

# Patient Protection and Affordable Care Act Basics



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# Contents

Course Introduction .....	6
Welcome.....	6
Disclaimers .....	7
Definitions .....	9
Course Goal.....	10
Overview of the PPACA.....	12
Introduction .....	12
Major Provisions of the PPACA.....	13
The Health Insurance Marketplaces.....	14
Using the Health Insurance Marketplaces .....	15
HealthCare.gov .....	16
Knowledge Check .....	17
Common Misconceptions About the PPACA.....	18
Key Points.....	19
Consumer Protections Under the PPACA.....	20
Introduction .....	20
Consumer Protections.....	21
Access to Coverage of Certain Preventive Services at No Extra Cost.....	22
Coverage Regardless of Pre-existing Conditions .....	23
Coverage for Young Adults .....	24
Knowledge Check .....	25
Key Points.....	26
Health Insurance Company Responsibilities Under the PPACA .....	27
Introduction .....	27
Requirements for Health Insurance Companies .....	28
Help Consumers Understand Their Health Coverage.....	29
Pre-existing Conditions and Canceling Coverage .....	31
Essential Health Benefits With or Without Annual or Lifetime Limits.....	32
Knowledge Check .....	33
Key Points.....	34
Consumer Responsibilities Under the PPACA.....	35

Introduction .....	35
Minimum Essential Coverage (MEC) (cont'd).....	37
Exemptions from the Requirement to Have MEC .....	39
Employer Shared Responsibility Payment.....	41
Knowledge Check .....	42
Key Points.....	43
Lowering Consumers' Health Coverage Costs.....	44
Introduction .....	44
Options for Lowering Health Coverage Costs .....	45
Premium Tax Credits .....	46
Reconciling Advance Payments of the Premium Tax Credit.....	47
Reconciling Advance Payments of the Premium Tax Credit (cont'd) .....	48
Cost-sharing Reductions: Out-of-pocket Savings Only With a Silver Plan .....	49
Knowledge Check .....	51
Key Points.....	52
Other Financial Provisions of the PPACA .....	53
Introduction .....	53
Financial Requirement: Modified Adjusted Gross Income .....	54
MAGI Family Size and Income Counting Rules.....	56
Duty to Report Accurate Income .....	57
Medicaid Expansion .....	58
Medicaid Expansion and the Marketplaces .....	60
Knowledge Check .....	61
Key Points.....	62
Introduction to Medicaid.....	63
Introduction .....	63
Medicaid Basics .....	64
Mandatory Medicaid Benefits .....	65
Medicaid Eligibility Based on Categorical Requirements .....	66
In All States: Mandatory Eligibility Groups.....	67
In Some States: Optional Eligibility Groups .....	69
Knowledge Check .....	70

Presumptive Eligibility for Medicaid .....	71
Nonfinancial Requirements for Medicaid .....	72
Medicaid and Immigration Status .....	73
Limited Medicaid Benefits .....	75
Key Points.....	76
Introduction to CHIP .....	77
Introduction .....	77
CHIP Basics.....	78
CHIP Benefits and Cost Sharing .....	79
CHIP Eligibility .....	80
CHIP Eligibility and Presumptive Eligibility .....	81
CHIP Eligibility and Immigration Status .....	82
Knowledge Check .....	83
Key Points.....	84
Introduction to Medicare .....	85
Introduction .....	85
Medicare Basics.....	86
Medicare Basics (cont'd).....	87
Referring Consumers to Other Organizations for Help with Medicare .....	88
Medicare Benefits: Different Parts.....	89
Premium-Free Part A Medicare and Eligibility .....	90
Premium Part A Medicare and Eligibility.....	91
Transition to Medicare and Interaction with Marketplace Coverage.....	92
Transition to Medicare and Interaction with Marketplace Coverage (cont'd).....	94
Help With Medicare Costs.....	95
Knowledge Check .....	96
Knowledge Check .....	97
Medicare Eligibility and Immigration Status .....	98
Key Points.....	99
The Coverage Gap .....	100
Introduction .....	100
Low-Income Consumers Who Don't Qualify for Public Coverage and Can't Afford Private Coverage .....	101

Options for Consumers that Fall into a Coverage Gap .....	102
Key Points.....	103
Conclusion.....	104
Resources .....	105

# Course Introduction

## Welcome

The screenshot shows a digital course interface. At the top, there is a dark blue header with 'Course Introduction' on the left, 'Text Version' with a red 'on' indicator in the middle, and 'Exit Course' on the right. Below this is a blue bar with the word 'Welcome'. The main content area is white. On the left, a woman named Taniya, wearing a blue button-down shirt and a dark skirt, stands with her right hand extended. A speech bubble next to her contains the text: 'Hello, my name is Taniya. How has the Patient Protection and Affordable Care Act (PPACA) made health coverage more accessible and affordable to consumers? You'll learn more details in this course.' To the right of Taniya is a large whiteboard with a grey border. The whiteboard has the heading 'Can you answer these questions?' in a cursive font. Below the heading are three questions: 'How does the PPACA protect consumers and help them get affordable health coverage?', 'What responsibilities do health insurance companies now have?', and 'How does the PPACA affect consumers who are eligible for public health coverage like Medicare and Medicaid?'. At the bottom of the slide is a dark blue navigation bar with icons and labels for 'Menu', 'Help', 'Glossary', 'Resources', 'Map', 'Module 1 of 11', 'Page 1 of 4', and navigation arrows.

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

How does the PPACA protect consumers and help them get affordable health coverage?

What responsibilities do health insurance companies now have?

How does the PPACA affect consumers who are eligible for public health coverage like Medicare and Medicaid?

## Disclaimers

The screenshot shows a training course interface. At the top, there are navigation options: 'Course Introduction', 'Text Version' (with a toggle switch), and 'Exit Course'. Below this is a blue header with the word 'Disclaimers'. On the left, a woman in a blue shirt and black skirt points towards a tablet. A speech bubble next to her says: 'Before we begin, you need to be aware of these training disclaimers. Select "Continue" on the tablet to read each disclaimer.' The tablet displays the 'Assister Training Content' disclaimer, which states that the course is not intended to replace statutes, regulations, and formal policy guidance, and that it summarizes current policy and operations as of the date it was uploaded. It also mentions that the course includes references and links to nongovernmental third-party websites for informational purposes only. At the bottom of the tablet screen, there are two buttons: 'Previous' and 'Continue'. The bottom of the screenshot shows a navigation bar with icons for 'Menu', 'Help', 'Glossary', 'Resources', and 'Map', along with the text 'Module 1 of 11' and 'Page 2 of 4'.

You need to be aware of these training disclaimers.

