphasize the key differences between networks, like:

- Costs of care inside and outside the network
- Size of the network
- Specialists in the network

Use **HealthCare.gov's** "window shopping" feature and the Summary of Benefits and Coverage to show differences between provider networks. Point out how plans vary in provider networks and how services are covered by out-of-network/non-participating providers versus in-network/participating providers. As you compare Marketplace plans

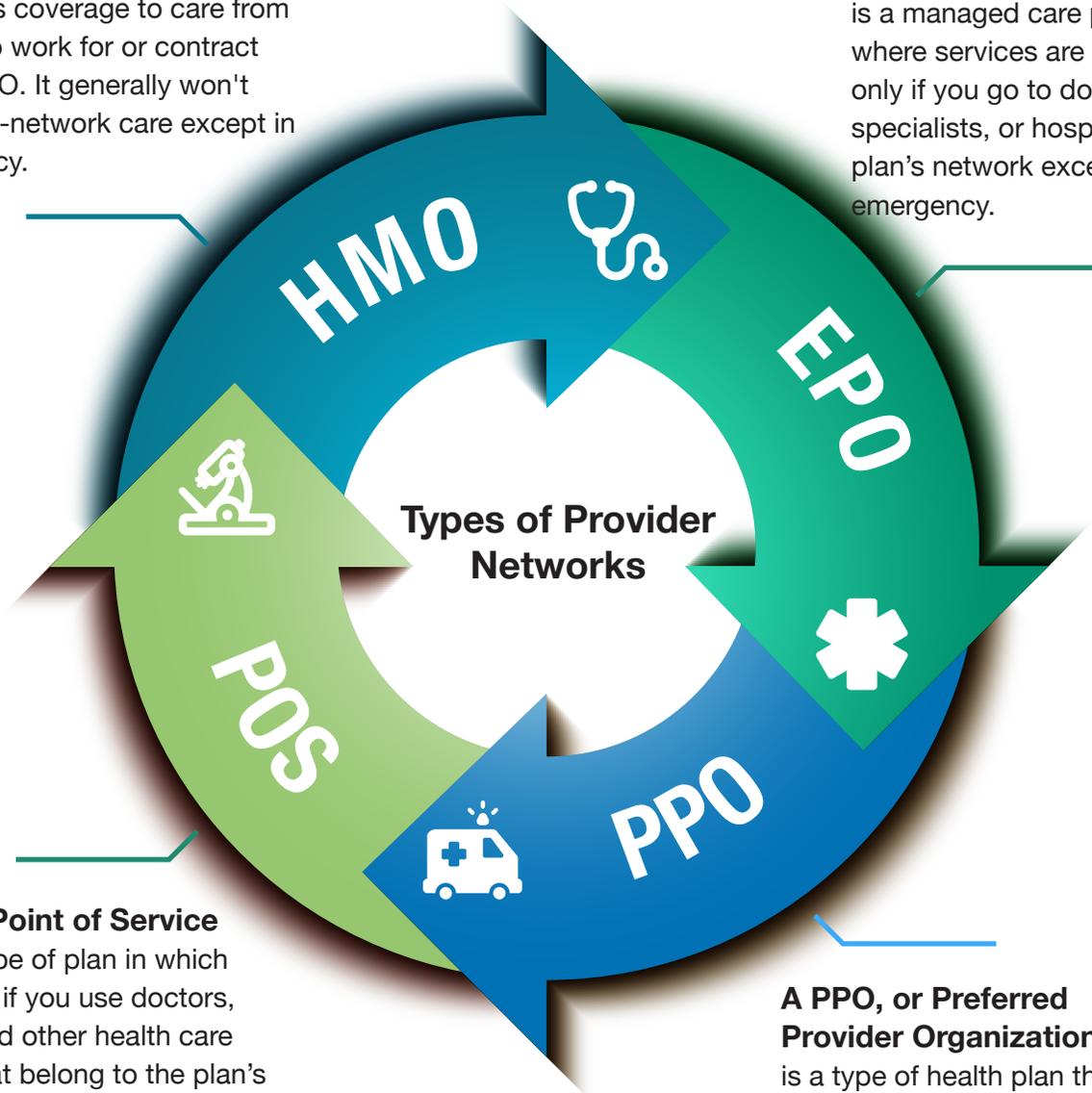


on **HealthCare.gov**, consumers can look at each plan's provider directory and search for a specific provider or hospital they want to continue using. **You may want to emphasize that for HMOs and EPOs, the plan may not pay anything for out of network services, but with PPOs and POS networks the plan will generally provide some coverage.** Refer to the definitions below and talk about each type of network. Have consumers look at a specific plan's Summary of Benefits and Coverage to understand how that plan covers in-network versus out-of-network services.

There are links at the end of this section on page 29 to a sample Summary of Benefits and Coverage and other resources to help you talk with consumers about provider network types.

An HMO, or Health Maintenance Organization, is a type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency.

An EPO, or Exclusive Provider Organization, is a managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network except in an emergency.



A POS, or Point of Service Plan, is a type of plan in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans also require you to get a referral from your primary care doctor in order to see a specialist.

A PPO, or Preferred Provider Organization, is a type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

3. Check For Your Providers Before Enrolling.

Ask if the consumer has a provider they would like to continue seeing. If a consumer wants to keep his or her provider, show how to check to see if the provider is “in-network” for the plan under consideration. You can use the provider directories linked on **HealthCare.gov**, or show consumers how to look up their provider by name on a particular plan’s website. However, since providers can change the plans they contract with at any time, encourage consumers to call their provider’s office directly to confirm their participation in a plan’s network before enrolling and, if possible, before seeking care.

If the provider they’re looking for isn’t in one plan’s network, a consumer may want to select a different plan to continue seeing the same provider. They can also look at the providers who are “in-network” and see if there are other options that meet their needs.

—————//—————
**ENCOURAGE CONSUMERS TO
CALL THEIR PROVIDER’S OFFICE
TO CONFIRM THEIR PLAN
PARTICIPATION.**
—————//—————

Consumers may not be familiar with mental health parity, or they may want to know if mental health services are covered in a particular plan. Explain that there’s a law that generally prevents health plans from limiting access to mental health and substance use disorder services any more than they restrict access to medical and surgical services. If consumers want to locate a treatment provider, suggest they use the provider locator on **MentalHealth.gov**. As with their primary care provider, remind consumers to check whether the provider they’re thinking about is in their network before they get care.



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CHECK A PLAN'S FORMULARY FOR EXPENSIVE PRESCRIPTION DRUGS.

////

4. Know What Prescription Drugs Are Covered And What They'll Cost.

A plan's formulary is a list of prescription drugs that are covered by a plan. Ask consumers if they're currently taking any prescription drugs. Consumers, especially those with a chronic condition, need to understand how much they'll pay. Help consumers see how much their drugs will cost by showing them how to find and read a plan's formulary. Consumers with Medicaid and CHIP generally have to pay some money for prescription drugs, but it's not a lot. Marketplace plans' formularies are posted on HealthCare.gov and consumers can see lists of covered drugs as they compare plans.

