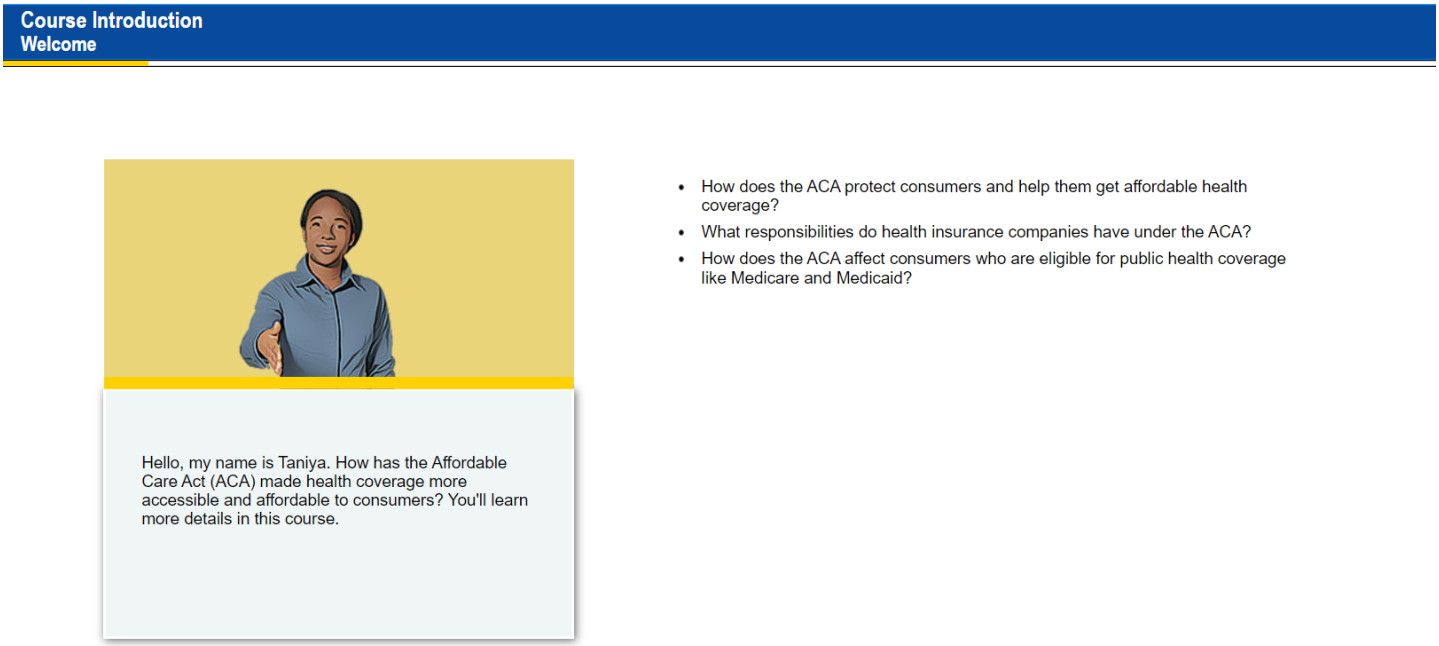
Affordable Care Act Basics

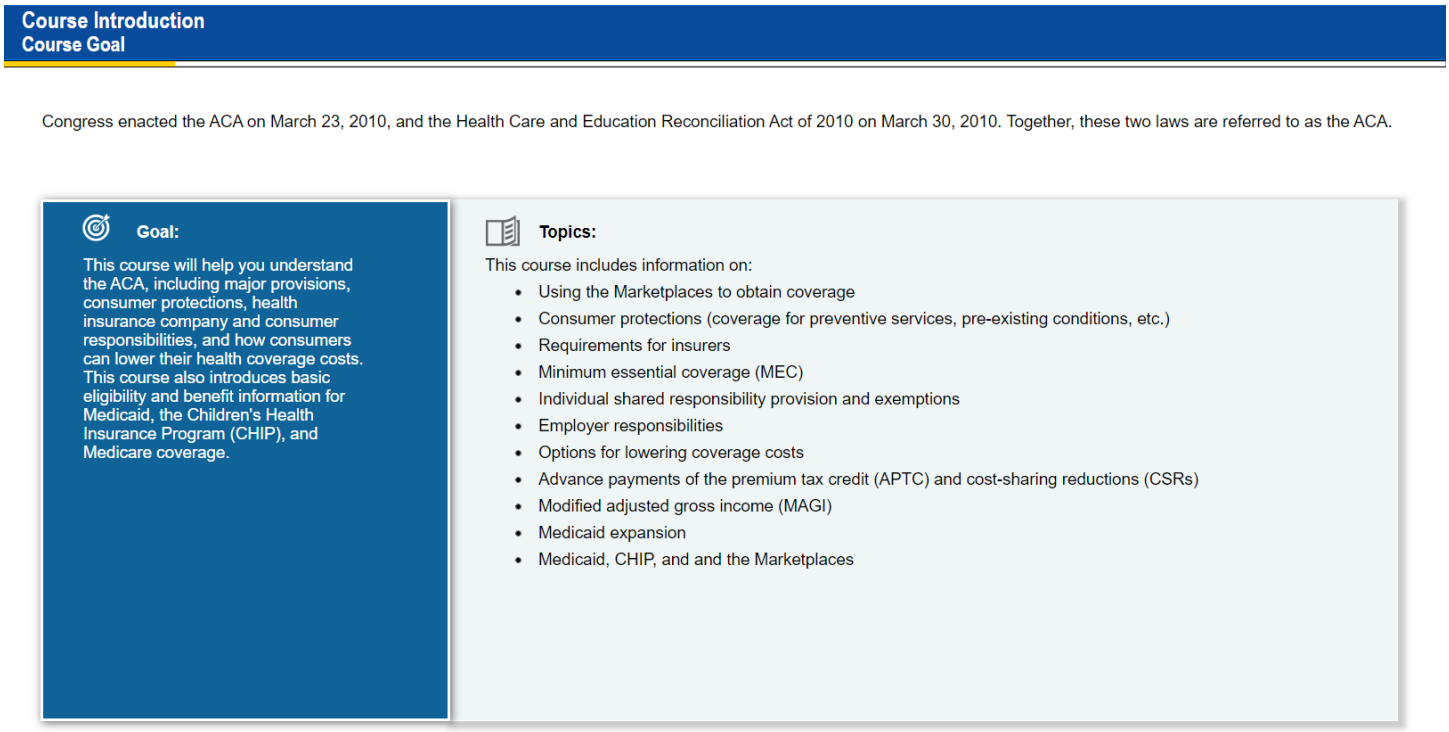
Welcome



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

- How does the ACA protect consumers and help them get affordable health coverage?
- What responsibilities do health insurance companies have under the ACA?
- How does the ACA affect consumers who are eligible for public health coverage like Medicare and Medicaid?

Course Goal



Congress enacted the ACA on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 on March 30, 2010. Together, these two laws are referred to as the ACA.

Goal:

This This course will help you understand the ACA, including major provisions, consumer protections, health insurance company and consumer responsibilities, and how consumers can lower their health coverage costs. This course also introduces basic eligibility and benefit information for Medicaid, the Children's Health Insurance Program (CHIP), and Medicare coverage.

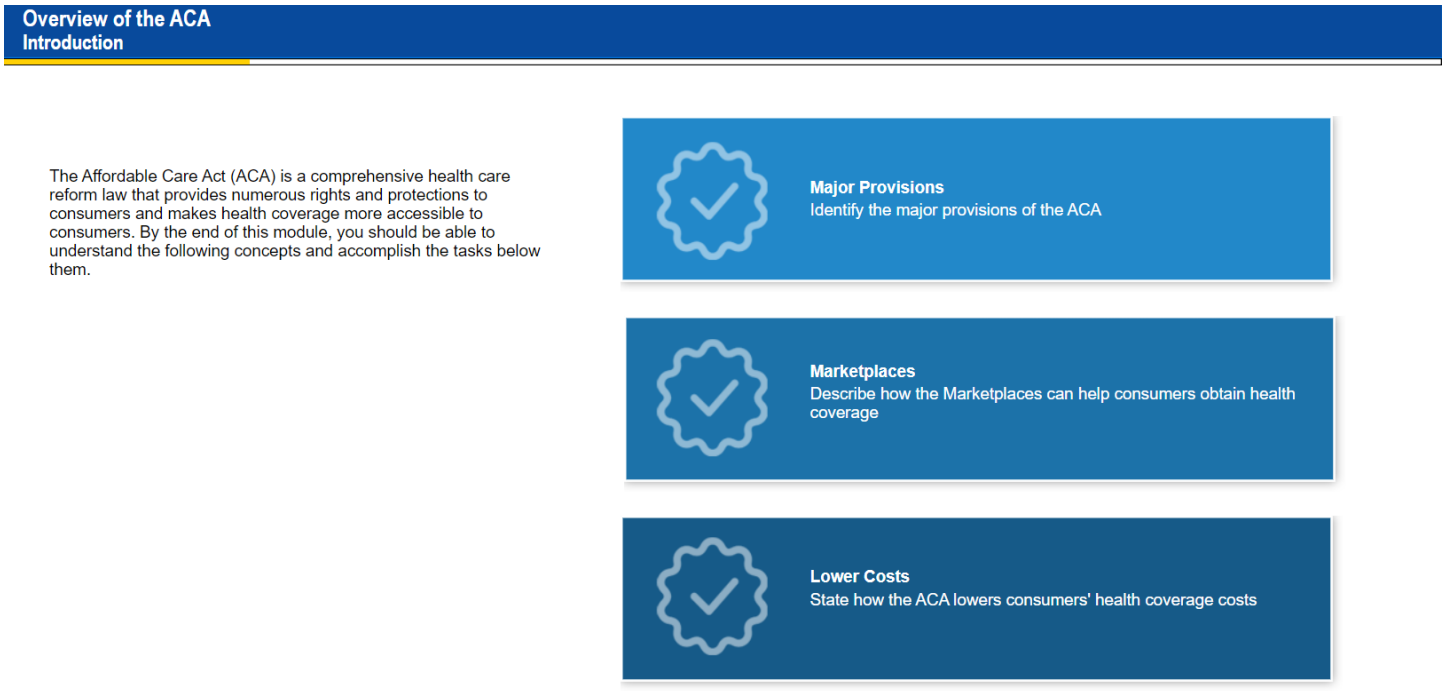
Topics:

This course includes information on:

- Using the Marketplaces to obtain coverage
- Consumer protections (coverage for preventive services, pre-existing conditions, etc.)
- Requirements for insurers
- Minimum essential coverage (MEC)
- Individual shared responsibility provision and exemptions
- Employer responsibilities
- Options for lowering coverage costs
- Advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs)
- Modified adjusted gross income (MAGI)
- Medicaid expansion
- Medicaid, CHIP, and the Marketplaces

Overview of the ACA

Introduction



The Affordable Care Act (ACA) is a comprehensive health care reform law that provides numerous rights and protections to consumers and makes health coverage more accessible to consumers. By the end of this module, you should be able to understand the following concepts and accomplish the tasks below them.

Major Provisions

Identify the major provisions of the ACA

Marketplaces

Describe how the Marketplaces can help consumers obtain health coverage

Lower Costs

State how the ACA lowers consumers’ health coverage costs

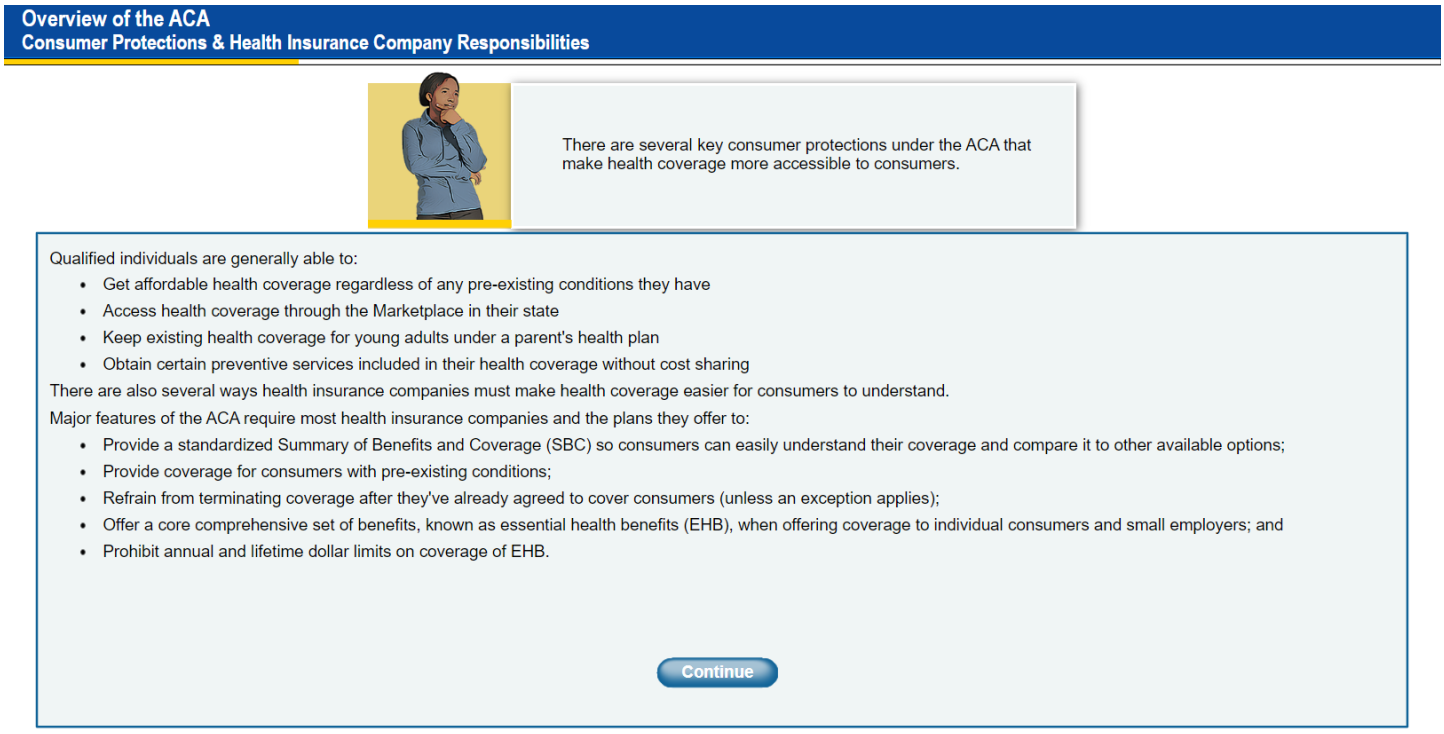
Major Provisions of the ACA

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

The law provides:

- Options for individuals, families, and small employers and their employees to enroll in health coverage
- Legal protections that help consumers get coverage— even if they're sick

Consumer Protections & Health Insurance Company Responsibilities



There are several key consumer protections under the ACA that make health coverage more accessible to consumers.

Qualified individuals are generally able to:

- Get affordable health coverage regardless of any pre-existing conditions they have
- Access health coverage through the Marketplace in their state
- Keep existing health coverage for young adults under a parent's health plan
- Obtain certain preventive services included in their health coverage without cost sharing

There are also several ways health insurance companies must make health coverage easier for consumers to understand.

Major features of the ACA require most health insurance companies and the plans they offer to:

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

The following table explains the changes to consumer protections and health insurance company responsibilities under the ACA.