### **Assister Training Content:**

The information provided in this training course is not intended to take the place of the statutes, regulations, and formal policy guidance that it is based upon. This course summarizes current policy and operations as of the date it was uploaded to the Marketplace Learning Management System. Links to certain source documents have been provided for your reference. We encourage persons taking the course to refer to the applicable statutes, regulations, CMS assister webinars, and other interpretive materials for complete and current information.

This course includes references and links to nongovernmental third-party websites. CMS offers these links for informational purposes only, and inclusion of these websites should not be construed as an endorsement of any third-party organization's programs or activities.

### **Coronavirus (COVID-19):**

This training does not address COVID-19-related guidance or related requirements for assisters. CMS will communicate applicable information to assisters and assister organizations through separate channels.

- To learn more about how we're responding to coronavirus, visit [HealthCare.gov/blog/coronavirus-marketplace-coverage/](https://www.hhs.gov/health-care/blog/coronavirus-marketplace-coverage/).
- For preventive practices and applicable state/local guidance, visit [CDC.gov/coronavirus](https://www.cdc.gov/coronavirus/).

### **Individual Shared Responsibility Payment, Exemptions, and Catastrophic Coverage:**

This course includes numerous references to the Patient Protection and Affordable Care Act's individual shared responsibility provision and exemptions from it. Under the Tax Cuts and Jobs Act, taxpayers must continue to report minimum essential coverage, qualify for an exemption, or pay an individual shared responsibility payment for tax years prior to 2019.

**For tax year 2018 only** (for which consumers generally filed taxes by April 2019), consumers do not have to fill out an application to get a hardship exemption certificate number (ECN). Consumers can claim the exemption without having to submit documentation about the hardship on their 2018 federal tax returns.

**Beginning with tax year 2019**, consumers do not need to make an individual shared responsibility payment or file Form 8965, Health Coverage Exemptions, with their tax returns if they don't have minimum essential coverage for part or all of the tax year.

**For all tax years**, as set forth in §155.305(h), 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.

**Remote Application Assistance:**

Effective June 18, 2018, Navigators in FFMs are not required to maintain a physical presence in their Marketplace service area. In some cases, Navigators may provide remote application assistance (e.g., online or by phone), provided that such assistance is permissible under their organization's contract, grant terms and conditions, or agreement with CMS and/or their organization.

Certified application counselors in FFMs may also provide remote application assistance if such assistance is permissible with their certified application counselor designated organization (CDO).

For guidance on obtaining consumers' consent remotely over the phone, visit: [Marketplace.cms.gov/technical-assistance-resources/obtain-consumer-authorization.pdf](https://www.cms.gov/technical-assistance-resources/obtain-consumer-authorization.pdf).

**Section 1557 of the Patient Protection and Affordable Care Act:**

This training content reflects the requirements of the Section 1557 Final Rule published on June 19, 2020 (85 FR 37160). Some of these requirements may change pending the outcome of lawsuits brought against HHS seeking declaratory and injunctive relief from the Final Rule, and are also affected by previous court orders dating back to December 2016 that continue to be litigated.

## Definitions

Course Introduction Text Version  Exit Course

### Definitions

In this lesson, the terms "you" and "assister" refer to the following types of assisters:  
Select each nametag.



**HealthCare.gov**  
**Navigators**  
in Federally-facilitated Marketplaces



**HealthCare.gov**  
**Certified application counselors**  
in Federally-facilitated Marketplaces

Note: In some cases, "you" is also used to refer to a consumer but it should be clear when this is the intended meaning.  
The terms "Federally-facilitated Marketplace" and "FFM," as used in this training course, include FFMs where the state performs plan management functions. The terms "Marketplace" or "Marketplaces," standing alone, often (but not always) refer to FFMs.

Menu Help Glossary Resources Map Module 1 of 11 Page 3 of 4

In this lesson, the terms "you" and "assister" refer to the following types of assisters:

**Navigators** in Federally-facilitated Marketplaces

**Certified application counselors** in Federally-facilitated Marketplaces

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

The terms "Federally-facilitated Marketplace" and "FFM," as used in this training course, include FFMs where the state performs plan management functions. The terms "Marketplace" or "Marketplaces," standing alone, often (but not always) refer to FFMs.

## Course Goal

Course Introduction Text Version Exit Course

### Course Goal

Congress enacted the Patient Protection and Affordable Care Act 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 PPACA.

**Goal:** 

This course provides an overview of the PPACA, 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
- Common misconceptions about the PPACA
- Consumer protections (coverage for preventive services, pre-existing conditions, etc.)
- New 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 Medicare eligibility and benefits
- Medicare premiums and help with costs
- Consumers in the coverage gap

Menu Help Glossary Resources Map Module 1 of 11 Page 4 of 4

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### Topics:

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- Modified adjusted gross income (MAGI)
- Medicaid expansion
- Medicaid, CHIP, and Medicare eligibility and benefits

- Medicare premiums and help with costs
- Consumers in the coverage gap

# Overview of the PPACA

## Introduction

The screenshot shows a course interface with a dark header bar containing 'Overview of the PPACA', 'Text Version' (with a toggle switch), and 'Exit Course'. Below the header is a blue bar labeled 'Introduction' with the text: 'The PPACA is a comprehensive health care reform law that provides numerous rights and protections to consumers.' The main content area features a central graphic of three large, overlapping arrows pointing right, numbered 01, 02, and 03. To the left of these arrows are three grey boxes: '01 Major Provisions Identify the major provisions of the PPACA', '02 Marketplaces Describe how the Marketplaces can help consumers obtain health coverage', and '03 Misconceptions State common misconceptions about the PPACA'. A bottom navigation bar includes icons for Menu, Help, Glossary, Resources, and Map, along with the text 'Module 2 of 11', 'Page 1 of 8', and navigation arrows.

The PPACA is a comprehensive health care reform law that provides numerous rights and protections to consumers.

### **Major Provisions**

Identify the major provisions of the PPACA

### **Marketplaces**

Describe how the Marketplaces can help consumers obtain health coverage

### **Misconceptions**

State common misconceptions about the PPACA

# Major Provisions of the PPACA

Overview of the PPACA Text Version Exit Course

## Major Provisions of the PPACA

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

The law provides:

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

Menu Help Glossary Resources Map Module 2 of 11 Page 2 of 8

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- Legal protections that help consumers get coverage— even if they're sick

# The Health Insurance Marketplaces

Overview of the PPACA Text Version  Exit Course

## The Health Insurance Marketplaces

The PPACA also established the Health Insurance Marketplaces. Eligible consumers can get coverage through the Marketplaces for individuals and families.