Some drugs cost more than others. Formularies are usually divided into categories, or tiers. They tell you how much drugs in each category cost for the health plan and for the consumer. The tiers are usually called:

- Generics (often the lowest cost for consumers)
- Preferred brands
- Non-preferred brands
- Specialty drugs (often the highest cost)

If a consumer takes an expensive prescription drug or fills several prescriptions, they should check the plan's formulary for these particular prescription drugs to see if they're covered. Some people may want to choose a Gold or Platinum plan because although the monthly premium may

cost more, if their prescription drugs or treatments are covered their care would cost less over the year.

For example, if a consumer is prescribed a drug to manage their cholesterol, the cost would depend on: 1) how the plan classifies that drug in its formulary, and 2) what level of coverage the plan provides for each type of drug. Also explain to the consumer that they can talk to their provider about switching from a particular brand to the generic brand for the same drug, which may cost less. Use the table below as an example of how a plan might cover different prescription drugs in its formulary.

SAMPLE CONSUMER COST TABLE

Bronze vs. Gold Plan for 30 day supply of a prescription drug

		BRONZE	GOLD
	Generic Drugs	\$20 copay	\$10 copay
	Preferred Brand Drugs	\$45 copay	\$35 copay
	Non-Offered Brand or Generic Drugs	\$75 copay	\$70 copay
	Specialty Drugs	40% coinsurance	30% coinsurance

Some drugs have special rules. Most health plan formularies have rules, or restrictions, on certain prescription drugs. These rules can include:

- Requiring prior authorization
- Limiting the amount of a drug a person can get over a certain period of time
- Requiring a consumer to use a cheaper drug that has been proven effective before covering the more expensive drug if the first option doesn't work (also known as "step therapy")

Talk to consumers about any restrictions in the formularies for the plans they're considering since this could impact their care. Reassure consumers that they can work with their provider and their plan to get the care they need.



Re-enrolling? Remind consumers that health plans update their formularies regularly and can change which drugs are covered, add new generic drugs, or change their costs. If there are changes that could affect their care, consumers may want to consider switching plans or talking with their provider about changing to another covered prescription drug instead.

Prescription drugs still too expensive?

Even with coverage, consumers may still be concerned about the cost of their prescription drugs. National and local patient assistance groups such as the Partnership for Prescription Assistance may be able to help qualifying patients get their prescription drugs for very low or no cost.

Go to sites like this one for help:

<https://www.pparx.org/>

5. Not All Plans Cover Dental And Vision Care.

Individuals and families who are new to coverage may assume that enrolling in a Marketplace plan will give them coverage for dental or vision care automatically. Ask consumers if they want dental or vision coverage. **All Marketplace plans are required to cover pediatric dental care for consumers who are 18 and under, and pediatric vision care.** This is not true for adults. Insurers do not have to offer adult dental coverage. If adult dental or vision coverage is important to them, check the Summary of Benefits and Coverage for a particular plan to see if it's included. If it is, let consumers know they'll pay one monthly premium for everything – the premium shown for the plan on **HealthCare.gov** includes both health and dental coverage.

If the plan they're considering doesn't cover adult dental or if they want different dental coverage, consumers can compare the stand-alone dental plans that may be available using the "window shopping" feature of **HealthCare.gov**. If they choose a separate dental plan, consumers will pay a separate, additional premium. If dental plans aren't available, or if consumers would like to enroll in other coverage like a stand-alone vision plan that is not offered in the Marketplace, talk about how to find a stand-alone plan in your state, including contacting your state's Department of Insurance or a local agent or broker.

—————
INSURERS ARE NOT REQUIRED TO OFFER ADULTS DENTAL AND VISION BENEFITS. BE SURE TO SHOP AROUND IF YOU WANT THIS TYPE OF COVERAGE.
—————



RESOURCES

Marketplace background guide for Federally Facilitated Marketplace and Partnership states (Partner)

<https://marketplace.cms.gov/technical-assistance-resources/marketplace-background-guide.pdf>

Explaining a Summary of Benefits and Coverage (Partner)

<http://marketplace.cms.gov/technical-assistance-resources/summary-of-benefits-and-coverage.pdf>

FAQs on coverage for young invincibles (Consumer)

<https://www.healthcare.gov/young-adults>

Marketplace coverage and metal levels (Consumer)

<https://www.healthcare.gov/choose-a-plan/plans-categories/>

How to find information on health care providers (Consumer)

<https://www.healthcare.gov/choose-a-plan/find-provider-information/>

Health insurance coverage of mental health and substance use disorder services (Partner/Consumer)

<http://www.mentalhealth.gov/get-help/health-insurance/index.html/>

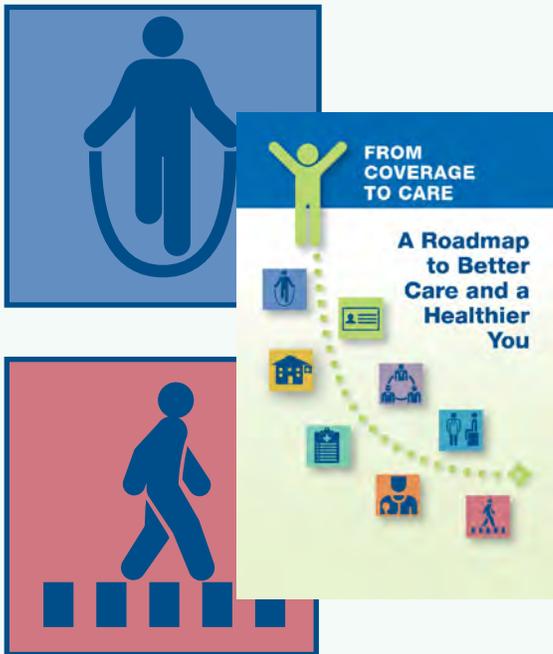


4



WHAT CONSUMERS SHOULD DO AFTER THEY GET COVERAGE

After enrolling, many consumers may be unsure what they should do next. Let consumers know that getting coverage is the first step in their journey to better health. Use the **From Coverage to Care Roadmap** and the messages in this section to help consumers understand how to use their coverage to live a long and healthy life.



ARE THERE QUESTIONS ABOUT ...

COMPLETING ENROLLMENT?

GO TO
31

HOW TO KNOW WHAT'S COVERED?

GO TO
32

PICKING OR CHANGING PROVIDERS?

GO TO
32

ONGOING TREATMENT OR PRESCRIPTION DRUGS?

GO TO
33

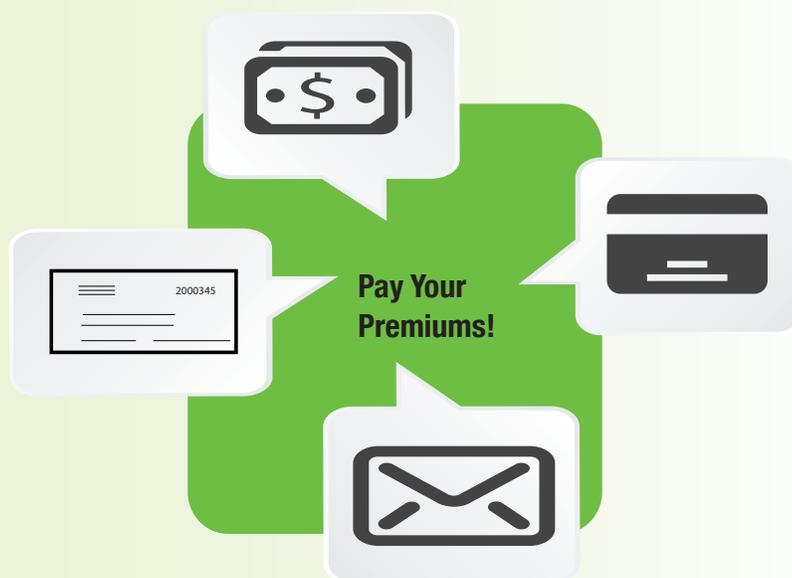
1. Confirm You're Covered.