Provision	Before the ACA	Under the ACA
Preventive services	Consumers with health coverage generally paid a copayment or other cost sharing amount for common preventive health care services.	Most health plans — whether offered inside or outside of the Marketplaces — must cover certain recommended preventive services (e.g., annual physicals, vaccines, and mammograms) without cost sharing.
Dollar limits on EHB	Federal law didn't prohibit health insurance companies from setting lifetime or annual dollar limits on the benefits they covered under their plans. After a consumer reached their annual or lifetime dollar limit, plans would no longer pay for covered services.	Health insurance companies generally can't set dollar limits on what they spend for coverage of EHB, either during the course of the plan year or over the entire period of time that consumers are enrolled in the plan. However, health insurance companies can still set lifetime or annual dollar limits on what they will spend on covered benefits that aren't EHB.
Pre-existing conditions Pre-existing conditions are health problems (e.g., diabetes or cancer) that started before an individual's health insurance went into effect.	Federal law generally didn't prohibit health insurance companies from denying health coverage to consumers in the individual market based on pre-existing conditions.	The ACA guarantees that consumers with pre-existing conditions can apply for and purchase health insurance if they're otherwise eligible. Consumers may generally renew an existing policy regardless of their health status. Health insurance companies can no longer refuse to sell coverage to consumers with pre-existing conditions or charge more for that coverage.
Coverage cancellation	Federal law didn't prohibit health insurance companies from retroactively canceling consumers' coverage because of mistakes on their applications.	Insurers can only cancel a consumer's coverage retroactively if the consumer committed fraud and/or made an intentional misrepresentation of material fact. Unless an exception applies, health insurance companies must also refrain from canceling consumers' coverage as long as any premiums are paid.
Coverage for young adults	States could limit how long young adults were allowed to remain enrolled in coverage through a parent's health insurance plan.	The ACA generally requires issuers in all states to allow children and young adults up to age 26 to stay on their parents' health insurance plans (if the plans cover dependent children).

Provision	Before the ACA	Under the ACA
Explanation of benefits and coverage	Health insurance companies weren't required by federal law to explain the benefits and cost of coverage to consumers in ways that were clear and easy to understand.	Health insurance companies are now required to provide clear, consistent, and comparable information about consumers' health benefits and coverage by providing a standard SBC for each plan they offer, free of charge. Each plan's SBC must be written and presented in a standard format and use basic terms. Health insurance companies must also provide consumers with a uniform glossary of commonly used terms.

Lifetime dollar limits

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

Annual dollar limits

Annual dollar limits are dollar limits on what plans will pay for covered benefits over the course of the plan year.

Parents' health insurance plan

- For plans purchased through the Marketplace, issuers must cover dependent children until the end of the plan year (e.g., December 31) in which they turn 26 (or the maximum age under state law). If a household with a dependent child who has reached age 26 qualifies for a Special Enrollment Period (SEP) after the child turns 26, the dependent child’s coverage will be terminated, and they will be enrolled into their own policy.
- For plans purchased outside the Marketplace, coverage usually ends when the dependent turns 26. Consumers should check with their plans to be sure. Some states and plans have different rules.

Knowledge Check

Overview of the ACA
Knowledge Check

The ACA provides consumers with several rights and protections. Which of the following is **NOT** a right or protection included in the ACA? Select the correct answer and then select **Check Your Answer**.

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

Check Your Answer

Correct!
Under the ACA, consumers who have pre-existing conditions can't be sold health coverage that excludes their pre-existing conditions. In addition, the law requires most health plans to cover certain preventive health services without cost sharing to consumers— including annual physicals. The ACA requires most plans that offer dependent child coverage to allow children and dependents to be covered under their parents' plans up to age 26 (for Marketplace plans, through December 31 of the year they turn 26) or other allowable age as defined by the plan or state.

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Answer: Under the ACA, consumers who have pre-existing conditions can't be sold health coverage that excludes their pre-existing conditions. In addition, the law requires most health plans to cover certain preventive health services without cost sharing to consumers— including annual physicals. The ACA requires most plans that offer dependent child coverage to allow children and dependents to be covered under their parents' plans up to age 26 (for Marketplace plans, through December 31 of the year they turn 26) or other allowable age as defined by the plan or state.

Knowledge Check

Overview of the ACA
Knowledge Check

Health insurance companies have certain responsibilities under the ACA. Which of the following is NOT a responsibility for health insurance companies included in the ACA? Select the correct answer and then select **Check Your Answer**.

- A. Nearly all health plans sold to individuals or small employers must cover a core comprehensive package of services known as EHB.
- B. Health insurance companies must provide clear, consistent, and comparable information about consumers' health benefits and coverage.
- C. Insurers must monitor and cancel consumers' coverage retroactively if information in consumers' Marketplace applications is incorrect.
- D. Health insurance companies generally can't set dollar limits on what they spend for coverage of EHB.

Check Your Answer

Correct!
Under the ACA, nearly all health plans sold to individuals or small employers must cover a core comprehensive package of items and services known as EHB. Insurers must provide clear, consistent, and comparable information about consumers' health benefits and coverage, and they generally can't set dollar limits on what they spend for coverage of EHB. Insurers can only cancel a consumer's coverage retroactively if the consumer committed fraud or if the consumer made an intentional misrepresentation of material fact.

Health insurance companies have certain responsibilities under the ACA. Which of the following is NOT a responsibility for health insurance companies included in the ACA?

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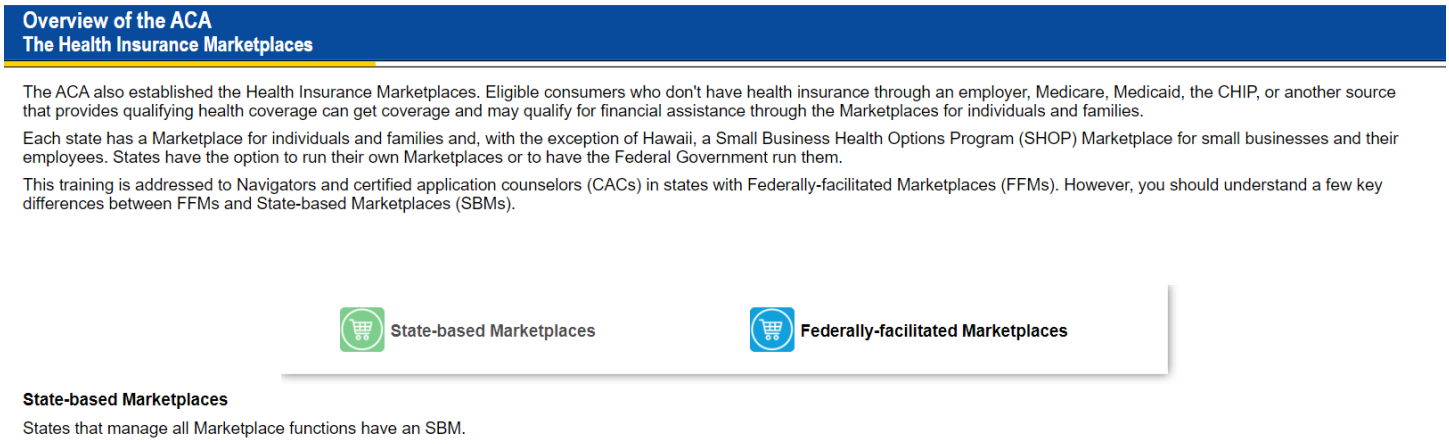
The Health Insurance Marketplaces



The ACA also established the Health Insurance Marketplaces. Eligible consumers who don’t have health insurance through an employer, Medicare, Medicaid, the CHIP, or another source that provides qualifying health coverage can get coverage and may qualify for financial assistance through the Marketplaces for individuals and families.

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

This training is addressed to Navigators and certified application counselors (CACs) in states with Federally-facilitated Marketplaces (FFMs). However, you should understand a few key differences between FFMs and State-based Marketplaces (SBMs).

State-based Marketplaces

States that manage all Marketplace functions have an SBM.

Federally-facilitated Marketplaces

States that choose to have the Federal Government manage all Marketplace functions have an FFM. In some FFMs, states choose to oversee or regulate plan management functions. Some states with an individual market FFM operate their own SHOP Marketplace. Others have a Federally-facilitated SHOP Marketplace (FF-SHOP). Some states operate a State-based Marketplace on the Federal Platform (SBM-FP) which are like SBMs, but they rely on the Department of Health and Human Services (HHS) to perform certain Marketplace functions, particularly eligibility and enrollment, while still retaining responsibility to perform certain Marketplace functions like qualified health plan (QHP) certification and consumer outreach and assistance functions. SBM-FPs are required to operate a SHOP; however, some SBM-FPs rely on the FF-SHOP on an interim basis as they transition to full SBMs (e.g., Veterans Affairs (VA)).

SHOP Marketplaces

Overview of the ACA
SHOP Marketplaces

Although this course generally focuses on the Marketplaces for individuals and families, it is also important for you to know some basic details about SHOP Marketplaces. You should be able to explain how both types of Marketplaces can function together within a state.

Small employers in states with an FF-SHOP can use the SHOP website to:

- Learn about the benefits of SHOP, including the availability of tax credits for qualified employers;
- Compare available medical and dental plans side by side using the SHOP See Plans and Prices tool; and
- Submit SHOP employer applications and obtain eligibility determinations.

In addition, small employers can contact the SHOP Call Center for any questions or assistance related to submitting employer applications for SHOP coverage.

The Marketplaces for individuals and families and the SHOP Marketplaces perform some of the same core functions, like allowing consumers to compare available medical and dental plans side by side. However, there are some key differences.

Marketplaces for Individuals and Families	SHOP Marketplaces
Collect and verify eligibility information from consumers and their families.	Collect eligibility information from small employers.
Consumers and their families may qualify for APTC and CSRs to help lower their costs. They can also be assessed or determined eligible for Medicaid and CHIP.	APTC and CSRs aren't available to lower the cost of health coverage to persons enrolled through the SHOP Marketplaces, but certain small employers may qualify for small business health care tax credits.
Verify all consumer information, including immigration status.	Don't review or verify citizenship or immigration status since employers are required to determine whether their employees have legal work status.
Consumers can apply for health coverage through the Marketplaces for individuals and families during the individual market Open Enrollment Period (OEP). For the 2024 plan year, Open Enrollment starts November 1, 2023, and ends January 15, 2024. Outside of the OEP, consumers may qualify for a Special Enrollment Period (SEP) to enroll in a Marketplace plan, or they can apply for free or low-cost coverage through Medicaid and CHIP at any time.	Employers can generally purchase SHOP Marketplace small group coverage during any month of the year. Qualified employers and employees can purchase coverage in SHOP plans by working with a QHP issuer or SHOP-registered agent or broker. Employers can obtain an eligibility determination from a SHOP Marketplace.
More information about the Marketplaces for individuals and families.	More information about the SHOP Marketplaces.

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Marketplaces for Individuals and Families	SHOP Marketplaces
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Verify all consumer information, including immigration status.	Don’t review or verify citizenship or immigration status since employers are required to determine whether their employees have legal work status.
Consumers can apply for health coverage through the Marketplaces for individuals and families during the individual market Open Enrollment Period (OEP).	Employers can generally purchase SHOP Marketplace small group coverage during any month of the year. Qualified employers and employees can

Marketplaces for Individuals and Families	SHOP Marketplaces
For the 2024 plan year, Open Enrollment starts November 1, 2023, and ends January 15, 2024. Outside of the OEP, consumers may qualify for a Special Enrollment Period (SEP) to enroll in a Marketplace plan, or they can apply for free or low-cost coverage through Medicaid and CHIP at any time.	purchase coverage in SHOP plans by working with a QHP issuer or SHOP-registered agent or broker. Employers can obtain an eligibility determination from a SHOP Marketplace.
More information about the Marketplaces for individuals and families.	More information about the SHOP Marketplaces.

Small Employers

Generally, a small employer is one that:

- Employed 1 to 50 (100 in some states) full-time and full-time-equivalent (FTE) employees, on average, on business days during the preceding calendar year, and
- Employs at least one employee on the first day of the plan year.

Participating employers determine the share of premium costs they will cover for their employees.

You can find more information about small employers and their options at HealthCare.gov/small-businesses/employers.

QHP

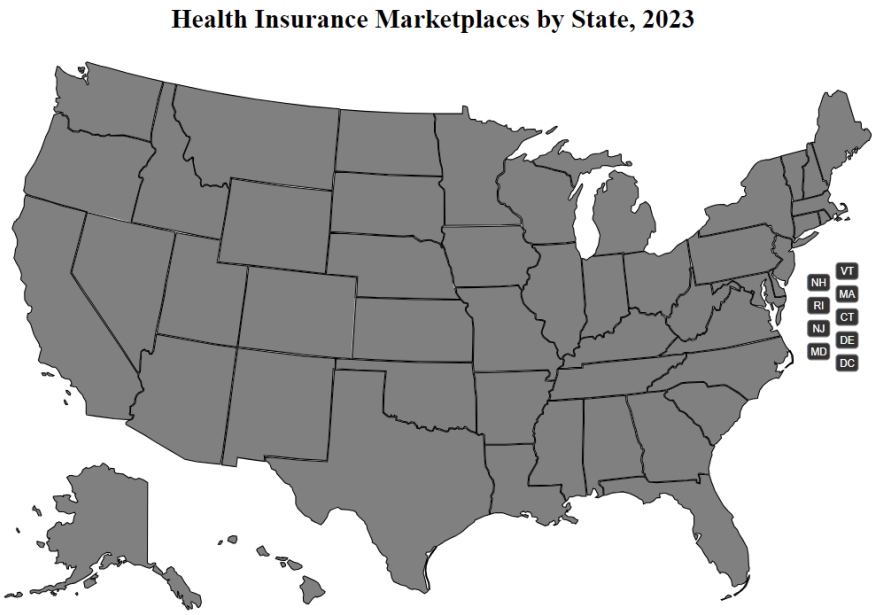
An employee with an offer of coverage through a SHOP Marketplace may instead choose to enroll in a QHP through a Marketplace for individuals and families and may also qualify for APTC and CSRs if the following conditions apply:

1. The employee hasn't enrolled in the SHOP coverage offered by their employer, **AND**
2. The employer's offer isn't considered affordable (more than 9.12% of an employee's household income in 2023), **OR**
3. The employer's offer doesn't meet minimum value.

2024 Marketplace Information by State

Overview of the ACA
2024 Marketplace Information by State

You can find important characteristics about your state's Marketplace by selecting your state in the "Marketplaces by State" map. We encourage you to record your state's information and store it for easy access, but you can access this map at any time by selecting the **Map tab** in the course **Menu**.



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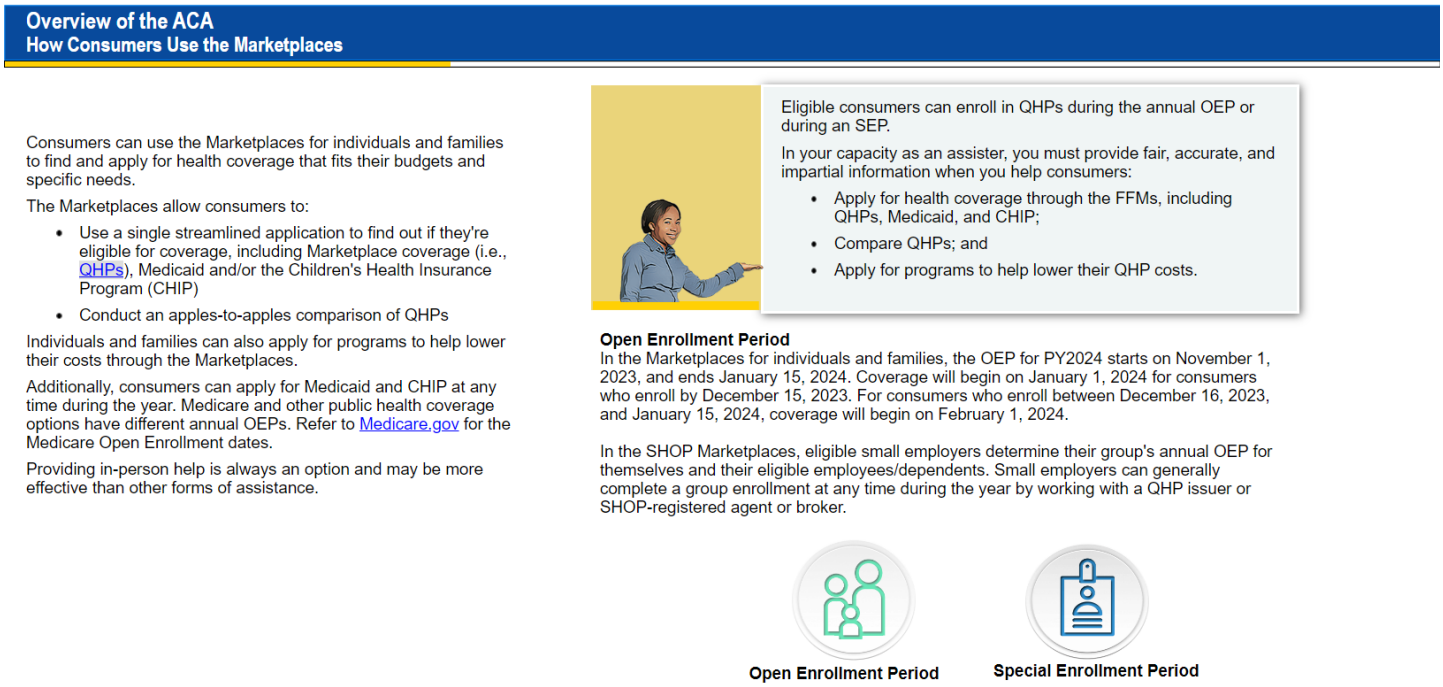
How Consumers Use the Marketplaces



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

The Marketplaces allow consumers to:

- Use a single streamlined application to find out if they're eligible for coverage, including Marketplace coverage (i.e., QHPs), Medicaid and/or the Children’s Health Insurance Program (CHIP)
- Conduct an apples-to-apples comparison of QHPs

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

QHPs

- Under the ACA, a health insurance plan that’s certified by a Marketplace is called a QHP. A QHP:
- Provides EHB, including certain recommended preventive services that are covered with no additional out-of-pocket cost to the consumer,
- Follows established limits on cost sharing (e.g., deductibles, copayments, coinsurance, and out-of-pocket maximum amounts) and meets other requirements,
- Must be certified by each Marketplace in which it is sold, and
- Meets other requirements.