To be eligible for coverage through a Marketplace, individuals and families must:

-  Be United States (U.S.) citizens or U.S. nationals, or noncitizens who are lawfully present in the U.S. for the entire time they plan to have health coverage
-  Not be [incarcerated](#) (unless pending the disposition of charges, i.e., being held without having been formally convicted of a crime)
-  Live in the U.S. and meet state residency requirements for the Marketplace where they want to get coverage

Learn about [eligible immigration statuses](#).

The Marketplaces allow consumers to:

- Use a single streamlined application to find out if they're eligible for coverage
- Conduct an apples-to-apples comparison of [qualified health plans](#) (QHPs)

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

Menu  Help  Glossary  Resources  Map Module 2 of 11  Page 3 of 8 

The PPACA also established the Health Insurance Marketplaces. Eligible consumers can get coverage through the Marketplaces for individuals and families.

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- Not be [incarcerated](#) (unless pending the disposition of charges, i.e., being held without having been formally convicted of a crime)
- Live in the U.S. and meet state residency requirements for the Marketplace where they want to get coverage

Learn about [eligible immigration statuses](#)

The Marketplaces allow consumers to:

Use a single streamlined application to find out if they're eligible for coverage

Conduct an apples-to-apples comparison of **qualified health plans\*** (QHPs)

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

### \*Qualified Health Plan

Under the PPACA, a health insurance plan that is certified by a Marketplace is called a QHP. A QHP:

- Provides essential health benefits (EHB), including certain recommended preventive services that are covered with no additional out-of-pocket cost to the consumer
- 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

# Using the Health Insurance Marketplaces

The screenshot shows a presentation slide with a woman on the left holding a document. A speech bubble next to her says: "Eligible consumers can enroll in QHPs during the annual Open Enrollment Period (OEP) or during a Special Enrollment Period (SEP)." To the right, a large blue box contains two text blocks. The top block states: "In the Marketplaces for individuals and families, the OEP starts on November 1, 2020 and ends December 15, 2020. Coverage can begin as soon as January 1, 2021 for consumers who enroll by December 15, 2020." The bottom block states: "In the Small Business Health Options Program (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 point throughout the year by working with a QHP issuer or SHOP-registered agent or broker." A "Continue" button is at the bottom right of the blue box. The slide has a header "Overview of the PPACA" and "Using the Health Insurance Marketplaces". The footer includes "Menu", "Help", "Glossary", "Resources", "Map", "Module 2 of 11", "Page 4 of 8", and navigation arrows.

Eligible consumers can enroll in QHPs during the annual Open Enrollment Period (OEP) or during a Special Enrollment Period (SEP).

In the Marketplaces for individuals and families, the OEP starts on November 1, 2020 and ends December 15, 2020. Coverage can begin as soon as January 1, 2021 for consumers who enroll by December 15, 2020.

In the Small Business Health Options Program (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 point throughout the year by working with a QHP issuer or SHOP-registered agent or broker.

Consumers who experience certain life events at any time during the year, such as 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](https://www.medicare.gov) for the Medicare Open Enrollment dates.

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.

Overview of the PPACA

Text Version  Exit Course

HealthCare.gov

Consumers can learn more about the PPACA and the Health Insurance Marketplaces at HealthCare.gov, including information such as:

- 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 PPACA, consumers can also visit:

- [HHS.gov/HealthCare](https://www.hhs.gov/HealthCare): For information about the benefits and progress of the PPACA, and
- [CMS.gov/CCIIO](https://www.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.

Menu Help Glossary Resources Map Module 2 of 11 Page 5 of 8

Consumers can learn more about the PPACA and the Health Insurance Marketplaces at HealthCare.gov, including information such as:

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

# Knowledge Check

Overview of the PPACA Text Version  Exit Course

## Knowledge Check



Susan, a freelance beautician, comes to you to find out how the PPACA can help her enroll in health coverage.

Which of the following do you tell her?

Choose **all that apply** and then select **Check Your Answer**.

- A. The PPACA may give Susan access to health coverage through a Marketplace if she is eligible.
- B. Susan can compare QHPs through the Marketplace in her state.
- C. The PPACA 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

Menu Help Glossary Resources Map Module 2 of 11 Page 6 of 8

Susan, a freelance beautician, comes to you to find out how the PPACA can help her enroll in health coverage. Which of the following do you tell her?

- A. The PPACA may give Susan access to health coverage through a Marketplace if she is eligible.
- B. Susan can compare QHPs through the Marketplace in her state.
- C. The PPACA 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.

The correct answers are A and B. The PPACA allows consumers to compare QHPs and enroll in health coverage through the Marketplaces if they're eligible. For individual market coverage starting in 2021, Open Enrollment starts November 1, 2020 and ends December 15, 2020. Consumers may qualify for SEPs if they experience certain life events.

## Common Misconceptions About the PPACA

Overview of the PPACA Text Version  Exit Course

### Common Misconceptions About the PPACA

There are some common misconceptions about the PPACA. To set the record straight, you can tell consumers that the law:

- ✓ Makes prescription drug coverage more affordable for Medicare beneficiaries and doesn't reduce Medicare benefits
- ✓ Requires many employers to offer health coverage to their full-time employees and their dependents but does not affect all employers
- ✓ Requires most individuals to have MEC or qualify for an exemption
- ✓ Offers consumer protections and makes coverage more affordable for eligible consumers



Menu Help Glossary Resources Map Module 2 of 11 Page 7 of 8

There are some common misconceptions about the PPACA. To set the record straight, you can tell consumers that the law:

- Makes prescription drug coverage more affordable for Medicare beneficiaries and doesn't reduce Medicare benefits
- Requires many employers to offer health coverage to their full-time employees and their dependents but does not affect all employers
- Requires most individuals to have MEC or qualify for an exemption
- Offers consumer protections and makes coverage more affordable for eligible consumers

## Key Points

Overview of the PPACA Text Version  Exit Course

### Key Points



- 01 The PPACA enables eligible consumers to get health coverage through the Marketplaces.
- 02 Eligible consumers can enroll in QHPs during the annual OEP or during an SEP.
- 03 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.

Menu Help Glossary Resources Map Module 2 of 11 Page 8 of 8

- The PPACA enables eligible consumers to get health coverage through the Marketplaces.
- 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 Protections Under the PPACA

## Introduction

Consumer Protections Under the PPACA Text Version  Exit Course

**Introduction**

The PPACA makes health coverage more accessible to consumers.

**01 Consumer Protections**  
State the consumer protections established by the PPACA

**02 Preventive Services**  
State the preventive services usually available without cost sharing

**03 Pre-existing Conditions & Young Adults**  
Describe protections for individuals with pre-existing conditions and for young adults

Menu Help Glossary Resources Map Module 3 of 11 Page 1 of 7

The PPACA makes health coverage more accessible to consumers.