After consumers complete the enrollment process, they should receive information from their plan about benefits and paying their premiums. Let consumers know there are ways to confirm they're covered if they don't hear from their plan or they aren't sure they've finished the enrollment process. They can:

- **Log in to their account on HealthCare.gov** and click on their application. Consumers will see a summary on the “My Applications & Coverage” page where they can find more details about their enrollment and plan benefits.
- **Call the Customer Service Center of their new plan**, using the listing and instructions on **HealthCare.gov**. Consumers can confirm whether they're enrolled and whether they've paid their first month's premium. Go to: <https://marketplace.cms.gov/outreach-and-education/contact-health-plan.pdf>.
- If they are still having trouble, **call the Marketplace Call Center** at 1-800-318-2596 (TTY: 1-855-889-4325).

2. Pay Your Monthly Premium To Keep Your Coverage.

Consumers who are new to health coverage may not realize they have to pay their premiums every month. Tell them they need to do this even if they don't use any services in the month. Let people know that once they are enrolled, they must pay their first premium directly to the insurance company – not to the Marketplace. They should follow any instructions from their insurer about how and when to make their premium payment. **Consumers who don't pay their premiums risk losing their coverage and having to pay for 100 percent of the cost of their health care.** It may also mean they have to pay the fee for not having coverage. Remind consumers that staying covered is as important as getting covered.



YOU'RE COVERED. NOW GET THE CARE YOU NEED.

3. Review Plan Materials And Learn About Your Benefits.

Suggest to consumers that they review their plan materials and coverage documents and store them in a safe place right after they enroll. They'll get the most out of their coverage if they know what's covered and what their costs will be. If they have questions, encourage them to call their health plan (or state Medicaid or CHIP office, if they are eligible for those programs) for answers.



4. Talk With A Provider About How To Improve Your Health And Well-Being.

While the consumer was enrolling in coverage, you probably talked about whether he or she already has a provider. If they don't, explain that having a regular provider is an important first step to getting the primary care and preventive services they need. Some consumers may have been assigned to a provider by their plan. If they want to change, show them how to contact their plan to do so.

You've picked a provider, now schedule an appointment. As soon as coverage begins, consumers can see a provider to learn about their health needs, and start working with them toward better health.

The **Roadmap, Steps 4, 5, and 6** help you talk with consumers about finding a provider, and how to scheduling and preparing for their first appointment.

The **Roadmap, Step 7** helps you guide the consumer to find the provider that's right for them.

Know where to go for care. Consumers who are new to coverage may have used the emergency department for care in the past. Remind them that they should only use the emergency department when they have a life-threatening illness or injury. Encourage them to use their primary care provider for other situations.

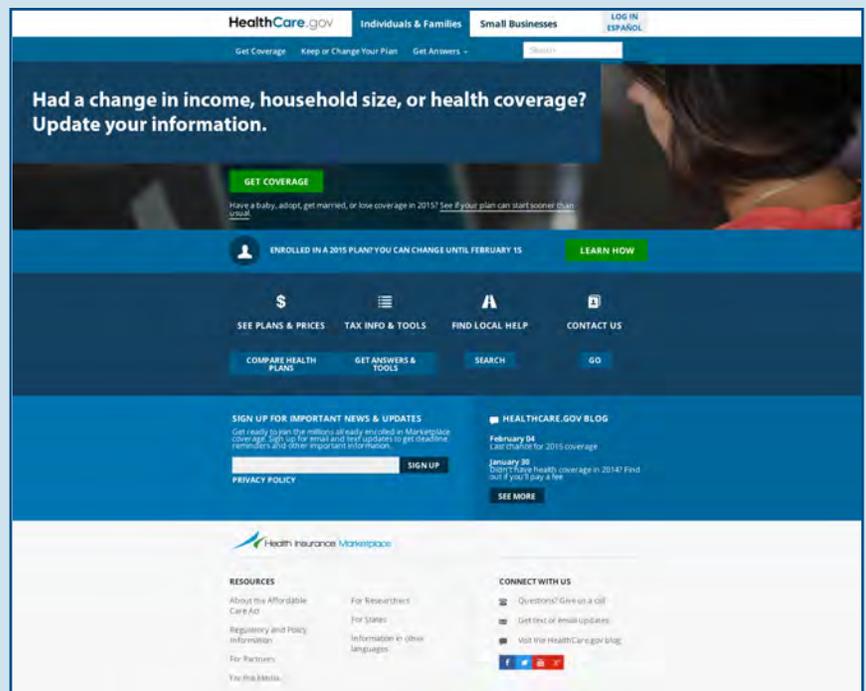
The **Roadmap, Step 3** helps you talk about where to go for care and the differences between primary care and the emergency department.

5. Keep Getting The Prescription Drugs And Treatment You Need.

You probably talked about consumers' ongoing treatment or prescription drugs earlier in the enrollment process. Remind individuals that they'll need to take action to keep getting care while their coverage changes. If a consumer needs ongoing treatment for a chronic condition or needs to fill a prescription regularly, urge them to talk with their provider immediately to see what needs to be done under their new plan. Let the consumer know that if their new plan has restrictions on certain prescription drugs or services, sometimes these can be waived if their provider and plan work together. If their treatment is denied they always have the right to appeal that decision. Talk about where to look for their plan's appeals process, and remind them that their provider can help them appeal a decision. There are links to more information about the appeals process at the end of this section on page 34.

6. Keep Your Information Current On Healthcare.gov.

The information consumers enter into their Marketplace application on **HealthCare.gov** (for example, family size and household income level) is used to calculate their premium tax credit. **Remind consumers about the importance of keeping their information current so they receive the right amount of financial assistance and don't end up owing money when they file their taxes.** Encourage them to update their information on **HealthCare.gov** when there is a change within 30 days of the change. In addition to keeping their records accurate, consumers may become eligible for a Special Enrollment Period if they have a major life event like a birth, adoption, marriage, or job loss, and they may want to choose a new plan that meets their changing health care needs.



The screenshot shows the HealthCare.gov website interface. At the top, there are navigation links for "Individuals & Families", "Small Businesses", and "LOG IN (SPANISH)". Below this is a search bar and a main banner with the text "Had a change in income, household size, or health coverage? Update your information." and a "GET COVERAGE" button. A secondary banner states "ENROLLED IN A 2015 PLAN? YOU CAN CHANGE UNTIL FEBRUARY 15" with a "LEARN HOW" button. The main navigation menu includes "SEE PLANS & PRICES", "TAX INFO & TOOLS", "FIND LOCAL HELP", and "CONTACT US". Below the menu are buttons for "COMPARE HEALTH PLANS", "GET ANSWERS & TOOLS", "SEARCH", and "GO". There are also sections for "SIGN UP FOR IMPORTANT NEWS & UPDATES" and "HEALTHCARE.GOV BLOG". At the bottom, there are "RESOURCES" and "CONNECT WITH US" sections.