Eligible consumers can enroll in QHPs during the annual OEP or during an SEP.

Open Enrollment Period

In the Marketplaces for individuals and families, the OEP for Plan Year (PY) 2024 starts on November 1, 2023, and ends January 15, 2024. Coverage will begin on January 1, 2024 for consumers who enroll by December 15, 2023. For consumers who enroll between December 16, 2023, and January 15, 2024, coverage will begin on February 1, 2024.

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

Special Enrollment Period

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

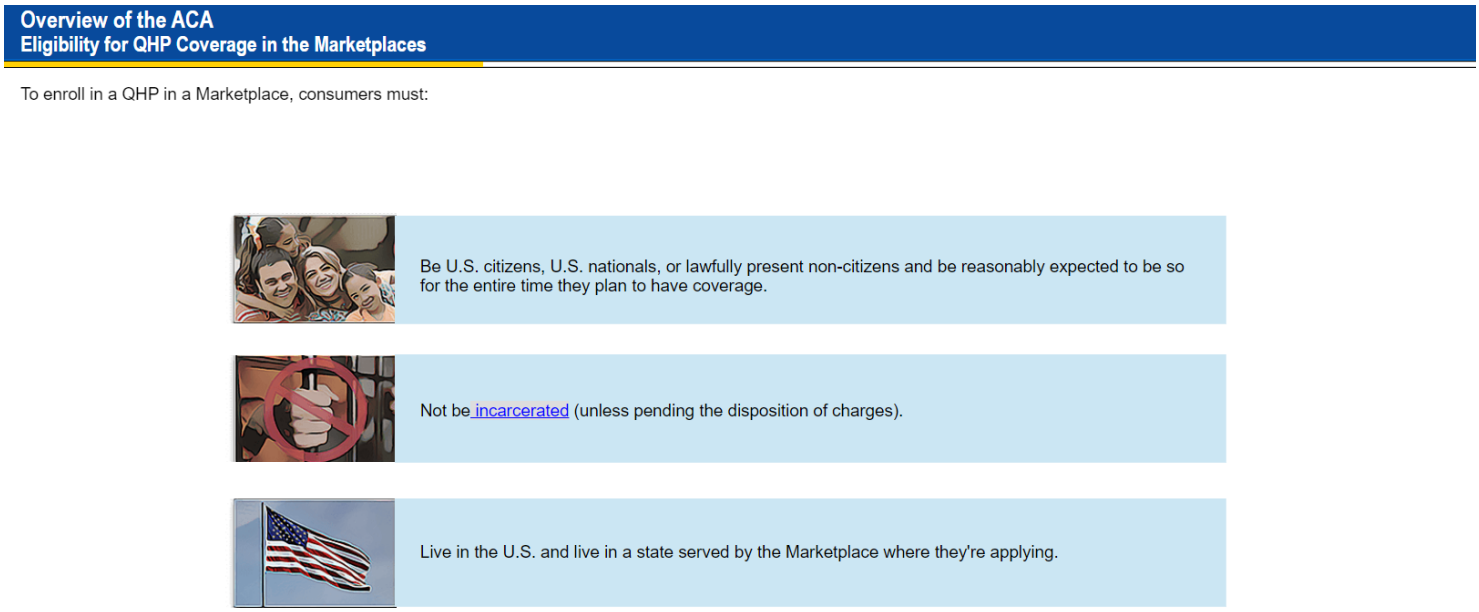
Additionally, consumers can apply for Medicaid and CHIP at any time during the year. Medicare and other public health coverage options have different annual OEPs. Refer to Medicare.gov for the Medicare Open Enrollment dates.

Providing in-person help is always an option and may be more effective than other forms of assistance.

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

- Apply for health coverage through the FFMs, including QHPs, Medicaid, and CHIP;
- Compare QHPs; and
- Apply for programs to help lower their QHP costs.

Eligibility for QHP Coverage in the Marketplaces



To enroll in a QHP in a Marketplace, consumers must:

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

Incarcerated

For purposes of the Marketplace, "incarcerated" means serving a term in prison or jail.

- Incarceration doesn't mean living at home or in a residential facility under supervision of the criminal justice system or living there voluntarily. In other words, incarceration doesn't include being on probation, parole, or home confinement.
- A person isn't considered incarcerated if they're in jail or prison pending disposition of charges – in other words, being held but not convicted of a crime.

Essential Health Benefits

Overview of the ACA
Essential Health Benefits

The ACA requires most types of health coverage to offer EHB, including:

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

A note about dental coverage:

- Routine adult dental coverage isn't considered an essential health benefit, and most QHPs don't offer it; however, consumers may be able to purchase stand-alone dental plans in the FFMs.
- The FFMs must offer pediatric dental care either as part of QHP coverage or through stand-alone dental plans; however, consumers aren't required to buy dental insurance for their dependent children.

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

EHB

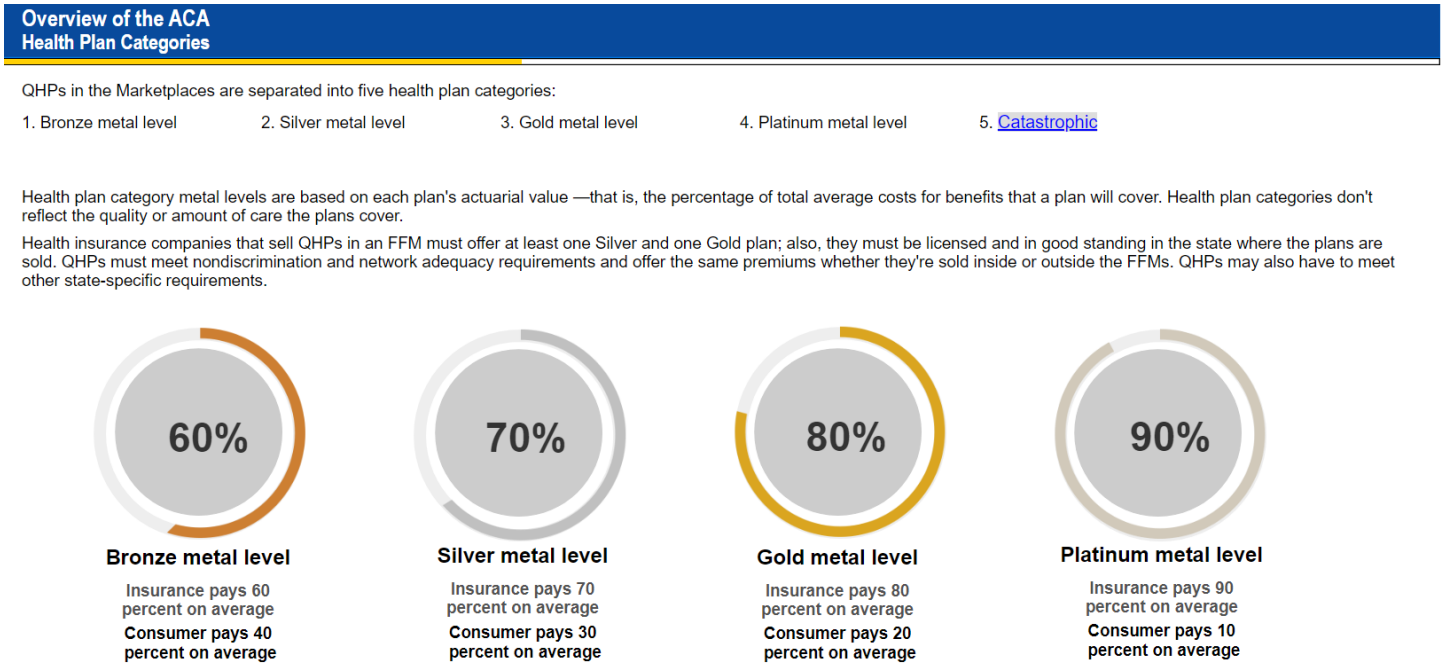
There are 10 categories of EHB that all QHPs must include:

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

A note about dental coverage:

- Routine adult dental coverage isn't considered an essential health benefit, and most QHPs don't offer it; however, consumers may be able to purchase stand-alone dental plans in the FFMs.
- The FFMs must offer pediatric dental care either as part of QHP coverage or through stand-alone dental plans; however, consumers aren’t required to buy dental insurance for their dependent children.

Health Plan Categories



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

1. Bronze metal level
2. Silver metal level
3. Gold metal level
4. Platinum metal level
5. Catastrophic

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

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

Bronze metal level: 60% actuarial value

Insurance pays 60 percent on average

Consumer pays 40 percent on average

Silver metal level: 70% actuarial value

Insurance pays 70 percent on average

Consumer pays 30 percent on average

Gold metal level: 80% actuarial value

Insurance pays 80 percent on average

Consumer pays 20 percent on average

Platinum metal level: 90% actuarial value

Insurance pays 90 percent on average

Consumer pays 10 percent on average

*The percentage a consumer pays for benefits under plans in each health plan category is an “average” for a typical population. These percentages don’t necessarily reflect the exact amount a consumer will pay for a particular service when using a specific plan.

Catastrophic health insurance plans

Catastrophic plans are only available to individual market consumers under age 30 or consumers age 30 or older who qualify for a hardship or affordability exemption (e.g., a life situation that may prevent them from affording health insurance coverage, like a flood or natural disaster). For PY 2024, individuals can be eligible for an affordability exemption if the amount they would pay for minimum essential coverage exceeds 7.97 percent of their annual household income. Catastrophic plans protect consumers from very high medical costs by only providing coverage when they need a lot of care. However, they do cover certain preventive services with no cost sharing and also cover at least three primary care visits per year before the deductible is met. Generally, Catastrophic plans have lower premiums than the other health plan categories, but consumers are responsible for higher cost sharing amounts. Consumers can’t use APTC and CSRs to lower the costs of a Catastrophic plan like they can with other health plan categories.

Overview of the ACA
HealthCare.gov

Consumers can learn more about the ACA and the Health Insurance Marketplaces at HealthCare.gov, including information like:

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

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

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

The Marketplaces and other Marketplace-related resources are covered in detail in other training courses.

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- Types of health coverage available,
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Knowledge Check

Overview of the ACA
Knowledge Check

Susan, a freelance beautician, comes to you to find out how the ACA can help her enroll in health coverage. Which of the following do you tell her? Select the two correct answers and then select **Check Your Answer**.

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

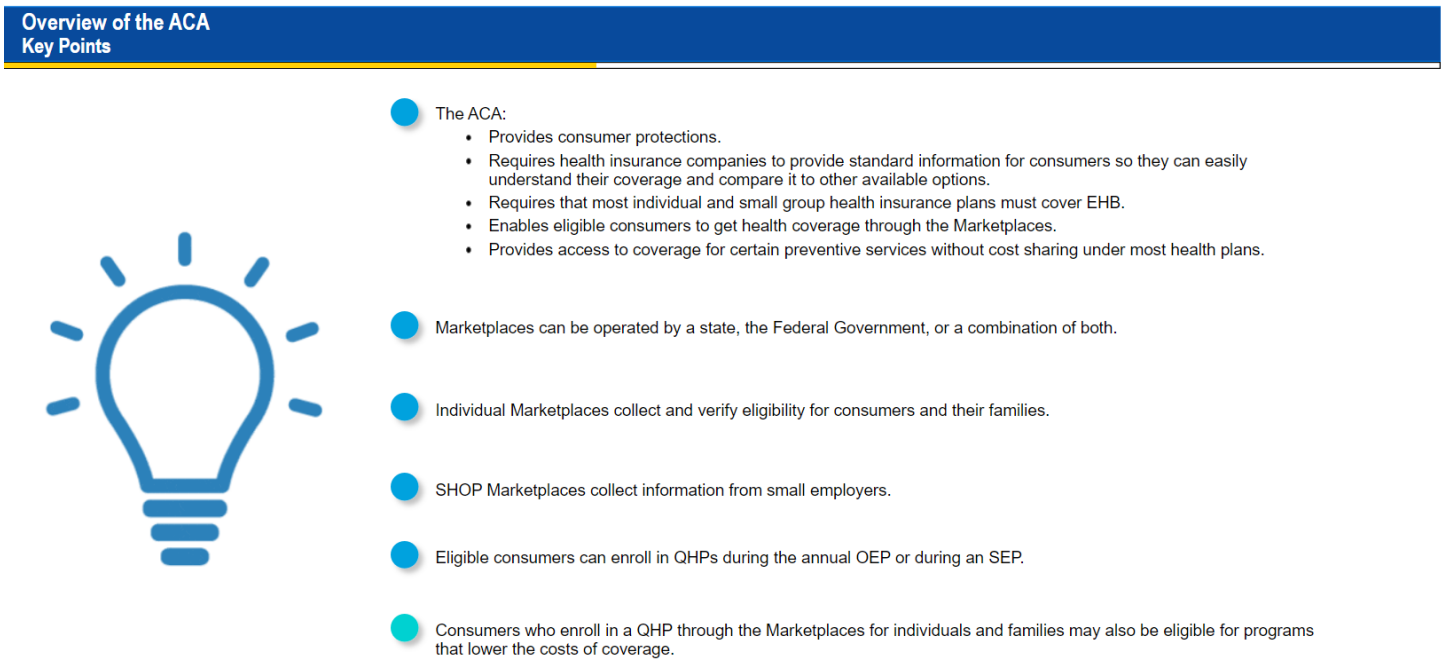
Check Your Answer

Correct!
The ACA allows consumers to compare QHPs and enroll in health coverage through the Marketplaces if they're eligible. For individual market coverage starting in 2024, Open Enrollment starts November 1, 2023, and ends January 15, 2024. Consumers may qualify for SEPs if they experience certain life events.

Susan, a freelance beautician, comes to you to find out how the ACA can help her enroll in health coverage. What do you tell her about her health care coverage choices?

Answer: The ACA allows consumers to compare QHPs and enroll in health coverage through the Marketplaces if they're eligible. For individual market coverage starting in 2024, Open Enrollment starts November 1, 2023, and ends January 15, 2024. Consumers may qualify for SEPs if they experience certain life events.