### **Consumer Protections**

State the consumer protections established by the PPACA

### **Preventive Services**

State the preventive services usually available without cost sharing

### **Pre-existing Conditions & Young Adults**

Describe protections for individuals with pre-existing conditions and for young adults

# Consumer Protections

Consumer Protections Under the PPACA

Text Version  Exit Course

## Consumer Protections

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 several key consumer protections under the PPACA that make health coverage more accessible to consumers.



Menu Help Glossary Resources Map Module 3 of 11 Page 2 of 7

There are several key consumer protections under the PPACA 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

## Access to Coverage of Certain Preventive Services at No Extra Cost

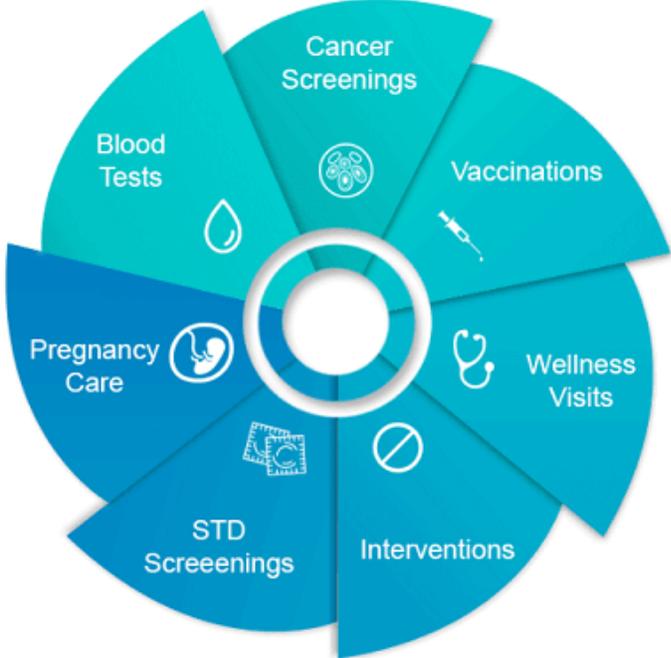
Consumer Protections Under the PPACA

Text Version  Exit Course

### Access to Coverage of Certain Preventive Services at No Extra Cost

Previously, consumers with health coverage generally paid a copayment or other cost-sharing amount for common preventive health care services.

Now 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.



The infographic is a circular wheel divided into seven segments, each representing a different preventive service. The segments are arranged in a circle around a central white circle. The services and their corresponding icons are: Blood Tests (water drop), Cancer Screenings (microscope), Vaccinations (syringe), Wellness Visits (stethoscope), Interventions (pill with slash), STD Screenings (microscope), and Pregnancy Care (pregnant woman).

Menu Help Glossary Resources Map Module 3 of 11 Page 3 of 7

Previously, consumers with health coverage generally paid a copayment or other cost-sharing amount for common preventive health care services.

Now 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.

## Coverage Regardless of Pre-existing Conditions

Consumer Protections Under the PPACA

Text Version  Exit Course

### Coverage Regardless of Pre-existing Conditions

Before the PPACA, federal law generally didn't prohibit health insurance companies from denying health coverage to consumers in the individual market based on 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.

The PPACA guarantees that consumers with pre-existing conditions – including diabetes and cancer – can apply for and purchase health insurance if they are otherwise eligible. Consumers may generally renew an existing policy regardless of their health status.



Menu  Help  Glossary  Resources  Map Module 3 of 11  Page 4 of 7 

Before the PPACA, federal law generally didn't prohibit health insurance companies from denying health coverage to consumers in the individual market based on 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.

The PPACA guarantees that consumers with pre-existing conditions – including diabetes and cancer – can apply for and purchase health insurance if they are otherwise eligible. Consumers may generally renew an existing policy regardless of their health status.

## Coverage for Young Adults

Consumer Protections Under the PPACA

Text Version  Exit Course

### Coverage for Young Adults

Previously, states could limit how long young adults were allowed to remain enrolled in coverage through a parent's health insurance plan.

Now, the PPACA 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).



Menu Help Glossary Resources Map Module 3 of 11 Page 5 of 7

Previously, states could limit how long young adults were allowed to remain enrolled in coverage through a parent's health insurance plan.

Now, the PPACA 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).

Consumers should check with their plans to be sure. Some states and plans have different rules.

## Knowledge Check

Consumer Protections Under the PPACA

Text Version  Exit Course

### Knowledge Check



The PPACA provides consumers with several rights and protections. Which of the following is **NOT** a right or protection included in the PPACA? Choose 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

Menu Help Glossary Resources Map Module 3 of 11 Page 6 of 7

The PPACA provides consumers with several rights and protections.

Which of the following is NOT a right or protection included in the PPACA?

- 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.

The correct answer is B. Under the PPACA, 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 PPACA requires most plans that offer dependent child coverage to allow children and dependents to be covered under their parents' plans up to age 26 or other allowable age as defined by the plan or state.

## Key Points

Consumer Protections Under the PPACA

Text Version  Exit Course

### Key Points

The PPACA:



- 01 Provides consumer protections and coverage options.
- 02 Provides a way for qualified individuals to get health coverage through a Marketplace.
- 03 Provides access to coverage for certain preventive services without cost sharing under most health plans.
- 04 Provides a way for qualified small employers to offer coverage to their employees, former employees, and dependents of employees/former employees through a SHOP Marketplace.

Menu Help Glossary Resources Map Module 3 of 11 Page 7 of 7

### The PPACA:

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# Health Insurance Company Responsibilities Under the PPACA

## Introduction

Health Insurance Company Responsibilities Under the PPACA Text Version  Exit Course

**Introduction**

In addition to making health coverage more accessible, the PPACA makes it easier for consumers to understand.

**01** **New Requirements**  
State the new requirements established for health insurance companies under the PPACA

**02** **Understanding Coverage**  
Describe the requirement for helping consumers understand their coverage

**03** **Required Coverage**  
Describe the requirement for providing coverage for pre-existing conditions and essential health benefits

Menu Help Glossary Resources Map Module 4 of 11 Page 1 of 7

In addition to making health coverage more accessible, the PPACA makes it easier for consumers to understand.

### **New Requirements**

State the new requirements established for health insurance companies under the PPACA

### **Understanding Coverage**

Describe the requirement for helping consumers understand their coverage

### **Required Coverage**

Describe the requirement for providing coverage for pre-existing conditions and essential health benefits

# Requirements for Health Insurance Companies

Health Insurance Company Responsibilities Under the PPACA

Text Version  Exit Course

## Requirements for Health Insurance Companies

Major features of the PPACA 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, EHB, when offering coverage to individual consumers and small employers; and
- Prohibit annual and lifetime dollar limits on coverage of EHB.