RESOURCES

Confirming enrollment in coverage

(Partner/Consumer)

<https://www.healthcare.gov/apply-and-enroll/complete-your-enrollment/>

Contact your Marketplace health plan

(Partner/Consumer)

<https://marketplace.cms.gov/outreach-and-education/contact-health-plan.pdf>

From Coverage to Care resources

(Partner/Consumer)

<https://marketplace.cms.gov/c2c>

Helping a consumer with appealing a plan's decision not to cover

(Partner)

<http://marketplace.cms.gov/technical-assistance-resources/internal-claims-and-appeals.pdf>

Options for coverage outside of Open Enrollment

(Partner/Consumer)

<https://www.healthcare.gov/coverage-outside-open-enrollment/>

Qualifying for a Special Enrollment Period

(Consumer)

<https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/>



5



WHAT CONSUMERS WITH SPECIAL CIRCUMSTANCES SHOULD KNOW ABOUT THEIR COVERAGE OPTIONS

Some consumers have special circumstances that affect their coverage options and enrollment. Three of these groups are discussed in this section, and there are resources on page 41 to help you work with these and other special populations. You may want to partner with others in your community to share resources, best-practices and tips to meet your consumers' needs.

ARE THERE QUESTIONS ABOUT ...

AMERICAN INDIANS & ALASKA NATIVES? GO TO 36

LIMITED ENGLISH PROFICIENCY? GO TO 38

IMMIGRANTS? GO TO 39

1. American Indians And Alaska Natives (Ai/An) May Have New Coverage Benefits And Protections.

Some benefits are available to members of federally recognized tribes or Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders. Others are available to people of Indian descent or who are otherwise eligible for services from the Indian Health Service, a tribal program, or an urban Indian health program.

Based on their eligibility, talk to American Indian and Alaska Native consumers about limited and zero cost-sharing plans and Medicaid. Help them compare plans by window shopping at “See Plans & Prices” on **HealthCare.gov** to find one that works for them. Remind consumers they will have to pay their premiums if they enroll in a Marketplace plan. You should also help them check to see if they're eligible for premium tax credits (discussed in **Section 2**).

Financial Assistance for American Indians and Alaska Natives

Members of federally recognized Indian tribes and ANCSA Corporation shareholders (regional or village) may qualify for zero or limited cost-sharing plans or cost-sharing reductions based on their income. Let consumers know that they can enroll in a Marketplace plan any time during the year, not just during the yearly Open Enrollment period.

- **Household income is below \$70,650 for a family of 4 (\$88,320 in Alaska):** can enroll in a zero cost-sharing plan. Let them know they have no out-of-pocket costs like copayments, deductibles, or coinsurance.
- **Household income is above \$70,650 for a family of 4 (\$88,320 in Alaska):** Can enroll in a limited cost-sharing plan. Let people know they won't have to pay out-of-pocket costs when they get services from an Indian health care provider – or from another provider, if they have a referral from an Indian health care provider.

American Indians or Alaska Natives, and others eligible for services from the Indian Health Service, tribal program, or urban Indian Health program have additional opportunities for coverage:

- **May qualify for Medicaid or CHIP:** Let consumers know they have special cost and eligibility rules for Medicaid and CHIP that make it easier to qualify for these programs.
- **Don't pay out-of-pocket costs for Indian health programs:** regardless of their income, consumers won't have any out of pocket costs for items or services provided by the Indian Health Service, tribal programs, or urban Indian programs, including Contract Health Services.
- **Don't pay the penalty:** Consumers who do not enroll in coverage won't have to pay the fee that most other people without health insurance must pay, but do have to apply for an exemption.

For more information about coverage for American Indian and Alaska Natives, go to:
<https://www.healthcare.gov/american-indians-alaska-natives/>

Where do you go for care? Consumers who've been using tribal health care services may not know which other providers will take their new coverage. American Indian and Alaska Natives can use an Indian health care provider as a primary care provider or choose to use a provider in their new plan's network. If they get health care from an Indian health provider already, let them know that they can continue to see that Indian health provider and many others after they enroll in Marketplace coverage. They may also qualify for coverage with low or zero cost-sharing. If they don't have a provider, show them how to find one using the plan's provider directory posted on **HealthCare.gov** or the health plan's website, if they have one. Let consumers know that getting covered will give them more options when they need health care.

Enroll in coverage or apply for an exemption. Many American Indians and Alaska Natives get health care at various types of Indian health care providers, including Indian Health Services, tribal programs, and urban Indian programs (called ITUs). Although they have access to health care services, explain that this health care is not considered insurance for purposes of the individual shared responsibility requirement. Let them know that they still need to enroll in minimum essential coverage or apply for an exemption to avoid having to pay the individual shared responsibility fee.

You can use the **Tribal version of the Roadmap** and resources at the end of this section on page 41 to help you work with tribal populations. You'll find more information about help with costs, how American Indian and Alaska Native consumers can get an exemption, what documents are required, and how to access care.

HEALTH CARE SERVICES YOU GET AT IHS, URBAN INDIAN PROGRAMS, OR TRIBAL PROGRAMS DOESN'T COUNT AS MINIMUM ESSENTIAL COVERAGE.





2. Help Is Available If You Speak A Language Other Than English.

If you're helping someone who speaks a language other than English, there are resources in the box below for help that may be available in his or her preferred language. Some of these resources include interpreters, call center support, and print and web resources like a Uniform Glossary and Marketplace application guides. You can also use the “local help” feature on **HealthCare.gov** to find in-person support in your community.

Get In-Language Assistance

You can use these resources together, or consumers can access these services on their own.

The Marketplace Call Center has representatives available in English and Spanish-speaking representatives, and interpretation and translation services in 150 languages. These services are free.

For help in a language other than English, call **1-800-318-2596**.

Some In-person “assisters,” like navigators, Certified Application Counselors, and others partner offer services in languages other than English. Consumers can get a list of local organizations with contact information, office hours, and types of help offered including non-English language support. Visit <https://localhelp.healthcare.gov/> and type enter a city and state or ZIP Code.

Online resources are available in many languages, with more being developed. You can find Marketplace application guides in 27 languages. For more information visit: <https://www.healthcare.gov/language-resource/>.

En Español: <https://www.cuidadodesalud.gov/es/>

3. Many Immigrants Can Enroll In Marketplace Plans, Medicaid, Or Chip, And May Be Eligible For Financial Assistance.

Non-U.S. citizens or members of their family may have questions about whether they can enroll in coverage and get help with costs. They may also wonder what documentation they need.