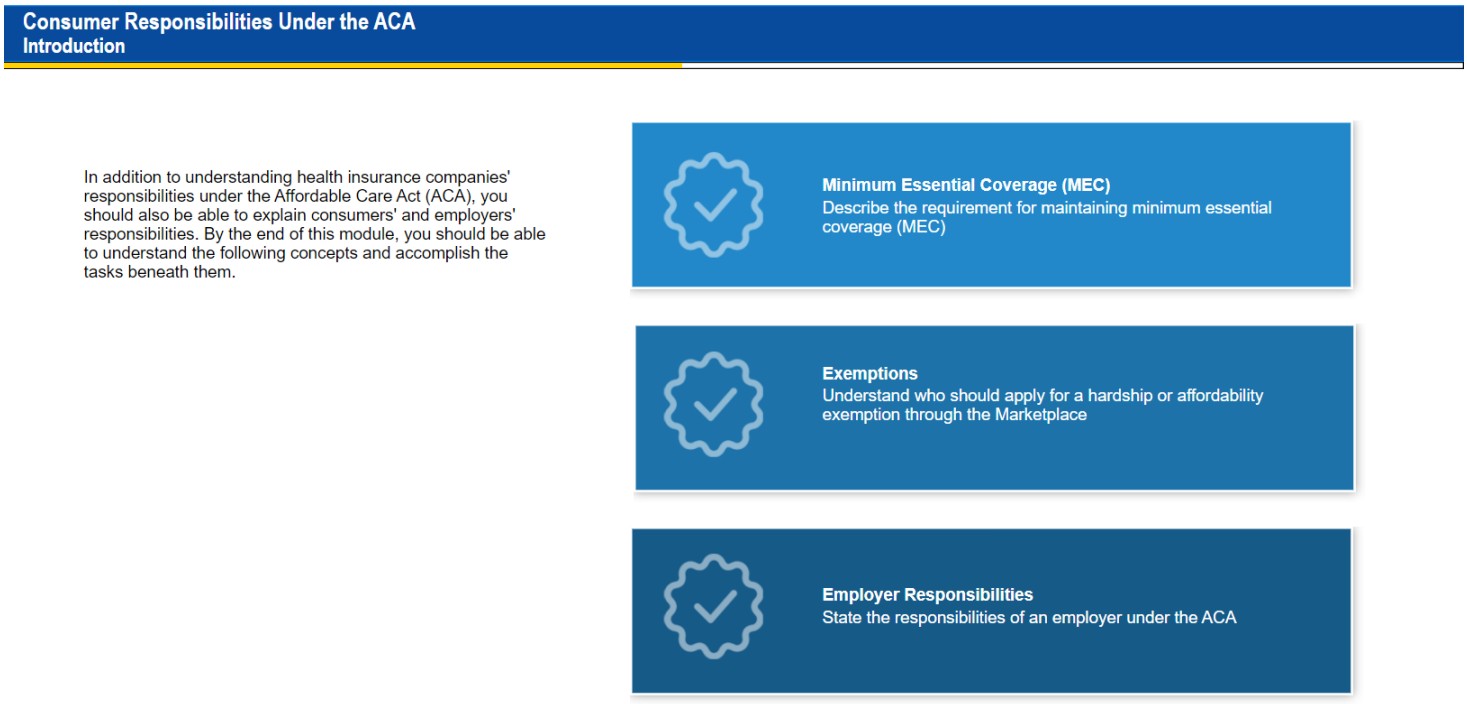
Key Points



- The ACA:
  - Provides consumer protections.
  - Requires health insurance companies to provide standard information for consumers so they can easily understand their coverage and compare it to other available options.
  - Requires that most individual and small group health insurance plans must cover EHB.
  - Enables eligible consumers to get health coverage through the Marketplaces.
  - Provides access to coverage for certain preventive services without cost sharing under most health plans.
- Marketplaces can be operated by a state, the Federal Government, or a combination of both.
- Individual Marketplaces collect and verify eligibility for consumers and their families.
- SHOP Marketplaces collect information from small employers.
- Eligible consumers can enroll in QHPs during the annual OEP or during an SEP.
- Consumers who enroll in a QHP through the Marketplaces for individuals and families may also be eligible for programs that lower the costs of coverage.

Consumer Responsibilities Under the Affordable Care Act (ACA)

Introduction



In addition to understanding health insurance companies' responsibilities under the Affordable Care Act (ACA), you should also be able to explain consumers' and employers' responsibilities. By the end of this module, you should be able to understand the following concepts and accomplish the tasks beneath them.

Minimum Essential Coverage (MEC)

Describe the requirement for maintaining minimum essential coverage (MEC)

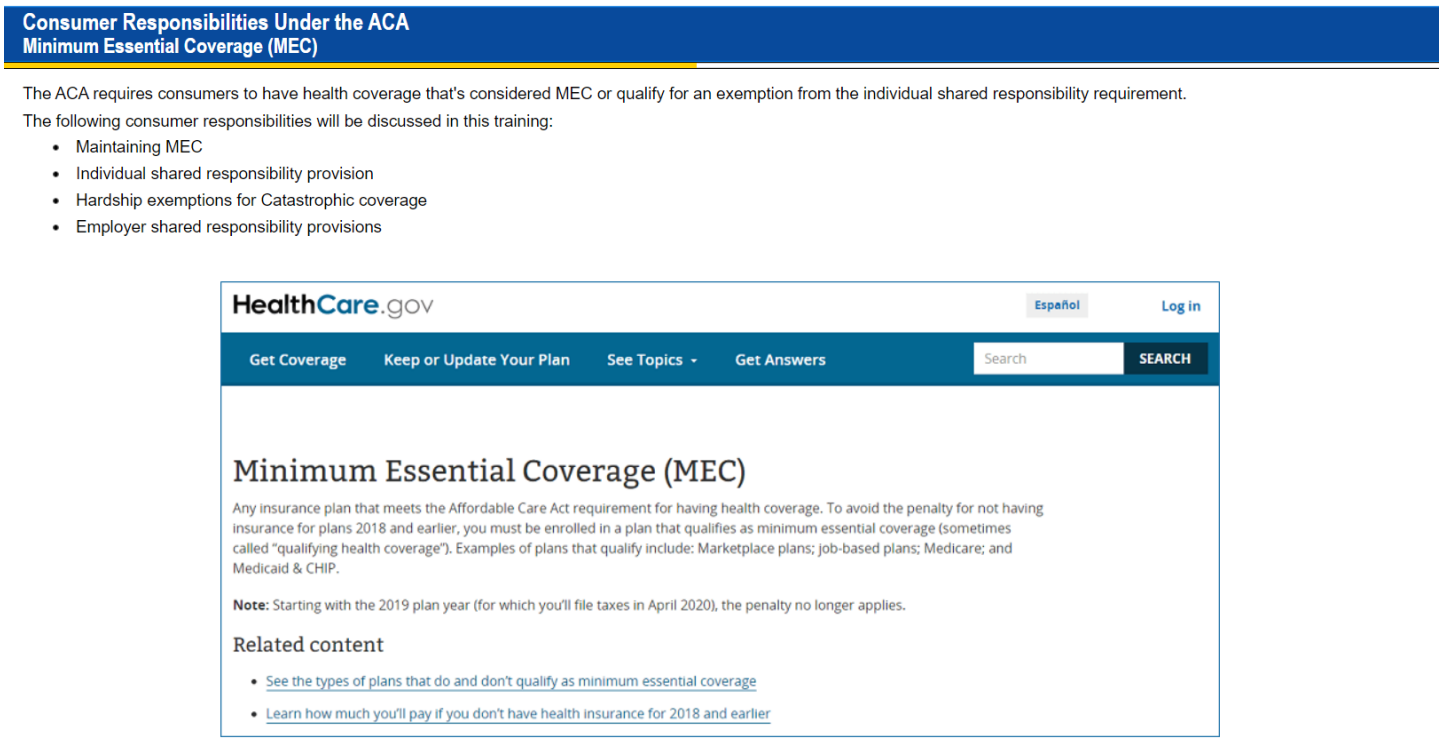
Exemptions

Understand who should apply for a hardship or affordability exemption through the Marketplace

Employer Responsibilities

State the responsibilities of an employer under the ACA

Minimum Essential Coverage (MEC)

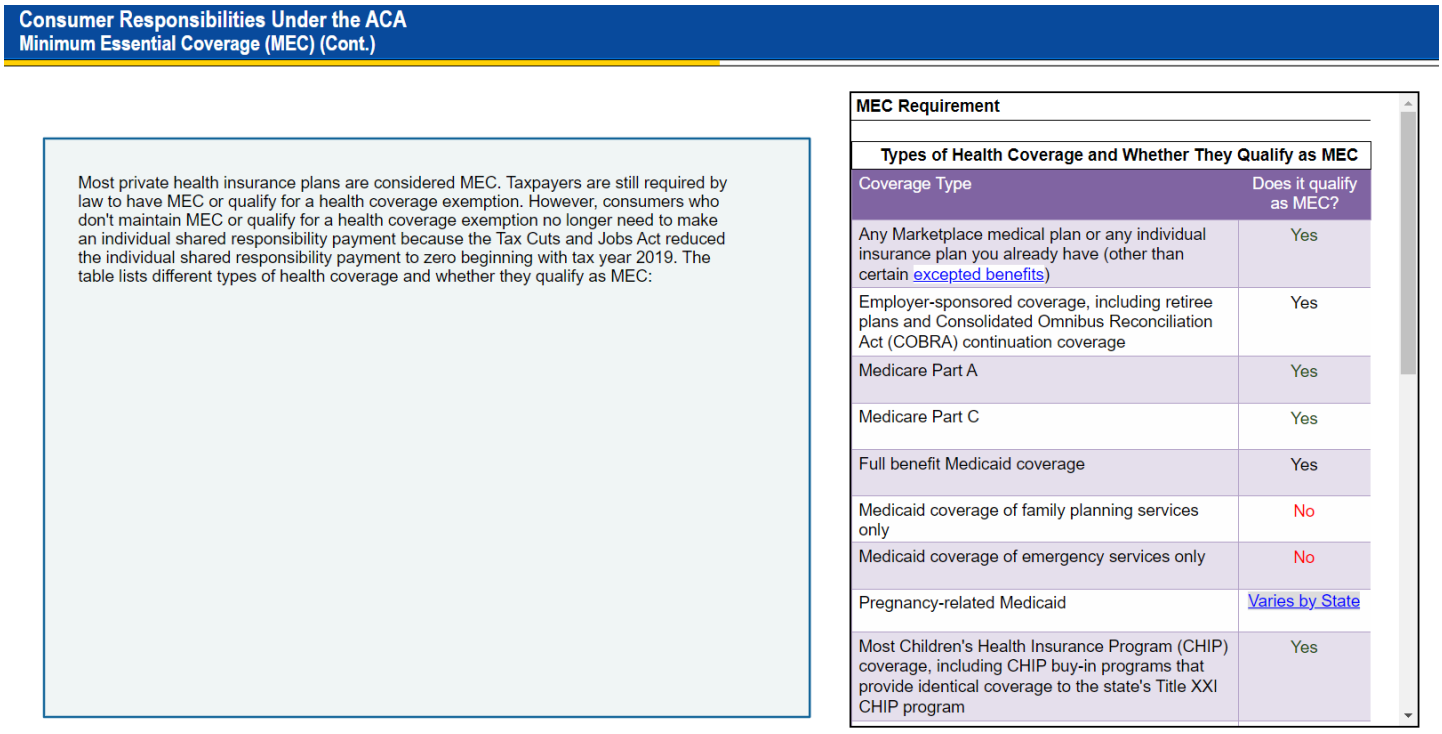


The ACA requires consumers to have health coverage that's considered MEC or qualify for an exemption from the individual shared responsibility requirement.

The following consumer responsibilities will be discussed in this training:

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

Minimum Essential Coverage (MEC) (Continued)



Most private health insurance plans are considered MEC. Taxpayers are still required by law to have MEC or qualify for a health coverage exemption. However, consumers who don't maintain MEC or qualify for a health coverage exemption no longer need to make an individual shared responsibility payment because the Tax Cuts and Jobs Act reduced the individual shared responsibility payment to zero beginning with tax year 2019. The table lists different types of health coverage and whether they qualify as MEC:

MEC Requirement

Types of Health Coverage and Whether They Qualify as MEC

Coverage Type	Does it qualify as MEC?
Any Marketplace medical plan or any individual insurance plan you already have (other than certain excepted benefits)	Yes
Employer-sponsored coverage, including retiree plans and Consolidated Omnibus Reconciliation Act (COBRA) continuation coverage	Yes
Medicare Part A	Yes
Medicare Part C	Yes
Full benefit Medicaid coverage	Yes
Medicaid coverage of family planning services only	No
Medicaid coverage of emergency services only	No
Pregnancy-related Medicaid	Varies by state
Most CHIP coverage, including CHIP buy-in programs that provide identical coverage to the state's Title XXI CHIP program	Yes
Most individual health plans bought outside the Marketplace, including grandfathered plans (not all plans sold outside the Marketplace qualify as MEC)	Yes
Coverage under a parent's plan (that qualifies as MEC)	Yes

Coverage Type	Does it qualify as MEC?
Self-funded health coverage offered to students by universities for plan or policy years that started on or before December 31, 2014 (after 2014, check with the university to see if the plan qualifies as MEC)	Yes
Health coverage for Peace Corps volunteers	Yes
Certain types of veterans' health coverage through the VA	Yes
Most TRICARE plans	Yes
Department of Defense Non-appropriated Fund Health Benefits Program	Yes
Refugee Medical Assistance	Yes
State high-risk pools for plan or policy years that started on or before December 31, 2014 (check with the high-risk pool plan to see if it qualifies as MEC)	Yes
Coverage only for vision care or dental care	No
Workers' compensation	No
Coverage only for a specific disease or condition	No
Plans that offer only discounts on medical services	No

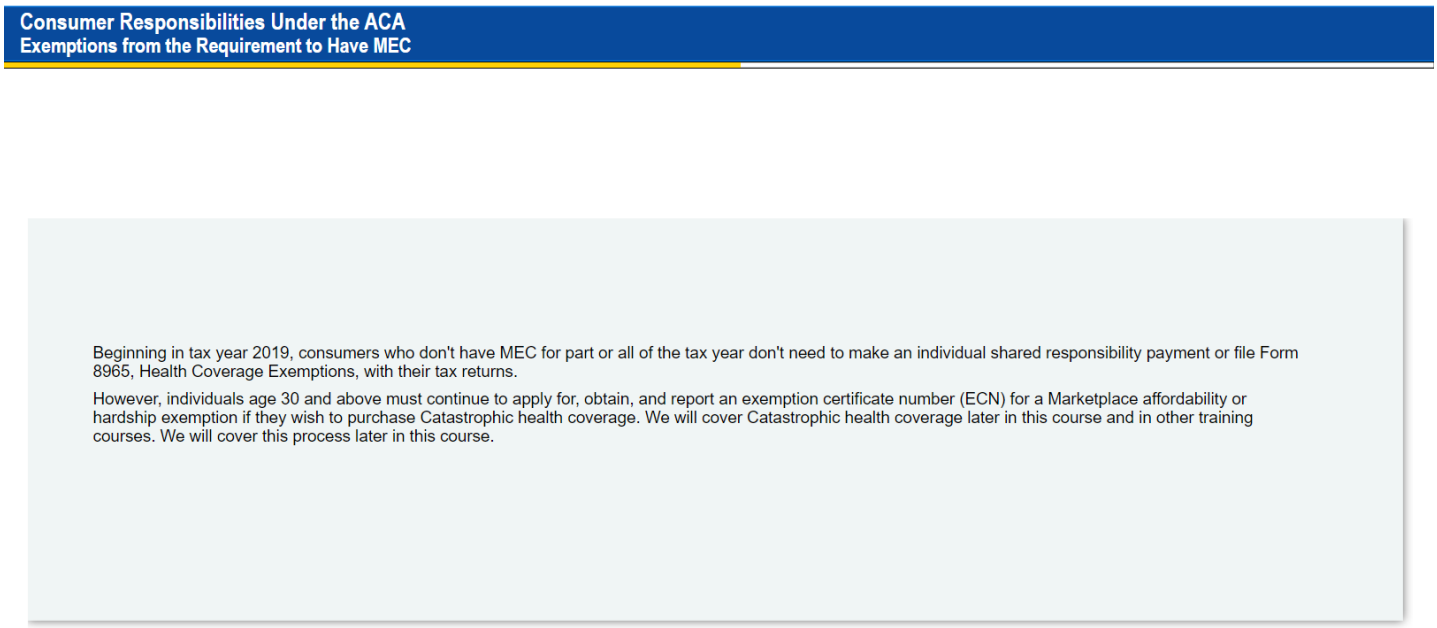
Excepted benefits

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

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

Medicaid coverage for pregnant individuals is considered MEC if it consists of or is equivalent to full Medicaid benefits. The Department of Health and Human Services (HHS) maintains a list of state-by-state MEC designations for such coverage at Medicaid.gov/sites/default/files/2020-01/state-mec-designations.pdf