Menu Help Glossary Resources Map Module 4 of 11 Page 2 of 7

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# Help Consumers Understand Their Health Coverage

Health Insurance Company Responsibilities Under the PPACA
Text Version ON
Exit Course

**Help Consumers Understand Their Health Coverage**

Previously, 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.

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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$35 copay/office visit and 20% coinsurance for other outpatient services	40% coinsurance	—none—
	Inpatient services	20% coinsurance	40% coinsurance	—none—
<b>If you are pregnant</b>	Office Visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
	Home health care	20% coinsurance	40% coinsurance	60 visits/year
	Rehabilitation services	20% coinsurance	40% coinsurance	60 visits/year. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	20% coinsurance	40% coinsurance	

Menu
Help
Glossary
Resources
Map
Module 4 of 11
Page 3 of 7

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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.

Sample of an SBC

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 copay/office visit and 20% coinsurance for other outpatient services	40% coinsurance	—none—
	Inpatient services	20% coinsurance	40% coinsurance	—none—
If you are pregnant	Office Visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	60 visits/year
	Rehabilitation services	20% coinsurance	40% coinsurance	60 visits/year. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	60 visits/calendar year
	Durable medical equipment	20% coinsurance	40% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice service	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	\$35 copay/ visit	Not Covered	Limited to one exam/year
	Children's glasses	20% coinsurance	Not Covered	Limited to one pair of glasses/year
	Children's dental check-up	No Charge	Not Covered	—none—

## Pre-existing Conditions and Canceling Coverage

Health Insurance Company Responsibilities Under the PPACA

Text Version  Exit Course

### Pre-existing Conditions and Canceling Coverage

Remember, health insurance companies can no longer refuse to sell coverage to consumers with pre-existing conditions or charge more for that coverage.

Unless an exception applies, health insurance companies must also refrain from canceling consumers' coverage as long as any premiums are paid.

Previously, federal law didn't prohibit health insurance companies from retroactively canceling consumers' coverage because of mistakes on their applications. Under the PPACA, insurers can only cancel a consumer's coverage retroactively if the consumer committed fraud and/or made an intentional misrepresentation of material fact.



Menu Help Glossary Resources Map Module 4 of 11 Page 4 of 7

Remember, health insurance companies can no longer refuse to sell coverage to consumers with pre-existing conditions or charge more for that coverage.

Unless an exception applies, health insurance companies must also refrain from canceling consumers' coverage as long as any premiums are paid.

Previously, federal law didn't prohibit health insurance companies from retroactively canceling consumers' coverage because of mistakes on their applications. Under the PPACA, insurers can only cancel a consumer's coverage retroactively if the consumer committed fraud and/or made an intentional misrepresentation of material fact.

# Essential Health Benefits With or Without Annual or Lifetime Limits

Health Insurance Company Responsibilities Under the PPACA

Text Version  Exit Course

## Essential Health Benefits With or Without Annual or Lifetime Limits

Previously, health insurance companies could sell health plans with different sets of benefits. Now, nearly all health plans that are sold to individuals or small employers must cover comprehensive core services or EHB.

Also, federal law did not 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.

Now, 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.



Menu Help Glossary Resources Map Module 4 of 11 Page 5 of 7

Previously, health insurance companies could sell health plans with different sets of benefits. Now, nearly all health plans that are sold to individuals or small employers must cover comprehensive core services or EHB.

Also, federal law did not 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.

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

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

Now, 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.

# Knowledge Check

Health Insurance Company Responsibilities Under the PPACA

Text Version  Exit Course

Knowledge Check

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

Choose 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 cannot set dollar limits on what they spend for coverage of EHB.

Check Your Answer



Menu Help Glossary Resources Map Module 4 of 11 Page 6 of 7

Health insurance companies have certain responsibilities under the PPACA.

Which of the following is **NOT** a responsibility for health insurance companies included in the PPACA?

- 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 cannot set dollar limits on what they spend for coverage of EHB.

The correct answer is C. Under the PPACA, 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 cannot 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.

## Key Points

Health Insurance Company Responsibilities Under the PPACA

Text Version  Exit Course

### Key Points

The PPACA establishes specific responsibilities for health insurance companies. Under the law, they must:



- 01 Provide standard information for consumers so they can easily understand their coverage and compare it to other available options
- 02 Offer EHB without annual or lifetime limits

Menu Help Glossary Resources Map Module 4 of 11 Page 7 of 7

The PPACA establishes specific responsibilities for health insurance companies. Under the law, they must:

- Provide standard information for consumers so they can easily understand their coverage and compare it to other available options
- Offer EHB without annual or lifetime limits

# Consumer Responsibilities Under the PPACA

## Introduction

Consumer Responsibilities Under the PPACA Text Version  Exit Course

**Introduction**

In addition to understanding health insurance companies' responsibilities under the PPACA, you should also be able to explain consumers' and employers' responsibilities.

**01** **Minimum Essential Coverage**  
Describe the requirement for maintaining minimum essential coverage

**02** **Exemptions**  
Understand that some consumers may need an exemption from the individual shared responsibility requirement under certain circumstances

**03** **Employer Responsibilities**  
State the responsibilities of an employer under the PPACA

Menu Help Glossary Resources Map Module 5 of 11 Page 1 of 7

In addition to understanding health insurance companies' responsibilities under the PPACA, you should also be able to explain consumers' and employers' responsibilities.

### **Minimum Essential Coverage**

Describe the requirement for maintaining minimum essential coverage

### **Exemptions**

Understand that some consumers may need an exemption from the individual shared responsibility requirement under certain circumstances

### **Employer Responsibilities**

State the responsibilities of an employer under the PPACA

# Minimum Essential Coverage (MEC)

Consumer Responsibilities Under the PPACA Text Version  Exit Course

## Minimum Essential Coverage (MEC)

The PPACA requires consumers to have health coverage that is considered MEC. Most people in the U.S. are required to have 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

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### Minimum Essential Coverage (MEC)

Any insurance plan that meets the Affordable Care Act requirement for having health coverage. To avoid the penalty for not having insurance for plans 2018 and earlier, you must be enrolled in a plan that qualifies as minimum essential coverage (sometimes called "qualifying health coverage"). Examples of plans that qualify include: Marketplace plans; job-based plans; Medicare; and Medicaid & CHIP.

**Note:** Starting with the 2019 plan year (for which you'll file taxes in April 2020), the penalty no longer applies.

#### Related content

- [See the types of plans that do and don't qualify as minimum essential coverage](#)
- [Learn how much you'll pay if you don't have health insurance for 2018 and earlier](#)

Menu Help Glossary Resources Map Module 5 of 11 Page 2 of 7

The PPACA requires consumers to have health coverage that is considered MEC. Most people in the U.S. are required to have 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) (cont'd)

Consumer Responsibilities Under the PPACA Text Version  Exit Course

### Minimum Essential Coverage (MEC) (cont'd)

Most private health insurance plans are considered MEC. Consumers are required to have coverage that qualifies as MEC unless they qualify for an [exemption](#).