People with the following immigration status qualify for Marketplace coverage:

- Lawful Permanent Resident (LPR or Green Card Holder)
- Asylees
- Refugees
- Cuban and Haitian entrants
- Paroled to the U.S. for at least 1 year
- Conditional entrant granted before 1980
- Battered non-citizens, spouses, children or parents
- Victims of trafficking or and their spouses, children, siblings or parents
- Granted withholding of deportation
- American Indian born in Canada
- Humanitarian statuses or circumstances (including Temporary Protected Status, Special Juvenile Status, asylum applicants, Convention Against Torture, victims of trafficking)
- Valid non-immigrant visas
- Legal status conferred by other laws (temporary resident status, LIFE Act, Family Unity individuals)

See a full list of eligible immigration statuses eligible to use the Marketplace here: <https://www.healthcare.gov/immigrants/immigration-status/>

In general, Medicaid and CHIP require lawfully present immigrants to become lawful permanent residents, and to wait five years before they can enroll in coverage. During this five-year waiting period eligible individuals may be able to get coverage to treat an emergency medical condition. Lawful permanent residents who haven't completed the five-year waiting period can enroll in a Marketplace plan and may be eligible for premium tax credits and cost-sharing reductions during that time. Some states don't have the five-year waiting period for children and pregnant women. Use the resource below to see if your state is one of them.

DO THEY HAVE TO WAIT 5 YEARS?

Check whether your state allows children and/or pregnant women to enroll in Medicaid and CHIP with no five-year waiting period. Go to:

http://insurekidsnow.gov/professionals/eligibility/lawfully_residing.html

FOR A COMPLETE LIST OF DOCUMENTATION IMMIGRANTS
CAN USE WHEN ENROLLING IN COVERAGE:

<https://www.healthcare.gov/help/immigration-document-types/>

Immigrants who aren't lawfully present aren't eligible to enroll for coverage through the Marketplace, get premium tax credits or cost-sharing reductions, or enroll in non-emergency Medicaid or CHIP. They can file a Marketplace application for their lawfully present children or family members. Family members who aren't applying for coverage for themselves will not have to give information about their immigration status, so they can help anyone in their family apply.

You may need documentation when you apply and enroll. The documents individuals need to enroll in Marketplace coverage will depend on their immigration status. Here are some of the documents immigrants may need:

- Permanent Resident Card, “Green Card” (I-551)
- Reentry Permit (I-327)
- Refugee Travel Document (I-571)
- Employment Authorization Card (I-766)
- Machine Readable Immigrant Visa (with temporary I-551 language)
- Temporary I-551 Stamp (on passport or I-94/I-94A)
- Arrival/Departure Record (I-94/I-94A)
- Arrival/Departure Record in foreign passport (I-94)
- Foreign Passport
- Certificate of Eligibility for Nonimmigrant Student Status (I-20)

- Certificate of Eligibility for Exchange Visitor Status (DS2019)
- Notice of Action (I-797)
- Document indicating membership in a federally recognized Indian tribe or American Indian born in Canada
- Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
- Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
- Document indicating withholding of removal
- Administrative order staying removal issued by the Department of Homeland Security (DHS)
- Alien number (also called alien registration number or USCIS number) or 1-94 number



RESOURCES

AMERICAN INDIANS AND ALASKA NATIVES

From Coverage to Care Roadmap – Tribal Version (Partner/Consumer)

<https://marketplace.cms.gov/c2c>

Tip sheet for Assisters working with AI/ANs (Partner)

<https://marketplace.cms.gov/technical-assistance-resources/working-with-aian.pdf>

Details on special Marketplace protections and benefits for AI/ANs (Consumer)

<https://www.healthcare.gov/tribal>

How to apply for an exemption (Consumer)

<https://www.healthcare.gov/fees-exemptions/apply-for-exemption/>

Information for tribal leaders and tribal health programs, National Indian Health Outreach and Education (NIHOE) (Partner/Consumer)

<http://tribalhealthcare.org/>

LIMITED ENGLISH PROFICIENCY

Glossary of health care terms for consumers with limited English proficiency (Partner/Consumer)

<https://marketplace.cms.gov/technical-assistance-resources/plan-compare-and-plan-selection-help.html>

Translated resources from Marketplace (Partner)

<https://marketplace.cms.gov/outreach-and-education/other-languages.html>

Videos in English and other languages for outreach and enrollment to diverse populations (Partner/Consumer)

https://www.youtube.com/playlist?list=PLBXgZMI_zqfRXt44Uk6YeMW0Npmbemc2h

Uniform Glossaries in other languages (Partner/Consumer)

<https://marketplace.cms.gov/outreach-and-education/tools-and-toolkits.html>

RESOURCES (Continued)

Marketplace Call Center instructions in other languages (Consumer)

<https://marketplace.cms.gov/outreach-and-education/getting-help-in-a-language-other-than-english.pdf>.

Find local enrollment help in other languages (Consumer)

<https://localhelp.healthcare.gov/>

HealthCare.gov resources in other languages (Consumer)

<https://www.healthcare.gov/language-resource/>

Spanish version of HealthCare.gov (Consumer)

<https://www.cuidadodesalud.gov/es/>

Help filing a complaint in other languages (Consumer)

<http://www.hhs.gov/ocr/office/file/languageaccess.html>

IMMIGRANTS

Overview of immigrant eligibility for affordable health coverage (Partner)

<http://www.healthreformbeyondthebasics.org/wp-content/uploads/2014/09/CMS-Assister-Webinar-09.19.14-Immigrant-Eligibility.pdf>

Information on immigration status and the Marketplace (Consumer)

<https://www.healthcare.gov/immigrants/immigration-status>

OTHER VULNERABLE POPULATIONS

Helping special populations enroll (Partner)

<https://marketplace.cms.gov/outreach-and-education/special-populations.html>

Understanding health coverage needs of people with disabilities (Partner)

http://www.nationaldisabilitynavigator.org/wp-content/uploads/presentations/NDNRC_CMS_Nov-21-14.pdf

Coverage options for people with disabilities (Consumer)

<https://www.healthcare.gov/people-with-disabilities/>

Overview of assisting people with disabilities in the Marketplace (Partner)

<https://marketplace.cms.gov/technical-assistance-resources/assisting-people-with-disabilities.pdf>

Tools for working with consumers with HIV/AIDS (Partner/Consumer)

<https://careacttarget.org/category/audience/consumers-and-community>

Enrollment assistance for lesbian, gay, bisexual, and transgender communities (Partner)

<http://store.samhsa.gov/product/PEP14-LGBTACAENROLL>

Health care toolkit for faith and community-based organizations (Partner)

http://www.hhs.gov/partnerships/aca_act_and_community/index.html



CMS Product No. 11909
May 2015

marketplace.cms.gov/c2c



October 15, 2014

Key Facts You Need to Know About: Income Definitions for Marketplace and Medicaid Coverage

Health reform provides new opportunities for millions of Americans to get affordable health coverage. Eligibility and benefit amounts are determined in part by household income. For premium tax credits, most categories of Medicaid eligibility, and the Children’s Health Insurance Program (CHIP), states and the federal government use a new tax-based measure of income called Modified Adjusted Gross Income (MAGI) to assess financial eligibility. The following key facts explain MAGI and what counts as income in determining eligibility for premium tax credits, Medicaid, and CHIP.

How do Marketplaces, Medicaid, and CHIP measure a person’s income?

For premium tax credits, most categories of Medicaid eligibility, and CHIP, all Marketplaces and state Medicaid and CHIP agencies determine a household’s income using MAGI. States’ previous rules for counting income continue to apply to people who qualify for Medicaid on the basis of age or disability or because they are children in foster care.