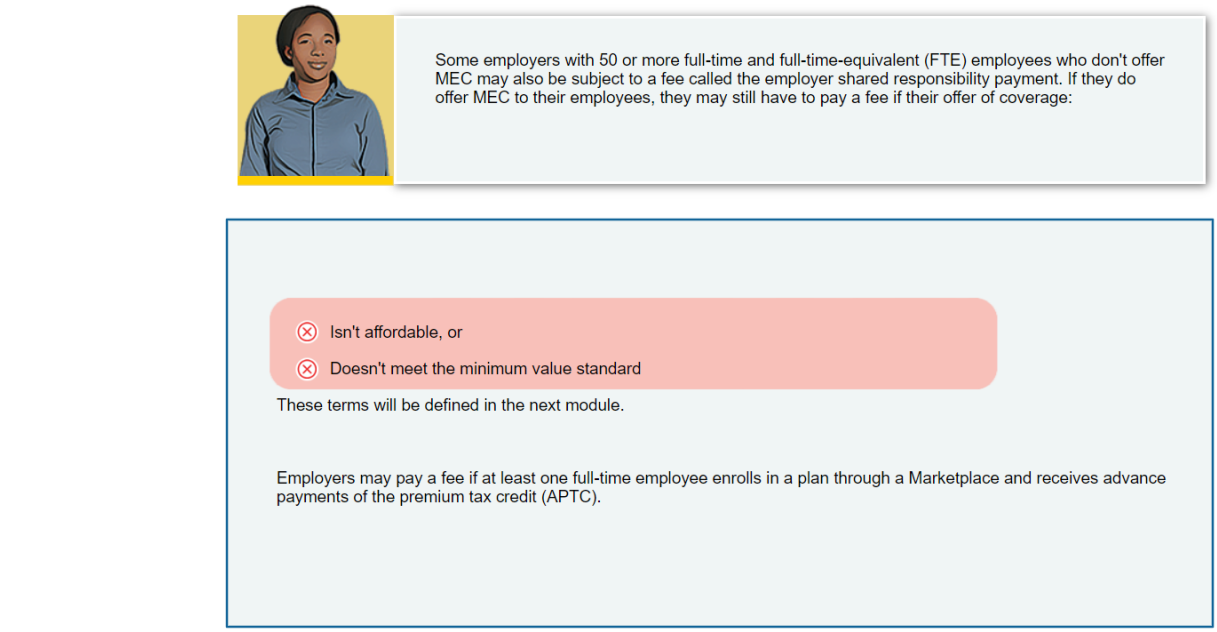
Exemptions from the Requirement to Have MEC



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

However, individuals age 30 and above must continue to apply for, obtain, and report an exemption certificate number (ECN) for a Marketplace affordability or hardship exemption if they wish to purchase Catastrophic health coverage. We will cover this process later in this course.

Employer Shared Responsibility Payment



Some employers with 50 or more full-time and full-time-equivalent (FTE) employees who don't offer MEC may also be subject to a fee called the employer shared responsibility payment. If they do offer MEC to their employees, they may still have to pay a fee if their offer of coverage:

- Isn’t affordable, or
- Doesn’t meet the minimum value standard

These terms will be defined in the next module.

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

Knowledge Check

Consumer Responsibilities Under the ACA
Knowledge Check

Jackie is a 28-year-old freelance writer who earned more than $50,000 in 2023. However, she didn't enroll in a qualified health plans (QHPs) or obtain MEC for the year. Jackie is concerned because she heard that she'll have to pay a fee. Which of the following should you explain to Jackie? Select the correct answer and then select **Check Your Answer**.

- (●) A. Beginning with tax year 2019, individuals who choose to go without insurance will no longer be subject to making individual shared responsibility payments. Jackie won't owe a fee for failing to obtain MEC in 2023.
- ( ) B. Because Jackie is self-employed and isn't offered employer-sponsored coverage, she doesn't have to have MEC in 2023.
- ( ) C. Because Jackie didn't enroll in a QHP or obtain other MEC in 2023, she may have to pay a fee when she files her 2023 tax return in 2024.
- ( ) D. If Jackie doesn't want coverage, she doesn't need to do anything.

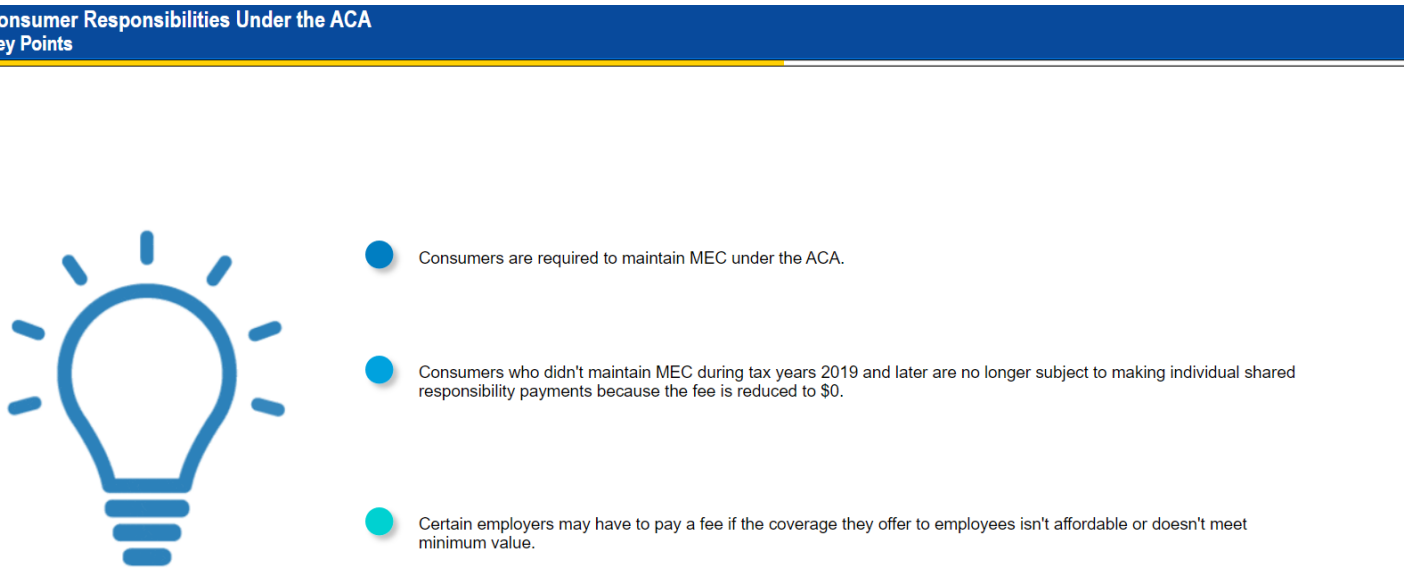
Check Your Answer

Correct!
Even if Jackie is self-employed and not offered employer-sponsored coverage, she is still required to maintain MEC under the ACA. However, Jackie won't owe a fee for failing to obtain MEC. Starting in tax year 2019, individuals who choose to go without insurance will no longer be subject to making shared responsibility payments.

Jackie is a 28-year-old freelance writer who earned more than $50,000 in 2023. However, she didn't enroll in a qualified health plans (QHPs) or obtain MEC for the year. Jackie is concerned because she heard that she'll have to pay a fee. What should you explain to Jackie?

Answer: Even if Jackie is self-employed and not offered employer-sponsored coverage, she is still required to maintain MEC under the ACA. However, Jackie won’t owe a fee for failing to obtain MEC. Starting in tax year 2019, individuals who choose to go without insurance will no longer be subject to making shared responsibility payments.

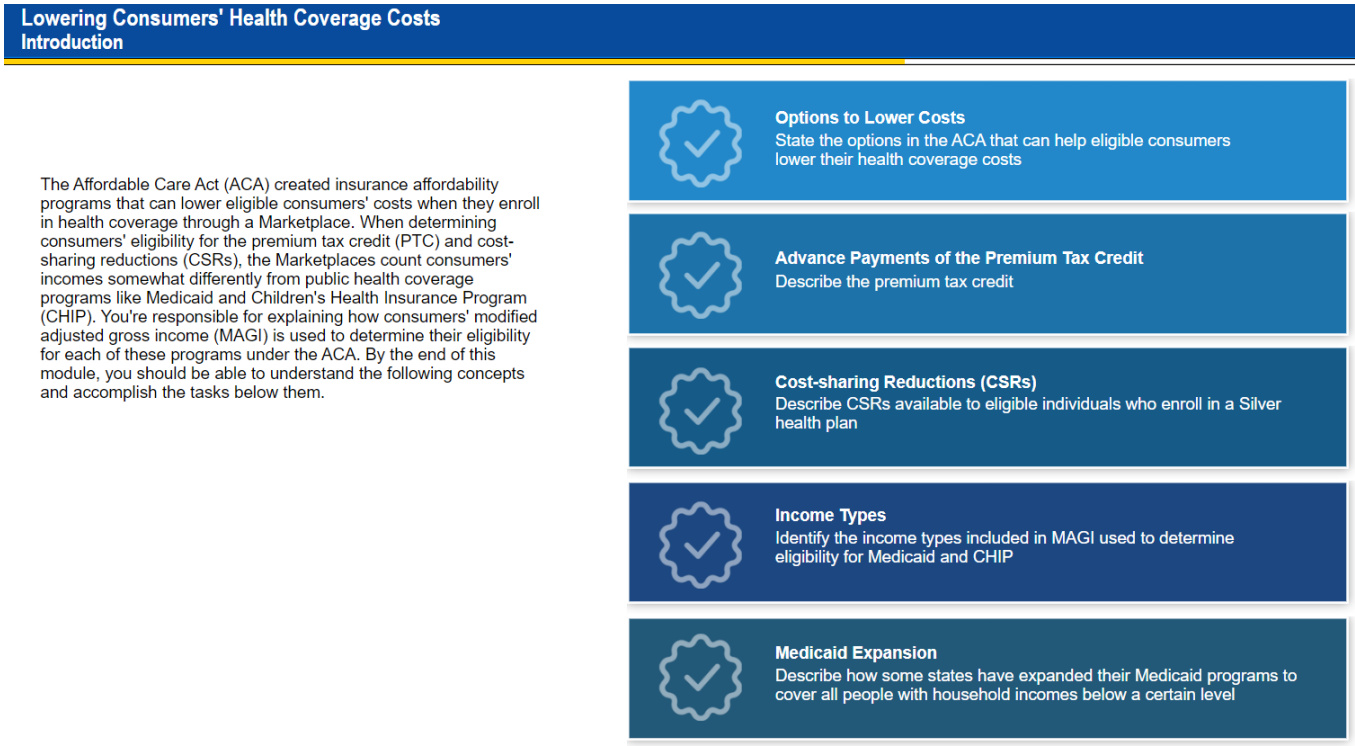
Key Points



- Consumers are required to maintain MEC under the ACA.
- Consumers who didn’t maintain MEC during tax years 2019 and later are no longer subject to making individual shared responsibility payments because the fee is reduced to $0.
- Certain employers may have to pay a fee if the coverage they offer to employees isn’t affordable or doesn’t meet minimum value.

Lowering Consumers' Health Coverage Costs

Introduction



The Affordable Care Act (ACA) created insurance affordability programs that can lower eligible consumers' costs when they enroll in health coverage through a Marketplace. When determining consumers' eligibility for the premium tax credit (PTC) and cost-sharing reductions (CSRs), the Marketplaces count consumers' incomes somewhat differently from public health coverage programs like Medicaid and Children's Health Insurance Program (CHIP). You're responsible for explaining how consumers' modified adjusted gross income (MAGI) is used to determine their eligibility for each of these programs under the ACA. By the end of this module, you should be able to understand the following concepts and accomplish the tasks below them.

Options to Lower Costs

State the options in the ACA that can help eligible consumers lower their health coverage costs

Advance Payments of the Premium Tax Credit

Describe the premium tax credit

Cost-sharing Reductions (CSRs)

Describe CSRs available to eligible individuals who enroll in a Silver health plan

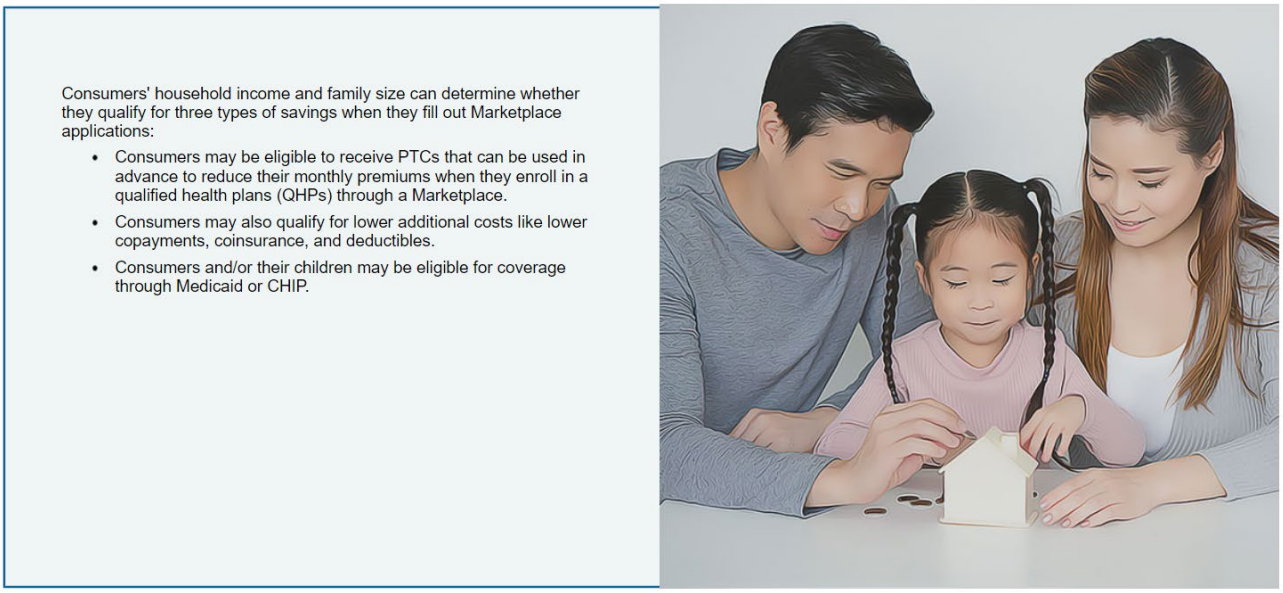
Income Types

Identify the income types included in MAGI used to determine eligibility for Medicaid and CHIP

Medicaid Expansion

Describe how some states have expanded their Medicaid programs to cover all people with household incomes below a certain level

Options for Lowering Health Coverage Costs



Consumers' household income and family size can determine whether they qualify for three types of savings when they fill out Marketplace applications:

- Consumers may be eligible to receive PTCs that can be used in advance to reduce their monthly premiums when they enroll in a qualified health plans (QHPs) through a Marketplace.
- Consumers may also qualify for lower additional costs like lower copayments, coinsurance, and deductibles.
- Consumers and/or their children may be eligible for coverage through Medicaid or CHIP.

Premium Tax Credits

Lowering Consumers' Health Coverage Costs
Premium Tax Credits

If consumers' projected annual household income falls between 100 percent and 400 percent of the federal poverty level (FPL), they may qualify for a PTC when they file federal income tax returns. The American Rescue Plan Act of 2021 expanded eligibility to include household income above 400 percent of the FPL and capped how much of a family's household income the family would pay towards the premiums for a benchmark plan at 8.5 percent. The Inflation Reduction Act (IRA), signed into law on August 16, 2022, extended the enhanced tax credits through Plan Year (PL) 2025.