Consumers can meet the [MEC requirement](#) in several ways, including:

- Qualifying for and enrolling in an available QHP
- Qualifying for and enrolling in certain public coverage programs such as Medicaid, CHIP, CHIP buy-in programs, or Medicare
- Being covered by programs such as TRICARE
- Being covered by job-based health coverage, including retiree or Consolidated Omnibus Reconciliation Act (COBRA) coverage

Other types of coverage that count as MEC can be found at [IRS.gov](https://www.irs.gov).



Menu Help Glossary Resources Map Module 5 of 11 Page 3 of 7

Most private health insurance plans are considered MEC. Consumers are required to have coverage that qualifies as MEC unless they qualify for an **exemption**.

Consumers can meet the **MEC requirement** in several ways, including:

- Qualifying for and enrolling in an available QHP
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- Being covered by job-based health coverage, including retiree or Consolidated Omnibus Reconciliation Act (COBRA) coverage

Other types of coverage that count as MEC can be found at [IRS.gov](https://www.irs.gov).

### Exemption

Under the PPACA, most people must maintain MEC under the individual shared responsibility requirement. However, the PPACA includes different categories of exemptions from this requirement. Exemptions are granted based on certain hardships and life events, health coverage or financial status, membership in some groups, and other circumstances.

### MEC requirement

The following are types of health coverage and whether they qualify as MEC:

- Any Marketplace medical plan or any individual insurance plan you already have (other than certain excepted benefits)
- Job-based plan, including retiree plans and COBRA coverage
- Medicare Part A
- Medicare Part C
- Most Medicaid coverage

- Most CHIP coverage, including CHIP buy-in programs that provide identical coverage to the state's Title XXI CHIP program
- Most individual health plans bought outside the Marketplace, including grandfathered plans (not all plans sold outside the Marketplace qualify as MEC)
- Coverage under a parent's plan (that qualifies 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)
- Health coverage for Peace Corps volunteers
- Certain types of veterans' health coverage through the VA
- Most TRICARE plans
- Department of Defense Non-appropriated Fund Health Benefits Program
- Refugee Medical Assistance
- State high-risk pools for plan or policy years that started on or before December 31, 2014 (check with the high-risk pool plan to see if it qualifies as MEC)

The following are types of health coverage that do not qualify as MEC:

- Coverage only for vision care or dental care
- Workers' compensation
- Coverage only for a specific disease or condition
- Plans that offer only discounts on medical services

# Exemptions from the Requirement to Have MEC

Consumer Responsibilities Under the PPACA

Text Version  Exit Course

## Exemptions from the Requirement to Have MEC

Under the Tax Cuts and Jobs Act of 2017, taxpayers must continue to report minimum essential coverage or qualify for an exemption from the PPACA's individual shared responsibility requirement. For tax years prior to 2019, individuals who fail to do so must pay an individual shared responsibility payment (fee) when they file federal income taxes. Consumers can apply for an exemption from the PPACA's individual shared responsibility requirement for the current year and up to two prior years. Here's a breakdown of the annual fee for each of the past three tax years:

Tax Year	Individual Shared Responsibility Payment	Consumers Needing Exemptions
2018	\$695 per adult, \$347.50 per child Maximum: \$2,085 OR 2.5% of household income, whichever is higher	<ul style="list-style-type: none"><li>Consumers claim all exemptions from the individual shared responsibility payment through the Internal Revenue Service (IRS) using <a href="#">Form 8965</a> when filing annual federal income tax returns.</li><li>Separately, consumers may apply for a hardship exemption from the Marketplace.</li></ul>
2019 and 2020	\$0	<ul style="list-style-type: none"><li>Consumers do not need an exemption unless they are age 30 or older and wish to purchase Catastrophic coverage. These consumers must apply for a hardship or affordability exemption through the Marketplace and obtain an exemption certificate number (ECN) to view and enroll in Catastrophic coverage.</li></ul>

There are different federal tax filing thresholds for individuals under age 65 and over age 65 and additional tax filing threshold categories, including head of household, married filing separately, and qualified widow/widower. Visit the [Internal Revenue Service \(IRS\)](#) website for more detailed information.

Let's review what this means for consumers you will assist in 2020.

- For tax year 2018**, consumers generally owed the fee for any month(s) in which they did not have coverage that qualified as MEC unless they obtained an exemption from the fee. Having MEC for one day in a month counts as having coverage during that month. Consumers could claim all hardship and affordability exemptions for 2018 through the IRS when filing their 2018 federal income taxes.
- Beginning with tax year 2019**, the fee is reduced to \$0 and individuals who choose to go without health insurance are no longer required to make shared responsibility payments. However, individuals age 30 and above must continue to obtain and report a hardship or affordability exemption from the individual shared responsibility requirement if they wish to purchase Catastrophic health coverage. Consumers under age 30 can apply for Catastrophic health coverage without obtaining an exemption. We will cover Catastrophic health coverage later in this course and in other training courses.

Menu Help Glossary Resources Map Module 5 of 11 Page 4 of 7

Under the Tax Cuts and Jobs Act of 2017, taxpayers must continue to report minimum essential coverage or qualify for an exemption from the PPACA's individual shared responsibility requirement. For tax years prior to 2019, individuals who fail to do so must pay an individual shared responsibility payment (fee) when they file federal income taxes. Consumers can apply for an exemption from the PPACA's individual shared responsibility requirement for the current year and up to two prior years. Here's a breakdown of the annual fee for each of the past three tax years:

### Tax year – 2018

Individual shared Responsibility Payment: \$625 per adult, \$347.50 per child, Maximum: \$2,085 or 2.5% of household income, whichever is higher

Consumers Needing Exemptions:

- Consumers claim all exceptions from the individual shared responsibility payment through the Internal Revenue Service (IRS) using [Form 8965](#) when filing annual federal income tax returns.
- Separately, consumers may apply for a hardship exemption from the Marketplace.

### Tax year – 2019 and 2020

Individual shared Responsibility Payment: \$0

Consumers Needing Exemptions:

There are different federal tax filing thresholds for individuals under age 65 and over age 65 and additional tax filing threshold categories, including head of household, married filing separately, and qualified widow/widower. Visit the [Internal Revenue Service \(IRS\)](#) website for more detailed information.

Let's review what this means for consumers you will assist in 2020.