MAGI is Adjusted Gross Income (AGI) plus tax-exempt interest, Social Security benefits not included in gross income, and excluded foreign income. Each of these items has a specific tax definition; in most cases they can be located on an individual’s tax return (see Figure 1). (Medicaid does not count certain Native American and Alaska Native income in MAGI.)

What Is Adjusted Gross Income?

Adjusted Gross Income is the sum of an individual’s gross income (that is, total earnings

subject to income tax) minus deductions for certain expenses.

The deductions taken to calculate AGI are referred to as “adjustments to income” or “above the line” deductions. These are specific expenses that the Internal Revenue Service (IRS) allows people to deduct to reduce their taxable income. Among the most common are alimony payments, IRA contributions, job-related moving expenses, student loan interest, and tuition and fees. For many of these adjustments, the amount of the deduction is capped or limited based on the person’s income. [IRS Publication 17](#) explains how to qualify for these adjustments.

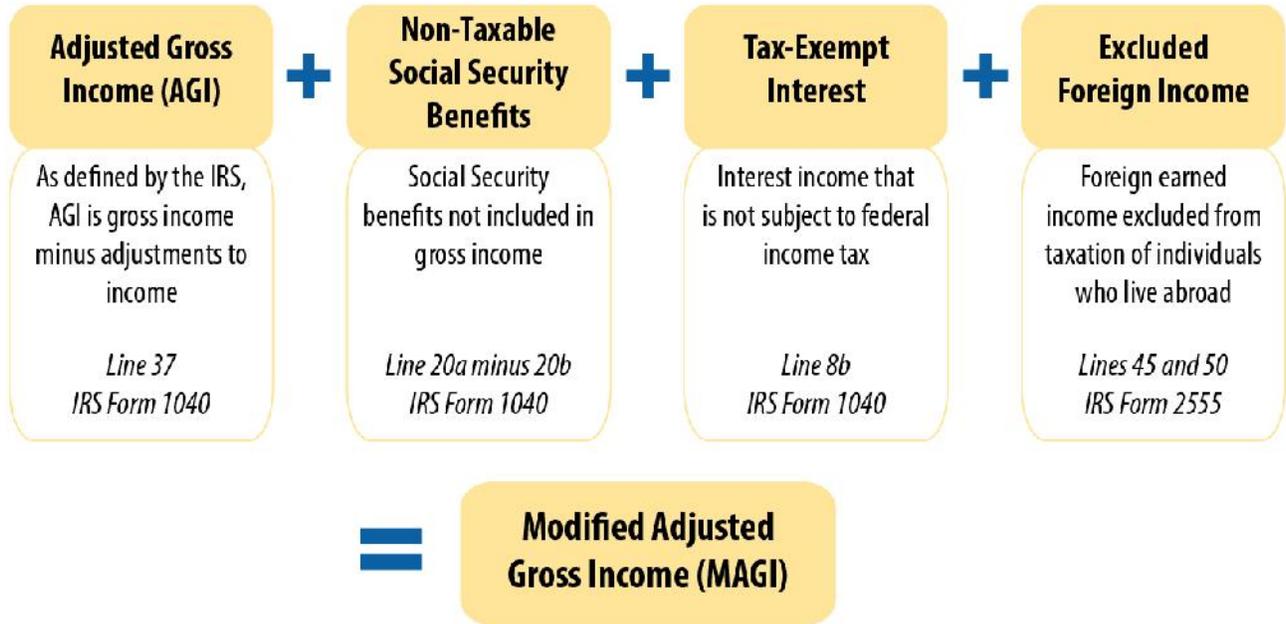
What types of income are taxable and count towards MAGI?

All income is subject to taxation unless it’s specifically exempted by law. Income does not only refer to cash wages. It can come in the form of money, property, or services that a person receives.



Figure 1

Formula for Calculating Modified Adjusted Gross Income



An applicant's most recent tax return can be useful in estimating income if their income has not changed. If a tax return is not available, or if income is different for any reason, the tax return can still be a useful list of what income and adjustments to include.

Table 1 provides examples of taxable and non-taxable income. [IRS Publication 525](#) provides a detailed discussion of many kinds of income and explains whether they are subject to taxation.

Is income deducted from workers' paychecks for pre-tax deductions counted in MAGI?

No. Pre-tax deductions are deductions that can be used to discount the amount of taxable wages. Among the most common are health care expenses such as insurance premiums or health savings account contributions, retirement account contributions, and flexible spending accounts for medical or child care expenses. Since income set aside for these purposes is not taxed, it does not count towards a household's MAGI.

Does MAGI count any income sources that are not taxed?

Yes. Some forms of income that are non-taxable or only partially taxable are included in MAGI and thus affect financial eligibility for premium tax credits and Medicaid, specifically:

- **Tax-exempt interest.** Interest on certain types of investments is not subject to federal income tax but is included in MAGI. These investments include many state and municipal bonds as well as exempt-interest dividends from mutual fund distributions. However, some other forms of tax-exempt interest, such as interest earned on an IRA, HSA, Archer or Medicare Advantage MSA, or Coverdell education savings account, is *not* included in MAGI.



Table 1

Examples of Taxable Income

Wages, salaries, bonuses, commissions	IRA distributions
Alimony	Jury duty fees
Annuities	Military pay
Awards	Military pensions
Back pay	Notary fees
Breach of contract	Partnership, estate, and S-corporation income
Business income/Self-employment income	Pensions
Compensation for personal services	Prizes
Debts forgiven	Punitive damages
Director's fees	Unemployment compensation
Disability benefits (employer-funded)	Railroad retirement—Tier I (portion may be taxable)
Discounts	Railroad retirement—Tier II
Dividends	Refund of state taxes
Employee awards	Rents (gross rent)
Employee bonuses	Rewards
Estate and trust income	Royalties
Farm income	Severance pay
Fees	Self-employment
Gains from sale of property or securities	Non-employee compensation
Gambling winnings	Social Security benefits (portion may be taxable)
Hobby income	Supplemental unemployment benefits
Interest	Taxable scholarships and grants
Interest on life insurance dividends	Tips and gratuities

Examples of Non-Taxable Income

Aid to Families with Dependent Children (AFDC)	Meals and lodging for the employer's convenience
Child support received	Payments to the beneficiary of a deceased employee
Damages for physical injury (other than punitive)	Payments in lieu of worker's compensation
Death payments	Relocation payments
Dividends on life insurance	Rental allowance of clergyman
Federal Employees' Compensation Act payments	Sickness and injury payments
Federal income tax refunds	Social Security benefits (portion may be taxable)
Gifts	Supplemental Security Income (SSI)
Inheritance or bequest	Temporary Assistance for Needy Families (TANF)
Insurance proceeds (accident, casualty, health, life)	Veterans' benefits
Interest on tax-free securities	Welfare payments (including TANF) and food stamps
Interest on EE/I bonds redeemed for qualified higher education expenses	Worker's compensation and similar payments

Source: Internal Revenue Service, [Income Quick Reference Guide](#)



- **Non-taxable Social Security benefits.** For many people, particularly those with no other source of income, Social Security benefits are not taxable. However, the full amount of a person's Social Security benefits as indicated on Form SSA-1099 (the Social Security Benefit Statement) — whether or not those benefits are taxable — is included in MAGI.
- **Foreign income.** Under section 911 of the Internal Revenue Code, U.S. citizens and resident aliens living outside the U.S. can exclude up to \$97,600 (in 2013) of earned income for tax purposes if they meet certain residency or physical presence tests. Any foreign income excluded under this section must be added back when calculating MAGI.