PTCs are only available to consumers who enroll in QHPs through a Marketplace. Eligible consumers can use all, some, or none of their PTC in advance to lower their monthly premiums—these are called APTCs.

Consumers with lower incomes or larger household sizes generally qualify for larger PTCs. For example, a family of two with a yearly household income of $35,000 would receive a larger PTC than a family of two with a yearly income of $45,000 if all else is equal.

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

You will learn more about reconciling APTC in another training course.

The Marketplaces will use the 2023 FPL table for eligibility determinations for PY 2024. Below is the 2023 FPL table for the 48 contiguous states and D.C. (Visit Aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines for PY 2024 FPL levels for Alaska and Hawaii)

Household Size	100%	133%	150%	200%	250%	300%	400%
1	$14,580	$19,391	$21,870	$29,160	$36,450	$43,740	$58,320
2	$19,720	$26,228	$29,580	$39,440	$49,300	$59,160	$78,880
3	$24,860	$33,064	$37,290	$49,720	$62,150	$74,850	$99,440
4	$30,000	$39,900	$45,000	$60,000	$75,000	$90,000	$120,000
5	$35,140	$46,736	$52,710	$70,280	$87,850	$105,420	$140,560
6	$40,280	$53,572	$60,420	$80,560	$100,700	$120,840	$161,120
7	$45,420	$60,409	$68,130	$90,840	$113,550	$136,260	$181,680
8	$50,560	$67,245	$75,840	$101,120	$126,400	$151,680	$202,240

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4	$30,000	$39,900	$45,000	$60,000	$75,000	$90,000	$120,000
5	$35,140	46,736	$52,710	$70,280	$87,850	$105,420	$140,560
6	$40,280	$53,572	$60,420	$80,560	$100,700	$120,840	$161,120
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8	$50,560	$67,245	$75,840	$101,120	$126,400	$151,680	$202,240

Federal Poverty Level (FPL)

The federal poverty guidelines, often referenced as the FPL, are a version of the federal poverty measure. They are issued each year by the Department of Health and Human Services (HHS). The guidelines are used to help determine consumers' financial eligibility for certain programs and benefits, including savings on Marketplace health insurance, Medicaid, and CHIP coverage.

For more information about the FPL, visit ASPE.hhs.gov/poverty-guidelines.

APTC

To be eligible for APTC, a consumer must:

- Be a non-incarcerated U.S. citizen, U.S. national, or legal U.S. resident.
- Have a household income which qualifies the tax filer as an applicable taxpayer according to the Internal Revenue Service's (IRS) income thresholds. Currently, the income threshold is between 100 percent and 400 percent of the FPL*.
- Have no other minimum essential coverage (MEC) and not be considered eligible for MEC, including employer-sponsored coverage that is affordable** (a premium less than 9.12 percent of household income for 2023) and meets the minimum value standard***.
- File a federal income tax return for the benefit year the consumer enrolled in a QHP and reconcile prior APTC.
- File a joint tax return, if married, unless the consumer is a victim of domestic abuse or spousal abandonment.
- Not be claimed as a dependent on another taxpayer's federal income tax return.

Under the American Rescue Plan Act of 2021: For PYs 2021 and 2022, PTC is available to taxpayers with household income above 400 percent of the FPL and caps how much of a family's household income the family will pay towards the premiums for a benchmark plan at 8.5 percent. The IRA, signed into law on August 16, 2022, extended the enhanced Marketplace tax credits through PY 2025.

Affordable

- An offer of employer-sponsored coverage is considered affordable for the employee if the employee's required contribution for self-only coverage does not exceed the required contribution percentage of household income. The required contribution is the portion of the annual premium the employee must pay for self-only coverage. For PY 2023, the required contribution percentage for household income is 9.12

percent. At the time of this publication, the required contribution percentage for PY2024 has not yet been released.

- Under the IRS Affordability of Employer Coverage for Family Members of Employees final rule published in October 2022, an offer of employer-sponsored coverage for related individuals in the employee's family is considered affordable for those related individuals if the employee's required contribution for family coverage does not exceed the required contribution percentage of household income. The required contribution for family coverage is the portion of the annual premium the employee must pay for coverage of the employee and all other individuals included in the employee's family who are offered coverage under the eligible employer-sponsored plan. For PY 2023, the required contribution percentage for household income is 9.12 percent. At the time of this publication, the required contribution percentage for PY 2024 has not yet been released.

Minimum Value

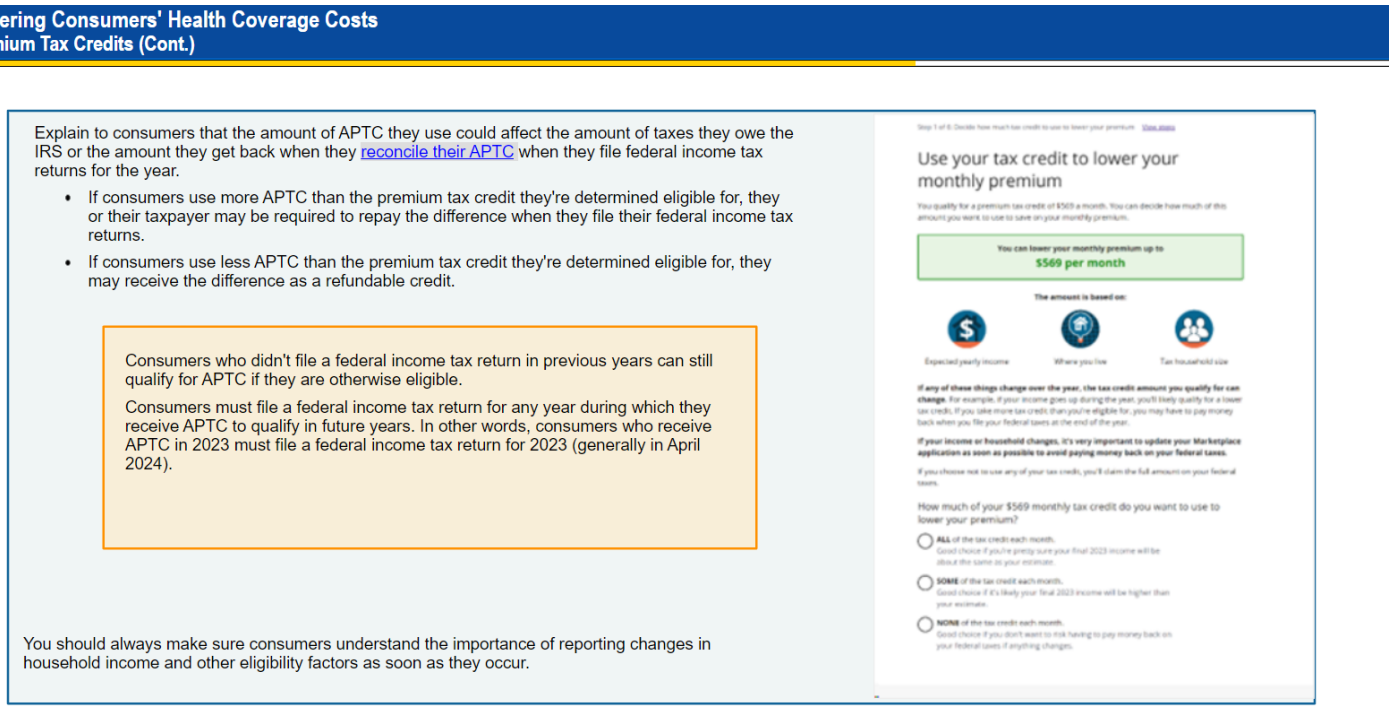
Minimum value is a standard of minimum coverage that applies to employer-sponsored health plans. A health plan meets the minimum value standard if, for both the employee and related individuals of the employee:

- It's designed to pay at least 60 percent of the total cost of medical services for a standard population,

AND

- Its benefits include substantial coverage of physician and inpatient hospital services.

Premium Tax Credits (Continued)



Explain to consumers that the amount of APTC they use could affect the amount of taxes they owe the IRS or the amount they get back when they reconcile their APTC when they file federal income tax returns for the year.

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

Consumers who didn't file a federal income tax return in previous years can still qualify for APTC if they are otherwise eligible.

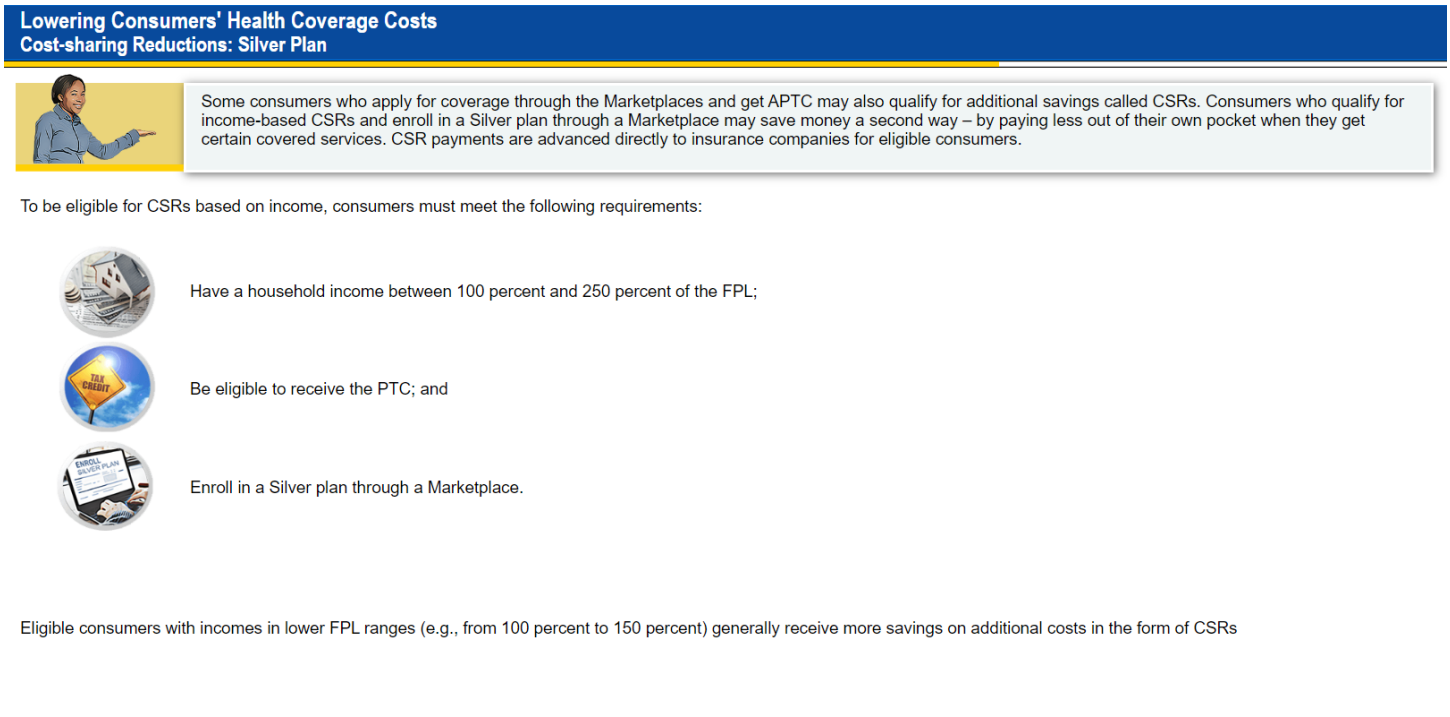
Consumers must file a federal income tax return for any year during which they receive APTC to qualify in future years. In other words, consumers who receive APTC in 2023 must file a federal income tax return for 2023 (generally in April 2024).

You should always make sure consumers understand the importance of reporting changes in household income and other eligibility factors as soon as they occur.

APTC Reconciliation

When consumers file federal income tax returns, they will need to use Form 8962 to calculate the amount of premium tax credit they were eligible for during the year and reconcile that amount with any APTC they received. You can learn more about APTC reconciliation in the *Marketplace Application Essentials* course.

Cost-sharing Reductions: Out of pocket Savings Only with a Silver Plan



Some consumers who apply for coverage through the Marketplaces and get APTC may also qualify for additional savings called CSRs. Consumers who qualify for income-based CSRs and enroll in a Silver plan through a Marketplace may save money a second way – by paying less out of their own pocket when they get certain covered services. CSR payments are advanced directly to insurance companies for eligible consumers.

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

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

Eligible consumers with incomes in lower FPL ranges (e.g., from 100 percent to 150 percent) generally receive more savings on additional costs in the form of CSRs.

Cost-sharing Reductions for American Indians/Alaska Natives

Lowering Consumers' Health Coverage Costs
Cost-sharing Reductions for American Indians/Alaska Natives

American Indians and Alaska Natives (AI/ANs) or members of Federally-recognized Indian Tribes with household incomes up to 300 percent of the FPL qualify for CSRs regardless of which metal level health plan category they choose. They can also continue to receive health services from the following:

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

For more information on helping AI/ANs with Marketplace coverage, refer to the *Serving Vulnerable and Underserved Populations* course.

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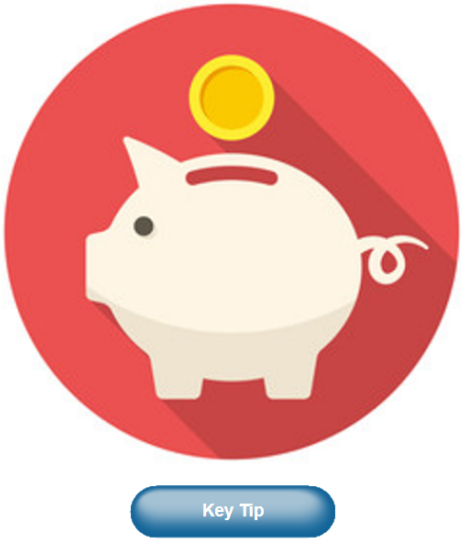
The Impact of CSRs on Affordability

Lowering Consumers' Health Coverage Costs
The Impact of CSRs on Affordability



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

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

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- They will generally have lower copayments or coinsurance. These are payments consumers make each time they get care. For example, if a particular Silver plan has a $30 copayment for a doctor visit, a consumer eligible for CSRs might pay a $20 or $15 copayment for doctor visits under that same plan.
- They will generally have a lower "out-of-pocket maximum." This is the maximum amount a consumer could have to pay out of pocket for their health care costs for EHB in a year if the consumer got seriously sick or had an accident. For example, if a particular Silver plan has a $5,000 out-of-pocket maximum, a consumer eligible for CSRs might have a $3,000 out-of-pocket maximum under that same plan.

Key Tip

Use the tool available at HealthCare.gov/see-plans to search for Silver plans available in a consumer's area.

Knowledge Check

Lowering Consumers' Health Coverage Costs
Knowledge Check

Generally, consumers must have a household income between ____ percent and ____ percent of the FPL to be eligible for APTC. Select the correct answer and then select **Check Your Answer**.

- (A.) 100 percent and 400 percent
- ( ) B. 200 percent and 400 percent
- ( ) C. 100 percent and 500 percent
- ( ) D. 200 percent and 500 percent

Check Your Answer

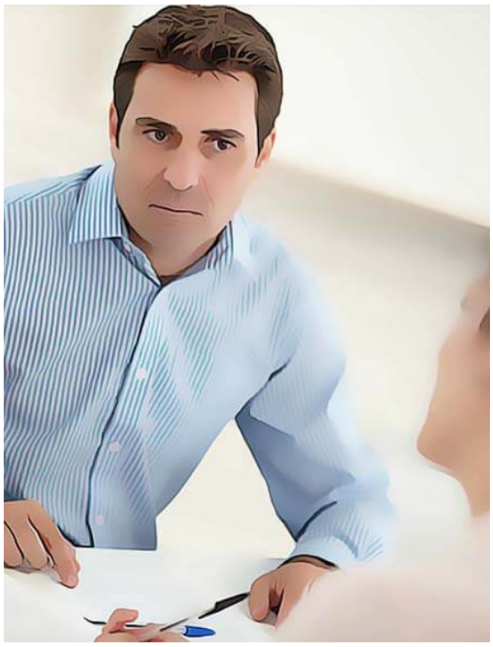
Correct!
Consumers must generally have a household income between 100 percent and 400 percent of the FPL to be eligible for APTC. However, for PYs 2021 and 2022, the PTC is available to taxpayers with household income above 400 percent of the FPL and caps how much of a family's household income the family will pay towards the premiums for a benchmark plan at 8.5 percent. The Inflation Reduction Act (IRA), signed into law on August 16, 2022, extended the enhanced Marketplace tax credits through PY 2025.