- For tax year 2018**, consumers generally owed the fee for any month(s) in which they did not have coverage that qualified as MEC unless they obtained an exemption from the fee. Having MEC for one day in a month counts as having coverage during that month. Consumers could claim all hardship and affordability exemptions for 2018 through the IRS when filing their 2018 federal income taxes.

- **Beginning with tax year 2019**, the fee is reduced to \$0 and individuals who choose to go without health insurance are no longer required to make shared responsibility payments. However, individuals age 30 and above must continue to obtain and report a hardship or affordability exemption from the individual shared responsibility requirement if they wish to purchase Catastrophic health coverage. Consumers under age 30 can apply for Catastrophic health coverage without obtaining an exemption. We will cover Catastrophic health coverage later in this course and in other training courses.

# Employer Shared Responsibility Payment

Consumer Responsibilities Under the PPACA Text Version  Exit 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:

- ⊗ Is not affordable, or
- ⊗ Does not meet the [minimum value](#) standard.

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).

Menu Help Glossary Resources Map Module 5 of 11 Page 5 of 7

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:

- Is not affordable, or
- Does not meet the minimum value standard.

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).

\*Minimum value is a standard of minimum coverage that applies to job-based health plans. A health plan meets the minimum value standard if:

- 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.

## Knowledge Check

Consumer Responsibilities Under the PPACA Text Version  Exit Course

**Knowledge Check**



Jackie is a 28-year-old freelance writer who expects to earn more than \$50,000 in 2020. However, she didn't enroll in a QHP 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?

Choose 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 will not owe a fee for failing to obtain MEC in 2020.
- B. Because Jackie is self-employed and isn't offered job-based coverage, she doesn't have to have MEC in 2020.
- C. Because Jackie didn't enroll in a QHP or obtain other MEC in 2020, she may have to pay a fee when she files her 2020 tax return in 2021.
- D. If Jackie doesn't want coverage, she doesn't need to do anything.

Check Your Answer

Menu Help Glossary Resources Map Module 5 of 11 Page 6 of 7

Jackie is a 28-year-old freelance writer who expects to earn more than \$50,000 in 2020. However, she didn't enroll in a QHP 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?

Choose 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 will not owe a fee for failing to obtain MEC in 2020.
- B. Because Jackie is self-employed and isn't offered job-based coverage, she doesn't have to have MEC in 2020.
- C. Because Jackie didn't enroll in a QHP or obtain other MEC in 2020, she may have to pay a fee when she files her 2020 tax return in 2021.
- D. If Jackie doesn't want coverage, she doesn't need to do anything.

The correct answer is A. The correct answer is A. Even if Jackie is self-employed and not offered job-based coverage, she is still required to maintain MEC under the PPACA. However, Jackie will not 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

Consumer Responsibilities Under the PPACA Text Version  Exit Course

## Key Points



- 01** Consumers are required to maintain MEC under the PPACA.
- 02** Consumers who did not 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.
- 03** Exemptions from the individual shared responsibility requirement are available to consumers under certain circumstances.
- 04** Certain employers may also have to pay a fee if the coverage they offer to employees is not affordable or does not meet minimum value.

Menu Help Glossary Resources Map Module 5 of 11 Page 7 of 7

- Consumers are required to maintain MEC under the PPACA.
- Consumers who did not 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.
- Exemptions from the individual shared responsibility requirement are available to consumers under certain circumstances.
- Certain employers may also have to pay a fee if the coverage they offer to employees is not affordable or does not meet minimum value.

# Lowering Consumers' Health Coverage Costs

## Introduction

Lowering Consumers' Health Coverage Costs Text Version  Exit Course

**Introduction**

The PPACA created insurance affordability programs that can lower eligible consumers' costs when they enroll in health coverage through a Marketplace.

**01 Options to Lower Costs**  
State the options in the PPACA that can help eligible consumers lower their health coverage costs

**02 Advance Payments of the Premium Tax Credit**  
Describe the premium tax credit

**03 Cost-sharing Reductions**  
Describe cost-sharing reductions available to eligible individuals who enroll in a Silver health plan

Menu Help Glossary Resources Map Module 6 of 11 Page 1 of 8

The PPACA created insurance affordability programs that can lower eligible consumers' costs when they enroll in health coverage through a Marketplace.

### **Options to Lower Costs**

State the options in the PPACA 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**

Describe cost-sharing reductions available to eligible individuals who enroll in a Silver health plan

## Options for Lowering Health Coverage Costs

Lowering Consumers' Health Coverage Costs Text Version  Exit Course

### 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 premium tax credits (PTCs) that can be used in advance to reduce their monthly premiums when they enroll in a QHP through a Marketplace.
- Consumers may also qualify for lower additional costs such as lower copayments, coinsurance, and deductibles.
- Consumers and/or their children may be eligible for coverage through Medicaid or CHIP.



Menu Help Glossary Resources Map Module 6 of 11 Page 2 of 8

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 premium tax credits (PTCs) that can be used in advance to reduce their monthly premiums when they enroll in a QHP through a Marketplace.
- Consumers may also qualify for lower additional costs such as 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 Text Version  Exit Course

### 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.

PTCs are only available to consumers who enroll in QHPs through a Marketplace. Eligible consumers can use all, some, or none of their PTCs in advance to lower their monthly premiums—these are called advance payments of the premium tax credit (APTC).

Household Size	100%	133%	150%	200%	250%	300%	400%
1	\$12,760	\$16,971	\$19,140	\$25,520	\$31,900	\$38,280	\$51,040
2	\$17,240	\$22,929	\$25,860	\$34,480	\$43,100	\$51,720	\$68,960
3	\$21,720	\$28,888	\$32,580	\$43,440	\$54,300	\$65,160	\$86,880
4	\$26,200	\$34,846	\$39,300	\$52,400	\$65,500	\$78,600	\$104,800
5	\$30,680	\$40,804	\$46,020	\$61,360	\$76,700	\$92,040	\$122,720
6	\$35,160	\$46,763	\$52,740	\$70,320	\$87,900	\$105,480	\$140,640
7	\$39,640	\$52,721	\$59,460	\$79,280	\$99,100	\$118,920	\$158,560
8	\$44,120	\$58,680	\$66,180	\$88,240	\$110,300	\$132,360	\$176,480

Menu Help Glossary Resources Map Module 6 of 11 Page 3 of 8

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.

PTCs are only available to consumers who enroll in QHPs through a Marketplace. Eligible consumers can use all, some, or none of their PTCs in advance to lower their monthly premiums—these are called advance payments of the premium tax credit (APTC).

The FPL is a measure of income issued every year by the Department of Health and Human Services (HHS). FPLs are used to determine consumers' eligibility for certain programs and benefits, including savings on Marketplace health insurance, Medicaid, and CHIP coverage.