Whose income is included in a household's MAGI?

A household's MAGI is the sum of the MAGI of each household member who has a tax filing requirement. The *requirement* to file taxes, not whether someone actually files taxes, determines whether an individual's income must be included in a household's MAGI.

Is a tax dependent's income ever counted in determining the household's MAGI?

Sometimes a dependent files a tax return even though he is not required to do so — for example, to get a refund of taxes withheld from his paycheck. In this situation, the dependent's income would not count toward the household's MAGI. However, if a dependent has a tax filing requirement, his MAGI is calculated and added to the taxpayer's MAGI to determine the household's MAGI.

In general, individuals claimed as dependents on someone else's tax return must file taxes if they receive at least \$6,100 in earned income or

\$1,000 in unearned income (for the 2013 tax year). Supplemental Security Income (SSI) and Social Security benefits are not counted for the purposes of determining whether a dependent will be required to file a tax return. However, if the dependent does have a tax filing requirement, then the dependent's Social Security benefits will be counted toward the household's MAGI.

What time frame is used to determine a household's MAGI?

Financial eligibility for premium tax credits and Medicaid is based on income for a specified "budget period." For premium tax credits, the budget period is the tax year (which coincides with the calendar year) during which the advance premium tax credit is received. When determining eligibility for advance premium tax credits, the Marketplace estimates the applicant's household MAGI over the entire calendar year for which the applicant seeks coverage.

Medicaid eligibility, however, is based on current monthly income. Some states allow current Medicaid beneficiaries to project their income for the rest of the calendar year; the state assesses eligibility based on the average monthly total. So, for example, if a family member has seasonal work that temporarily raises household income, that increase is effectively spread across all months of the year. States may also allow both applicants and beneficiaries to account for any reasonably predictable increases or decreases in income they anticipate over the year. These options help minimize coverage gaps that could result if beneficiaries had to recertify their income every month.

How does MAGI differ from Medicaid's former rules for counting household income?

The MAGI methodology for calculating income differs significantly from previous Medicaid rules.



Table 2

Differences in Counting Income Sources Between Former Medicaid Rules and MAGI Medicaid Rules

Income Source	Former Medicaid Rules	MAGI Medicaid Rules
Self-employment income	Counted with deductions for some, but not all, business expenses	Counted with deductions for most expenses, depreciation, and business losses
Salary deferrals (flexible spending, cafeteria, and 401(k) plans)	Counted	Not counted
Child support received	Counted	Not counted
Alimony paid	Not deducted from income	Deducted from income
Veterans' benefits	Counted	Not counted
Workers' compensation	Counted	Not counted
Gifts and inheritances	Counted as lump sum income in month received	Not counted
TANF & SSI	Counted	Not counted

Some income that Medicaid used to consider part of household income is no longer counted, such as child support received, veterans' benefits, workers' compensation, gifts and inheritances, and Temporary Assistance for Needy Families (TANF) and SSI payments. Table 2 summarizes the differences between the former Medicaid rules and the new MAGI rules.

In addition, states can no longer impose asset or resource limits, and various income disregards have been replaced by a standard disregard equal to 5 percent of the poverty line. There are also changes to who is included in a household and, therefore, whose income is counted.

2015 Federal Poverty Guidelines to use for 2016 Marketplace Enrollment

Household	2015	Medicaid Eligibility (138% of FPL)	Cost Sharing (250%)	Premium Subsidy Threshold (400% of FPL)
1	\$11,770	\$16,243	\$29,425	\$47,080
2	\$15,930	\$21,983	\$39,825	\$63,720
3	\$20,090	\$27,724	\$50,225	\$80,360
4	\$24,250	\$33,465	\$60,625	\$97,000
5	\$28,410	\$39,206	\$71,025	\$113,640
6	\$32,570	\$44,947	\$81,425	\$130,280
7	\$36,730	\$50,687	\$91,825	\$146,920
8	\$40,890	\$56,428	\$102,225	\$163,560

Failing to file 2014 tax returns will prevent advance payments in 2016

Information from IRS.gov

The IRS reminds taxpayers who received advance payments of the premium tax credit in 2014 that they should file their 2014 tax return as soon as possible this summer to ensure they can timely receive advance payments next year from their Marketplace.

If advance payments of the premium tax credit were paid on behalf of you or an individual in your family in 2014, and you do not file a 2014 tax return, you will not be eligible for advance payments of the premium tax credit or cost-sharing reductions to help pay for your Marketplace health insurance coverage in 2016. This means you will be responsible for the full cost of your monthly premiums and all covered services. In addition, we may contact you to pay back some or all of the 2014 advance payments of the premium tax credit.

Because Marketplaces will determine eligibility for advance tax credit payments and cost-sharing reductions for the 2016 coverage year this fall, it will substantially increase your chances of avoiding a gap in receiving this help if you file your 2014 tax return with Form 8962 electronically as soon as possible.

If you missed the April 15 deadline or received an extension to file until Oct. 15, you should file your return as soon as possible. You should not wait to file. File now to reconcile any advance credit payments you received in 2014 and to maintain your eligibility for future premium assistance. You can file a federal return for free by using Free File.

Remember that filing electronically is the best and simplest way to file a complete and accurate tax return as it guides you through the process and does all the math.

People are asking...

The IRS hears many questions about the health care law. Here are commonly-asked questions that we are hearing from taxpayers and seeing on social media.

Q: I do not normally have to file a tax return. Why is the IRS telling me that I should file as soon as possible?

A. The IRS believes that you enrolled in health coverage through the Health Insurance Marketplace. If the government sent advance payments of the premium tax credit to your insurer, you are required to file a 2014 income tax return. If you do not file a 2014 income tax return, you will not be eligible for financial help next year. This means you will be responsible for the full cost of your monthly premiums. *Do not wait to file.* File now to stay eligible for future premium assistance.

Q. My income is below the threshold to be required to file a tax return, but advance payments of the premium tax credit were sent to my insurance company in 2014 to help pay my monthly premium; do I need to file a tax return?

A. Yes, you are required to file a tax return. If advance payments of the premium tax credit were paid for you or an individual in your tax family, you must file a tax return to reconcile the difference between the advance credit payments made on your behalf and the actual amount of the credit that you may claim. This requirement applies whether or not you would otherwise be required to file a return. File as soon as you can even if you missed the April 15 deadline. If you missed the April 15 deadline or you received an extension to file until Oct. 15, you should file your return as soon as possible. You should not wait to file. File now to reconcile any advance credit payments that were made for you or a member of your tax family in 2014 and to maintain your eligibility to get advance credit payments for your 2016 coverage.

If you don't file a 2014 tax return, you will not be eligible for advance payments of the premium tax credit to help pay for your Marketplace health insurance coverage in 2016. This means you will be responsible for the full cost of your monthly premiums and all covered services.