Generally, consumers must have a household income between what percent and what percent of the FPL to be eligible for APTC.

Answer: Consumers must generally have a household income between 100 percent and 400 percent of the FPL to be eligible for APTC. However, for PYs 2021 and 2022, the PTC is available to taxpayers with household income above 400 percent of the FPL and caps how much of a family's household income the family will pay towards the premiums for a benchmark plan at 8.5 percent. The IRA, signed into law on August 16, 2022, extended the enhanced Marketplace tax credits through PY 2025.

Modified Adjusted Gross Income

Lowering Consumers' Health Coverage Costs
Modified Adjusted Gross Income



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

Generally, MAGI is:

- A household's adjusted gross income (AGI),
- Untaxed foreign income,
- Non-taxable Social Security benefits, and
- Tax-exempt interest

For example, earned wages and unemployment benefits are counted in MAGI calculations while most kinds of cash assistance, including child support and Supplemental Security Income (SSI), are not.

It's important for consumers to know that state Medicaid and CHIP agencies calculate MAGI using monthly income while the Marketplaces use annual income. Medicaid and CHIP agencies also construct a MAGI household by counting a pregnant person's household as including the number of children expected in the household size and have options for the household size of other people in a household that includes a pregnant person, whereas the Marketplaces always count a pregnant person as one in the household. There are some other key differences in how state Medicaid and CHIP agencies count MAGI—select here to learn more.

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

Tax Filers + Tax Dependents = Household Size

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

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

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

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

Generally, MAGI is:

- A household's adjusted gross income (AGI),
- Untaxed foreign income,
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It's important for consumers to know that state Medicaid and CHIP agencies calculate MAGI using monthly income while the Marketplaces use annual income. Medicaid and CHIP agencies also construct a MAGI household by counting a pregnant person's household as including the number of children expected in the household size and have options for the household size of other people in a household that includes a pregnant person, whereas the Marketplaces always count a pregnant person as one in the household. There are some other key differences in how state Medicaid and CHIP agencies count MAGI—read further to learn more.

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

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

Most Categories

MAGI is generally used to determine Medicaid and CHIP eligibility for children, pregnant individuals, parents, and

other adults who may be eligible for the adult group.

Adjusted Gross Income (AGI)

Federal tax rules for determining AGI include the following kinds of income:

- Earned income (e.g., wages, salary, or any compensation for work) minus any pretax deductions (i.e., dependent care, retirement)
- Net income from self-employment
- Taxable and non-taxable Social Security income, including Social Security Disability Insurance (SSDI) and retirement benefits but not SSI
- Unemployment benefits
- Investment income, including interest, dividends, and capital gains (MAGI doesn't consider resources like bank accounts or stocks when determining Medicaid eligibility)

MAGI Calculation

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

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

The MAGI calculation for Medicaid and CHIP does NOT include:

- Educational scholarships, awards, or fellowship grants not used for living expenses.
- Certain American Indian/Alaska Native income, like:
    - Distributions from Alaska Native Corporations and Settlement Trusts.
    - Distributions from any property held in trust, subject to federal restrictions located within the most recent boundaries of a prior federal reservation, or otherwise under the supervision of the Secretary of the Interior.
    - Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from:
        - Rights of ownership or possession in any lands; or
        - Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources.
    - Distributions resulting from real property ownership interests related to natural resources and improvements:
        - Located on or near a reservation or within the most recent boundaries of a prior federal reservation; or
        - Resulting from the exercise of federally protected rights relating to such real property ownership interests.
    - Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.
    - Student financial assistance provided under the Bureau of Indian Affairs education programs.

MAGI Family Size and Income Counting Rules

Lowering Consumers' Health Coverage Costs
MAGI Family Size and Income Counting Rules

If consumers choose to apply for APTC and CSRs to help lower their costs using a Marketplace application, they should be aware that they must file a federal income tax return to qualify. However, consumers who apply for Medicaid or CHIP don't have to file federal income tax returns to be assessed or determined eligible. Here are a couple of quick questions for you.

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

Answer

If consumers choose to apply for APTC and CSRs to help lower their costs using a Marketplace application, they should be aware that they must file a federal income tax return to qualify. However, consumers who apply for Medicaid or CHIP don't have to file federal income tax returns to be assessed or determined eligible. Here are a couple of quick questions for you.

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

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

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

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

Remember, Medicaid and CHIP MAGI calculations don't include certain American Indian/Alaska Native income.

Duty to Report Accurate Income

You should always help consumers report their current and projected yearly income accurately (and make any changes as soon as they occur) and remind them not to misrepresent personal information when applying for coverage.

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

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Medicaid/CHIP and the Marketplaces: Assessment Versus Determination

Lowering Consumers' Health Coverage Costs
Medicaid and the Marketplaces: Assessment Versus Determination

When a consumer applies for coverage and help paying for it, the FFMs also assess or determine the consumer's eligibility for Medicaid and CHIP. You should be able to explain the role of the FFM in your state in assessing or determining consumers' eligibility for these programs.

- In a Medicaid assessment state, the FFM uses Medicaid rules and any applicable state-specific rules to evaluate a consumer's MAGI and make a preliminary assessment of eligibility for MAGI-based Medicaid and/or CHIP. If the FFM assesses the consumer as potentially eligible on a MAGI basis, the FFM sends the consumer's account information to the state Medicaid/CHIP agency via a secure account transfer (AT) for a final eligibility determination by the state. The state then requests additional information from the consumer if necessary, conducts a final eligibility determination, sends a notice to the consumer with the final eligibility determination, and enrolls the consumer in Medicaid or CHIP coverage, as applicable.
- In a Medicaid/CHIP determination state, the state formally delegates to the FFM the authority to make final eligibility determinations for MAGI-based Medicaid and/or CHIP, when the application information is fully verified. Therefore, these FFMs use Medicaid/CHIP rules and applicable state-specific rules to evaluate a consumer's MAGI and make a final determination of eligibility for MAGI-based Medicaid/CHIP when no verification issues are present. The FFMs send the consumer's account information to the state Medicaid/CHIP agency via AT for applicable next steps, such as prompt enrollment (for fully verified applications), a completion of applicable eligibility verifications and subsequent final eligibility determination and enrollment, and consumer notification.

Consumers will be automatically referred via AT from the FFM to the state Medicaid or CHIP agency if the consumer appears potentially eligible for Medicaid on a non-MAGI basis, based on their responses to certain questions on the FFM application. All FFM states (regardless of assessment or determination status) must make final eligibility determinations for all non-MAGI referrals.

In addition, an applicant whom the FFM evaluates as ineligible for MAGI-based Medicaid, Emergency Medicaid, and who did not attest to a recent Medicaid/CHIP denial by the state, can request to be sent to the state for a full determination. If this is requested by a consumer:

- In an assessment state, the state must determine the applicant's eligibility on all bases (MAGI and non-MAGI).
- In a determination state, the state Medicaid or CHIP agency will determine the applicant's eligibility only on non-MAGI bases, as the FFM has already made a final determination on the basis of MAGI.

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

Additional Information

Key Tip

Additional Information

You can find more detailed information about assisting consumers with Medicaid and CHIP eligibility in the *Medicaid and CHIP Overview* tip sheet at Marketplace.cms.gov/technical-assistance-resources/fast-facts-medicaid-chip.pdf.

Key Tip

If an individual is assessed or determined **ineligible** for Medicaid and CHIP, their Eligibility Determination Notice will state whether that individual can enroll in a QHP and receive APTC and CSRs.

CHIP Eligibility and the Marketplaces

If a child is eligible for both QHP coverage and CHIP coverage, remind consumers that CHIP qualifies as MEC. Children who are eligible for CHIP aren't eligible for APTC or CSRs in a Marketplace; however, they may still enroll in a QHP without APTC and CSRs. If they choose to enroll in Marketplace coverage without APTCs and CSRs, they should tell their state CHIP agency that they're still enrolled in Marketplace coverage without financial help, as they may no longer be eligible for CHIP.

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Knowledge Check

Lowering Consumers' Health Coverage Costs
Knowledge Check

George is 30 years old, single, has no dependents, and works at a local coffee shop. His employer doesn't offer health insurance and he's asked you to help him apply for health coverage through the Marketplace. George currently makes $26,000 a year, which is between 150 percent and 200 percent of the FPL. Based on his income only, which programs will George likely be eligible for when he submits his application through a Marketplace? Select the two correct answers and then select **Check Your Answer**.

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

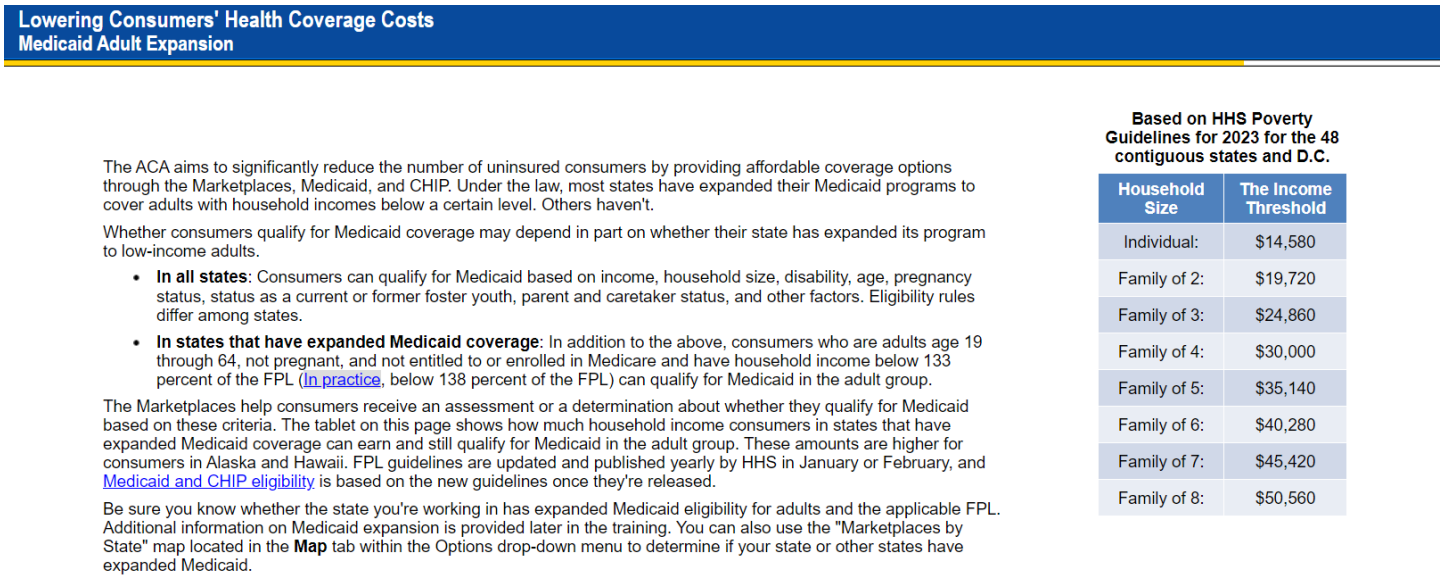
Check Your Answer

Correct!
George is likely above the income levels for Medicaid but within the income range for financial assistance through a Marketplace. It's likely that George will be eligible for the premium tax credit if he enrolls in a Marketplace plan, since his annual income is between 100 and 400 percent of the FPL. It's also likely that he'll be eligible for CSRs if he enrolls in a Silver plan, since his income is between 100 and 250 percent of the FPL. CHIP is generally only available for children up to age 19.

George is 30 years old, single, has no dependents, and works at a local coffee shop. His employer doesn't offer health insurance and he's asked you to help him apply for health coverage through the Marketplace. George currently makes $26,000 a year, which is between 150 percent and 200 percent of the FPL. Based on his income only, which programs will George likely be eligible for when he submits his application through a Marketplace?

Answer: George is likely above the income levels for Medicaid but within the income range for financial assistance through a Marketplace. It's likely that George will be eligible for the premium tax credit if he enrolls in a Marketplace plan, since his annual income is between 100 and 400 percent of the FPL. It’s also likely that he’ll be eligible for CSRs if he enrolls in a Silver plan, since his income is between 100 and 250 percent of the FPL. CHIP is generally only available for children up to age 19.

Medicaid Adult Expansion



Lowering Consumers' Health Coverage Costs
Medicaid Adult Expansion

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

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

- **In all states**: Consumers can qualify for Medicaid based on income, household size, disability, age, pregnancy status, status as a current or former foster youth, parent and caretaker status, and other factors. Eligibility rules differ among states.
- **In states that have expanded Medicaid coverage**: In addition to the above, consumers who are adults age 19 through 64, not pregnant, and not entitled to or enrolled in Medicare and have household income below 133 percent of the FPL (In practice, below 138 percent of the FPL) can qualify for Medicaid in the adult group.

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

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

Based on HHS Poverty Guidelines for 2023 for the 48 contiguous states and D.C.

Household Size	The Income Threshold
Individual:	$14,580
Family of 2:	$19,720
Family of 3:	$24,860
Family of 4:	$30,000
Family of 5:	$35,140
Family of 6:	$40,280
Family of 7:	$45,420
Family of 8:	$50,560

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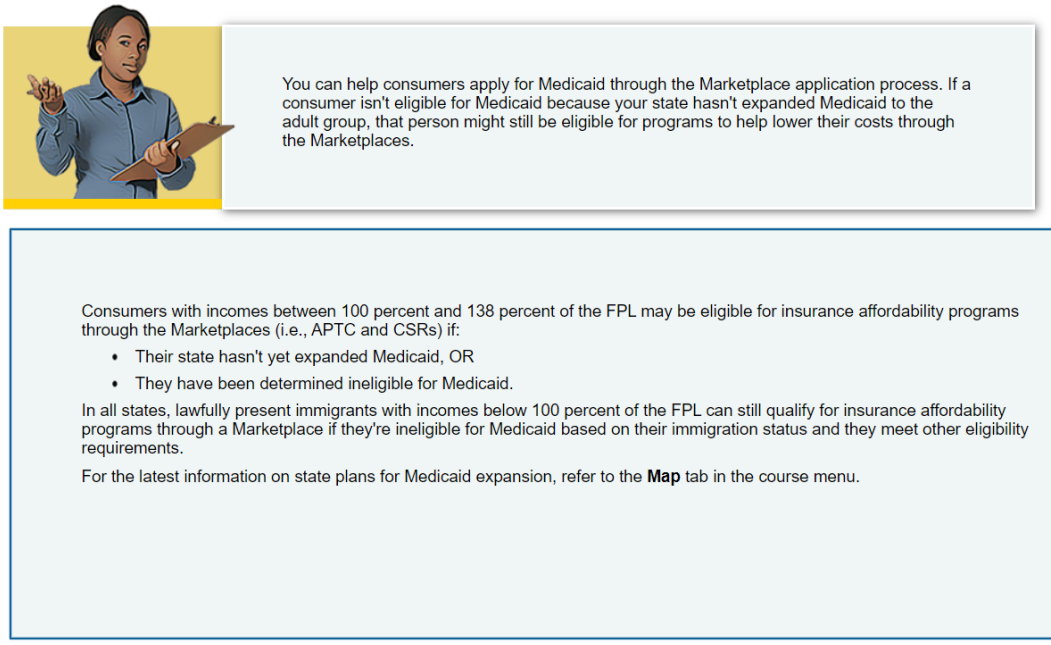
In Practice

The ACA's MAGI calculation is generally based on taxable income as defined in the Internal Revenue Code. For Medicaid and CHIP, the MAGI-based methodology includes a disregard equivalent to five percentage points of the FPL (when considering eligibility for the MAGI-based group with the highest income standard). With this five-percentage-point-equivalent disregard, the Medicaid adult group eligibility threshold is effectively 138 percent of the FPL.

Medicaid Adult Expansion and the Marketplaces



You can help consumers apply for Medicaid through the Marketplace application process. If a consumer isn’t eligible for Medicaid because your state hasn't expanded Medicaid to the adult group, that person might still be eligible for programs to help lower their costs through the Marketplaces.

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

- Their state hasn’t yet expanded Medicaid, OR
- They have been determined ineligible for Medicaid.

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

For the latest information on state plans for Medicaid expansion, refer to the Map tab in the course menu.

Medicare and the Marketplace

Lowering Consumers' Health Coverage Costs
Medicare and the Marketplace

It's important that consumers close to age 65 who are applying for coverage through a Marketplace know about the benefits of enrolling in Medicare as soon as they become eligible.

Consumers who don't sign up for Medicare during their Initial Enrollment Period (IEP) and don't have employer-sponsored coverage (ESC) based on current employment (of the individual, the individual's spouse, or in limited cases, another family member of the individual), including coverage through a SHOP Marketplace, may have to pay higher premiums when they sign up for Medicare later.

Beginning January 1, 2023, consumers who were unable to enroll during their IEP due to exceptional circumstances can access four new Medicare special enrollment periods (SEPs) that allow them to enroll without having to wait for the general enrollment period (GEP) and without being subject to a late enrollment penalty. The SEPs are for eligible individuals who miss an enrollment opportunity because:

1. They were impacted by a disaster or government-declared emergency;
2. Their employer or health plan materially misrepresented information related to timely enrollment in Medicare Part B;
3. They were incarcerated;
4. Their Medicaid coverage was terminated after the COVID-19 Public Health Emergency (PHE) ends or on or after January 1, 2023 (whichever is earlier); or
5. They demonstrate to the Centers for Medicare & Medicaid Services (CMS) that they missed an enrollment period because of an event or circumstance outside of the individual's control and those conditions are exceptional in nature.

Select each tab for what you should tell these consumers depending on their circumstances.

Select this link to open a PDF you can print.

If consumers….

Are receiving Social Security retirement/ or Social Security disability benefits, then....	Are newly eligible for Medicare and don't get social security benefits yet, then…	Have ESC coverage based on current employment, including coverage through a SHOP Marketplace, then…	Are eligible for programs to lower their QHP costs through a Marketplace (i.e., APTC and CSRs), then…	Want help to pay for some of their health care costs that their original Medicare plan doesn't cover, then…

It's important that consumers close to age 65 who are applying for coverage through a Marketplace know about the benefits of enrolling in Medicare as soon as they become eligible.

Consumers who don't sign up for Medicare during their Initial Enrollment Period (IEP) and don't have employer-sponsored coverage (ESC) based on current employment (of the individual, the individual's spouse, or in limited cases, another family member of the individual), including coverage through a SHOP Marketplace, may have to pay higher premiums when they sign up for Medicare later.

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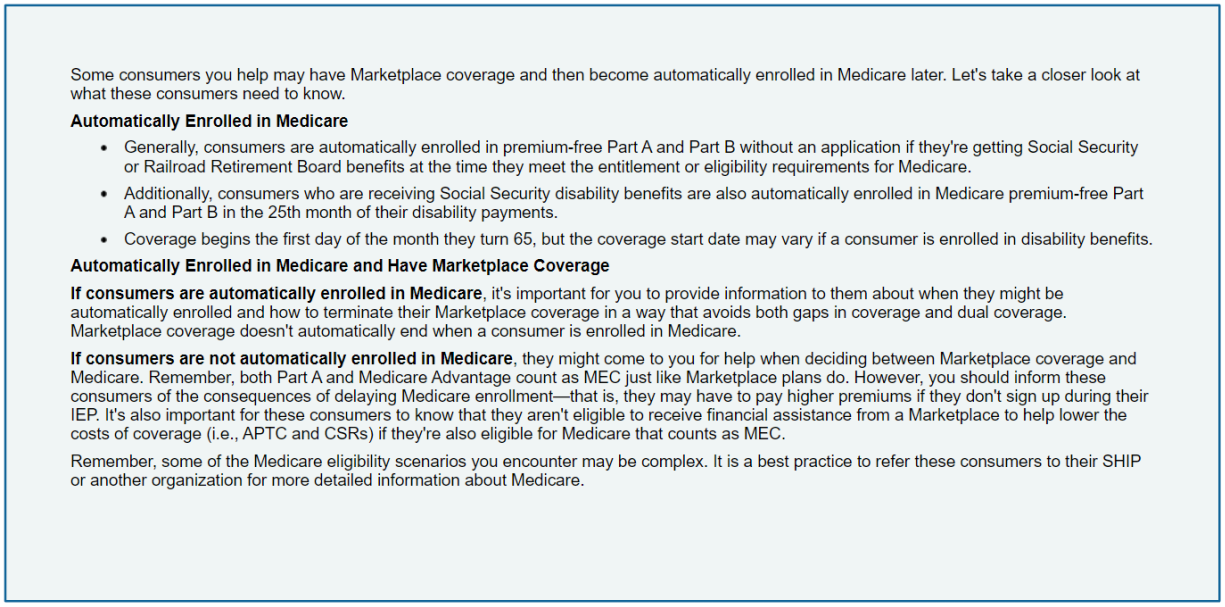
5. They demonstrate to the Centers for Medicare & Medicaid Services (CMS) that they missed an enrollment period because of an event or circumstance outside of the individual's control and those conditions are exceptional in nature.

Each item in the first column on this table will teach what you should tell these consumers depending on their circumstances. You may want to print this table and keep it handy when you assist them.

If consumers...	Then consumers...	And…
Are receiving Social Security retirement or Social Security disability benefits,	Will be automatically enrolled in premium-free Part A and Part B once they are eligible. The consumer will receive information about Medicare in the mail a few months before they're automatically enrolled in Part A and Part B.	They should consider signing up for Part D during their IEP so they will have prescription drug coverage on their first day of eligibility and so they don't have to pay a late enrollment penalty that may apply if they enroll later.
Are newly eligible for Medicare and don't get Social Security benefits yet,	Will have an IEP to sign up for Part A and Part B and can contact Social Security to sign up for Medicare. These consumers should also consider applying for Part D at that time if they want prescription drug coverage. If the individual signs up for Part D later, a late enrollment penalty may apply, depending on the timing and circumstances.	For someone turning 65 years old, the IEP includes the three months before, the month of, and the three months after a consumer turns 65. If consumers don't sign up for Medicare during their IEP and don't have ESC (including coverage through a Small Business Health Options Program (SHOP) Marketplace), they may have to pay a late enrollment penalty or wait for a General Enrollment Period to enroll in Part B coverage.
Have ESC coverage based on current employment, including coverage through a SHOP Marketplace,	Should consider signing up for premium-free Part A (if eligible) when their IEP begins. The individual may wish to consider whether they can delay enrollment in Part B until the ESC or the current employment ends, whichever occurs first, and at which time they may be able to apply during a SEP based on their ESC or current employment ending.	N/A
Are eligible for programs to lower their QHP costs through a Marketplace (i.e., APTC and CSRs),	Will lose eligibility for APTC and CSRs through a Marketplace plan when they become eligible for premium-free Part A based on their age or when their Part A coverage starts, regardless of the basis for their eligibility for premium-free Part A. Note: Consumers who are enrolled in a Marketplace plan first and then become eligible for Medicare can stay enrolled in the Marketplace plan but will no longer qualify for APTC or CSRs once Medicare begins.	N/A
Want help to pay for some of their health care costs that their original Medicare plan doesn't cover,	Should consider purchasing a Medicare Supplement Insurance (Medigap) policy.	For consumers enrolled in original Medicare (Part A and Part B) and a Medigap policy, Medicare and Medigap will each pay its share of covered health care costs. Generally, when a consumer buys a Medigap policy, they must have Part A and Part B. Note: Part C (called Medicare Advantage or MA) is not a type of Medigap policy. Consumers can't enroll in a Medigap policy if they are enrolled in an MA plan because Medigap only helps consumers with costs that original Medicare (Part A and Part B) doesn't cover. MA Plans are a type of Medicare health plan offered by private health insurance companies that contract with Medicare to provide Part A and Part B benefits for their enrollees. Most MA Plans also offer prescription drug coverage (Part D) for enrollees, and some MA plans may offer other supplemental benefits. For more information, visit Medicare.gov.

Lowering Consumers' Health Coverage Costs
Medicare Marketplace Coverage (Cont.)



Some consumers you help may have Marketplace coverage and then become automatically enrolled in Medicare later. Let's take a closer look at what these consumers need to know.

Automatically Enrolled in Medicare

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

Automatically Enrolled in Medicare and Have Marketplace Coverage

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

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

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

Knowledge Check

Lowering Consumers' Health Coverage Costs
Knowledge Check

You're meeting with Easton, a 30-year-old songwriter who lives with a roommate in a Medicaid expansion state. Easton has no dependents. He makes $60,000 a year and is therefore above 400 percent of the FPL. Easton is interested in learning more about the ACA. Which of the following are accurate statements that you should tell Easton about the law and its key provisions? Select the three correct answers and then select **Check Your Answer**.

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

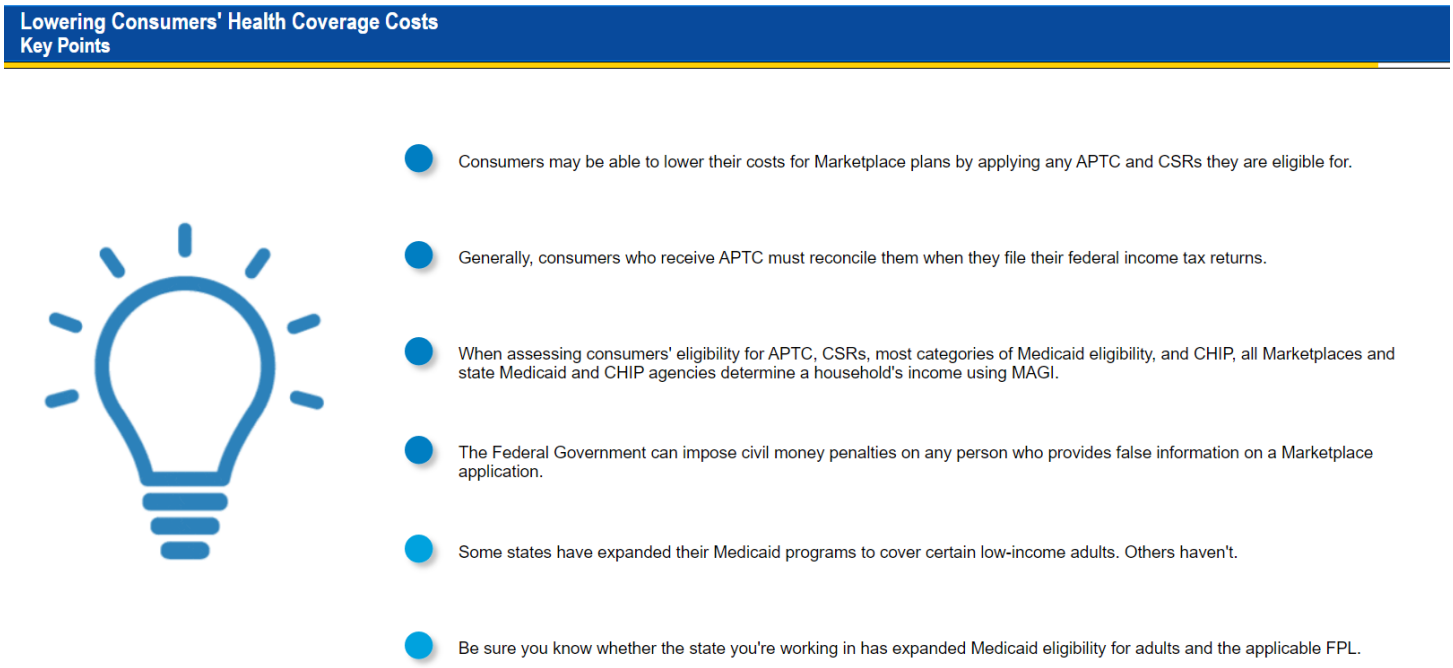
Check Your Answer

Correct!
Correct! Based on his income alone, Easton could only be eligible for Medicaid with a household income of 138 percent of the FPL or less—that is, $20,120 for a household of one in 2023.

You're meeting with Easton, a 30-year-old songwriter who lives with a roommate in a Medicaid expansion state. Easton has no dependents. He makes $60,000 a year and is therefore above 400 percent of the FPL. Easton is interested in learning more about the ACA. What is an accurate statement you could tell Easton about the law and its key provisions?

Answer: Based on his income alone, Easton could only be eligible for Medicaid with a household income of 138 percent of the FPL or less—that is, $20,120 for a household of one in 2023.

Key Points



Consumers may be able to lower their costs for Marketplace plans by applying any APTC and CSRs they are eligible for.

- Generally, consumers who receive APTC must reconcile them when they file their federal income tax returns.
- When assessing consumers' eligibility for APTC, CSRs, most categories of Medicaid eligibility, and CHIP, all Marketplaces and state Medicaid and CHIP agencies determine a household's income using MAGI.
- The Federal Government can impose civil money penalties on any person who provides false information on a Marketplace application.
- Some states have expanded their Medicaid programs to cover certain low-income adults. Others haven't.
- Be sure you know whether the state you’re working in has expanded Medicaid eligibility for adults and the applicable FPL.

Conclusion

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Congratulations! You have learned about the key features of the ACA, including provisions that can help eligible consumers lower their health coverage costs. You also read about the responsibilities that all consumers must meet to obtain health coverage.

You've finished the learning portion of this course. Select the link to take the *Affordable Care Act Basics* exam, or you can close the course and return to the exam later.

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You've finished the learning portion of this course. You can return to the web-based training to take the Affordable Care Act Basics exam or you can close this document and return to the exam later. If you choose to take the exam, the code to access this exam is: 732133. Good luck!

Resources

More Information on Immigration Status:

Information about immigration status requirements for consumers in a Marketplace.

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

Incarcerated Consumers:

Explanation of incarceration status in relation to eligibility for coverage through a Marketplace.

HealthCare.gov/incarcerated-people

Medicaid Expansion:

Official resource at HealthCare.gov that provides information for consumers who live in states that did not expand Medicaid.

HealthCare.gov/medicaid-chip/medicaid-expansion-and-you

More Information about the ACA:

The text of the Affordable Care Act can be accessed through this link at HealthCare.gov.

HealthCare.gov/where-can-i-read-the-affordable-care-act

Federal Poverty Guidelines:

Official HHS guidance on FPL levels for 2023.

aspe.hhs.gov/poverty-guidelines

Medicaid and CHIP Eligibility Levels by State:

A CMS chart of Medicaid and CHIP eligibility levels for selected MAGI groups in each state.

Medicaid.gov/medicaid/program-information/medicaid-and-chip-eligibility-levels/index.html

Medicaid and CHIP Fast Facts for Assisters:

A fact sheet for helping low-income individuals, families, or children who are uninsured or who are seeking information about health coverage options.

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

How to find low-cost health care in your community:

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

HealthCare.gov/community-health-centers

Catastrophic Plans:

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

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

Pharmaceutical Assistance Programs:

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

Medicare.gov/pharmaceutical-assistance-program

Exemptions from the requirement to have health insurance:

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

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

Individual Shared Responsibility Provision:

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

Individual Shared Responsibility Provision – Exemptions: Claiming or Reporting

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

Hardship and Affordability Health Coverage Exemption Forms:

HealthCare.gov/exemption-form-instructions

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

Types of Health Insurance that Count as MEC:

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

Incarceration:

HealthCare.gov/incarcerated-people

If you already have Medicare coverage:

HealthCare.gov/medicare

How to get or stay on a parent's plan:

HealthCare.gov/young-adults/children-under-26

Student health plans & other options:

HealthCare.gov/young-adults/college-students