You should file your 2014 tax return with Form 8962 as soon as possible even if you don't usually have to file. You should have received Form 1095-A from your Marketplace. This form provides the information you will need to complete Form 8962. If you need a copy of your Form 1095-A, go to HealthCare.gov or your state Marketplace website and log into your Marketplace account or call your [Marketplace](#) call center.

Q. I filed my return claiming the premium tax credit. Why did I get a letter from the IRS asking for more information and a copy of my 1095-A?

A. You do not have to send your Form 1095-A to the IRS with your tax return when you file and claim the premium tax credit. However, using the information on your Form 1095-A you must complete and file Form 8962, Premium Tax Credit. The IRS verifies the information on your Form 8962 by comparing it to information received from the Marketplace and to other information you entered on your tax return.

In some situations, before we can send your refund, the IRS may send you a letter asking you to clarify or verify information that you entered on your income tax return. The letter may ask for a copy of your Form 1095-A.

Some common examples of issues or questions that may arise are:

- It appears that you are required to reconcile but did not include Form 8962.
- You submitted Form 8962 but it is incomplete.

- Based on the income that you reported, it appears that you are not eligible for the credit.
- The income or other entries on your Form 8962 are inconsistent with information on your tax return.
- The premium that you entered on your Form 8962 appears to be an annual amount, rather than monthly.
- There are questions about entries on your Form 8962 that may be clarified by a review of your 1095-A.
- We need to review your Form 1095-A to verify your Marketplace coverage.

You should follow the instructions on the correspondence that you receive in order to help the IRS verify information that has been entered on the tax return and issue the appropriate refund. For more information about Forms 1095-A, visit our [Health Insurance Marketplace Statements](#) page.

Q. What documentation or proof of insurance coverage do I have to submit with my return?

A. You do not need to attach documentation or proof of insurance coverage to your tax return. If you had coverage for yourself and everyone in your household for the entire year, you or your preparer will check a box on your tax return. Although nothing in the IRS rules or regulations require you to provide proof of coverage at the time you file, if you have documents that verify your coverage, you should show them to your tax preparer. The IRS will follow its normal compliance approach to filed tax returns, and may ask you to substantiate the information on your tax return, therefore you should keep these documents with your tax records. Learn more about the types of documents you should keep at our [Gathering Your Health Coverage Documentation](#) page.

Q. Does everyone need to have health insurance coverage?

A. The Affordable Care Act requires you and each member of your family to have basic health coverage (called minimum essential coverage), qualify for an exemption from the requirement to have coverage, or make an individual shared responsibility payment when you file your federal income tax return. If you are not required to file a tax return and don't want to file a return, you do not need to file a return solely to report your coverage or to claim an exemption.

Visit our [Individual Shared Responsibility Provision page](#) for information about what coverage qualifies, and our [Exemptions page](#) for details about who is eligible for an exemption from the requirement to have coverage.

For more questions and answers about the health care law, see the [Affordable Care Act Tax Provisions Questions and Answers page](#).

Page Last Reviewed or Updated: 11-Sep-2015

Individual Mandate

Exempt from the mandate if:

Religious exemption exists

Not lawfully present in the United States

Incarcerated

No penalty assessed if:

Individual cannot afford coverage

Income below tax filing threshold

Member of an Indian tribe

Uninsured for short coverage gaps of less than 3 months

Individual has received a hardship waiver from the Secretary

2014

\$95 per adult and \$47.50 per child (up to \$285 for a family) or 1% of family income whichever is greater

2015

\$325 per adult and \$162.50 per child (up to \$975 for a family) or 2.0% of family income whichever is greater

2016 and beyond

\$695 per adult and \$347.50 per child (up to \$2085 for a family) or 2.5% of family income whichever is greater

Penalty is pro-rated for the number of months without coverage, unless less than three months. The overall penalty is capped at the national average premium of a bronze level plan purchased through an Exchange. Penalties will be increased by COLA in 2017.

Report Life Changes to the Marketplace After You Enroll in Coverage

Once you have Marketplace coverage, you must report certain life changes. This information may change the coverage or savings you're eligible for.

You'll report changes directly to the Marketplace. Some changes also need to be reported to your insurance company, if you're covered by a private insurance plan. It's your responsibility to report changes in a timely way.

Your changes can make a difference in the kind of coverage you qualify for. If this is the case, you may be eligible for a Special Enrollment Period (SEP). A SEP allows a consumer to enroll in new health coverage and have it be effective, even if the normal enrollment period is over. Changes can also make a difference in the amount you pay for a plan.

After you report your changes to the Marketplace, you'll receive a notice explaining what you need to do next, like enroll in new coverage, or adjust your tax credit amounts.

Life changes to report

You must report a change if you:

- Get married or divorced
- Have a child, adopt a child, or place a child for adoption
- Have a change in income
- Get health coverage through a job or program like Medicare or Medicaid
- Change your place of residence
- Have a change in disability status
- Gain or lose a dependent
- Become pregnant
- Experience other changes that may affect your income and household size.
- **Other changes to report:** change in tax filing status; change of citizenship or immigration status; incarceration or release from incarceration (prison); change in status as an American Indian/Alaska Native or tribal status; correction to name, date of birth, or Social Security Number (SSN).



When and how to report changes

When changes like these happen, you should report them to the Marketplace as soon as possible.

If these changes qualify you for a Special Enrollment Period to change plans, in most cases you have 60 days from the life event to enroll in new coverage, or choose your same plan.

You can report these changes 2 ways:

- **Online:** Visit **HealthCare.gov** and log in to your Marketplace account (or create an account if you don't have one). Select your submitted application, then select "Report a life change" from the menu on the left.
- **By phone:** Contact the Marketplace Call Center at 1-800-318-2596. TTY users should call 1-855-889-4325.

After you report a change

After you report changes to the Marketplace, you'll get a new eligibility notice that will explain:

- Whether you qualify for a Special Enrollment Period that allows you to change plans.
- Whether you're eligible for lower costs based on your new income, household size, or other changed information. You may become eligible for the first time, for a different amount of savings, or for new coverage through Medicaid or the Children's Health Insurance Program (CHIP). You also could become ineligible for savings – if your income has gone up, for example.

If you're eligible for a Special Enrollment Period

You'll be able to shop for a different plan in the Marketplace. You usually have 60 days from the date of the qualifying event to enroll in a new plan, or you can choose your same plan.

If you have a Special Enrollment Period, you can change plans 2 ways:

- **Online:** Visit **HealthCare.gov** and log in to your Marketplace account (or create a new account if you don't have one). Select your submitted application. Then select "Eligibility and Appeals" from the menu on the left. Next, scroll down and click the green "Continue to enrollment" button. You can shop for plans and change your selection.
- **By phone:** Contact the Marketplace Call Center at 1-800-318-2596. TTY users should call 1-855-889-4325.

If you're not eligible for a Special Enrollment Period, but the tax credit you qualify for has changed:

You can't change plans. But if your tax credit amount changes, you can choose to adjust the amount of tax credit to apply to your monthly premiums after you report your life change.

Changing your contact information

Some changes don't affect your coverage or savings, but you still need to report them to the Marketplace and also to your insurance company.

- Home address
- Email address
- Phone number

Report contact information changes to the Marketplace:

You can update the information in your Marketplace account under "My Profile." You can also contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

Report contact information changes to your insurance company:

Contact them directly. Otherwise they may not know about your new contact information.