For more information about the FPL, visit <https://aspe.hhs.gov/poverty-guidelines>.

# Reconciling Advance Payments of the Premium Tax Credit

Lowering Consumers' Health Coverage Costs Text Version  Exit Course

## Reconciling Advance Payments of the Premium Tax Credit

If consumers use APTC in excess of the PTC they are determined eligible for, they may be required to repay the difference when they file their federal income tax returns.

If consumers use less PTC than they qualify for, they may receive the difference as a refundable credit.



**Report Changes in Household Income**

You should tell consumers who use APTC to report changes in household income or family size to the Marketplaces as soon as possible to avoid owing money to the IRS.



537.37 550.72  
538.29 557.16  
545.5 557.07  
01 559.71  
558.35

Menu Help Glossary Resources Map Module 6 of 11 Page 4 of 8

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### **Report Changes in Household Income**

You should tell consumers who use APTC to report changes in household income or family size to the Marketplaces as soon as possible to avoid owing money to the IRS.

## Reconciling Advance Payments of the Premium Tax Credit (cont'd)

Lowering Consumers' Health Coverage Costs Text Version  Exit Course

### Reconciling Advance Payments of the Premium Tax Credit (cont'd)

Remember, PTCs may be available to eligible consumers with household incomes between 100 percent and 400 percent of the FPL. In 2020, household income limits are:

-  Up to \$51,040 for an individual
-  Up to \$68,960 for a family of two
-  Up to \$104,800 for a family of four

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 residing immigrants 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 other training courses.



MenuHelpGlossaryResourcesMapModule 6 of 11Page 5 of 8

Remember, PTCs may be available to eligible consumers with household incomes between 100 percent and 400 percent of the FPL. In 2020, household income limits are:

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

Lowering Consumers' Health Coverage Costs Text Version  Exit 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 might also qualify for extra savings called cost-sharing reductions (CSRs). Consumers who qualify for 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.

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 APTC
- Enroll in a [Silver plan](#) through a Marketplace

Menu Help Glossary Resources Map Module 6 of 11 Page 6 of 8

Some consumers who apply for coverage through the Marketplaces and get APTC might also qualify for extra savings called cost-sharing reductions (CSRs). Consumers who qualify for 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.

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 APTC
- Enroll in a Silver plan through a Marketplace

Silver plans are designed so that the plan will typically pay an average of 70 percent of the cost of providing EHB. Consumers typically pay an average of 30 percent of their EHB costs for Silver plans in the form of out-of-pocket expenses such as deductibles, copayments, and coinsurance.

How CSRs work

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

- They will 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, such as annual physicals). A consumer eligible for CSRs might have a \$300 or \$500 deductible for that same Silver plan depending on his or her income.
- They will 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 have a lower “out-of-pocket maximum.” This is the maximum amount a consumer could have to pay out-of-pocket for his or her health care costs 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.

## Knowledge Check

Lowering Consumers' Health Coverage Costs Text Version  Exit Course

### Knowledge Check



George is a single 30 year old with no dependents who 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 \$20,000 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?

Choose **all that apply** and then select **Check Your Answer**.

- A. Advance payments of the premium tax credit
- B. Cost-sharing reductions
- C. CHIP
- D. Medicaid

Check Your Answer

Menu Help Glossary Resources Map Module 6 of 11 Page 7 of 8

George is a single 30 year old with no dependents who 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 \$20,000 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?

- A. Advance payments of the premium tax credit
- B. Cost-sharing reductions
- C. CHIP
- D. Medicaid

The correct answers are A and B. 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 advance payments of the premium tax credit and cost-sharing reductions if he enrolls in a Silver plan through a Marketplace for individuals and families. CHIP is generally only available for children up to age 19.

## Key Points

Lowering Consumers' Health Coverage Costs Text Version  Exit Course

### Key Points



**01** Eligible consumers may be able to lower their costs for Marketplace plans by taking advantage of APTC and CSRs.

---

**02** Generally, consumers who qualify for APTC must reconcile them when they file their federal income tax returns.

Menu Help Glossary Resources Map Module 6 of 11 Page 8 of 8

- Eligible consumers may be able to lower their costs for Marketplace plans by taking advantage of APTC and CSRs.
- Generally, consumers who qualify for APTC must reconcile them when they file their federal income tax returns.

# Other Financial Provisions of the PPACA

## Introduction

Other Financial Provisions of the PPACA Text Version  Exit Course

### Introduction

When determining consumers' eligibility for APTC and CSRs, the Marketplaces count consumers' incomes somewhat differently from public health coverage programs such as Medicaid and 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 PPACA.

- 01 Income Types**  
Identify the income types included in MAGI for various programs
- 02 Eligibility**  
Explain how MAGI is used to determine eligibility for Medicaid and CHIP
- 03 Medicaid Expansion**  
Describe how some states have expanded their Medicaid programs to cover all people with household incomes below a certain level

Menu Help Glossary Resources Map Module 7 of 11 Page 1 of 8

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### **Income Types**

Identify the income types included in MAGI for various programs

### **Eligibility**

Explain how MAGI is 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

## Financial Requirement: Modified Adjusted Gross Income

Other Financial Provisions of the PPACA Text Version  Exit Course

### Financial Requirement: 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 \(AGI\)](#) plus these, if any: untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest. 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. 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**

Sometimes a consumer's household includes people they live with who are not in their tax household, such as parents, siblings, and children. 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 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.



Menu Help Glossary Resources Map Module 7 of 11 Page 2 of 8

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.

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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. There are some other key differences in how state Medicaid and CHIP agencies count MAGI.

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:

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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 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 eligibility for children, pregnant women, parents, and single adults enrolled under the adult eligibility group created by the PPACA.

### MAGI Calculation

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.

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, such as:
  - 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.

### **Adjusted Gross Income (AGI)**

Federal tax rules for determining AGI in a tax-filing household include:

- 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 income
- Taxable and non-taxable Social Security income, including Social Security Disability Insurance (SSDI) and retirement benefits but not Supplemental Security Income (SSI)
- Unemployment benefits
- Investment income, including interest, dividends, and capital gains (MAGI does not consider resources such as bank accounts or stocks when determining Medicaid eligibility)

# MAGI Family Size and Income Counting Rules

Other Financial Provisions of the PPACA Text Version  Exit Course

## 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's a quick question for you.

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

**Answer**

Menu Help Glossary Resources Map Module 7 of 11 Page 3 of 8

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's a quick question for you.

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

No. For Medicaid and CHIP eligibility, consumers' household size can be based on immediate family members they live with such as 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 also used to determine a consumer's eligibility for APTC and CSRs through a Marketplace?

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

Other Financial Provisions of the PPACA

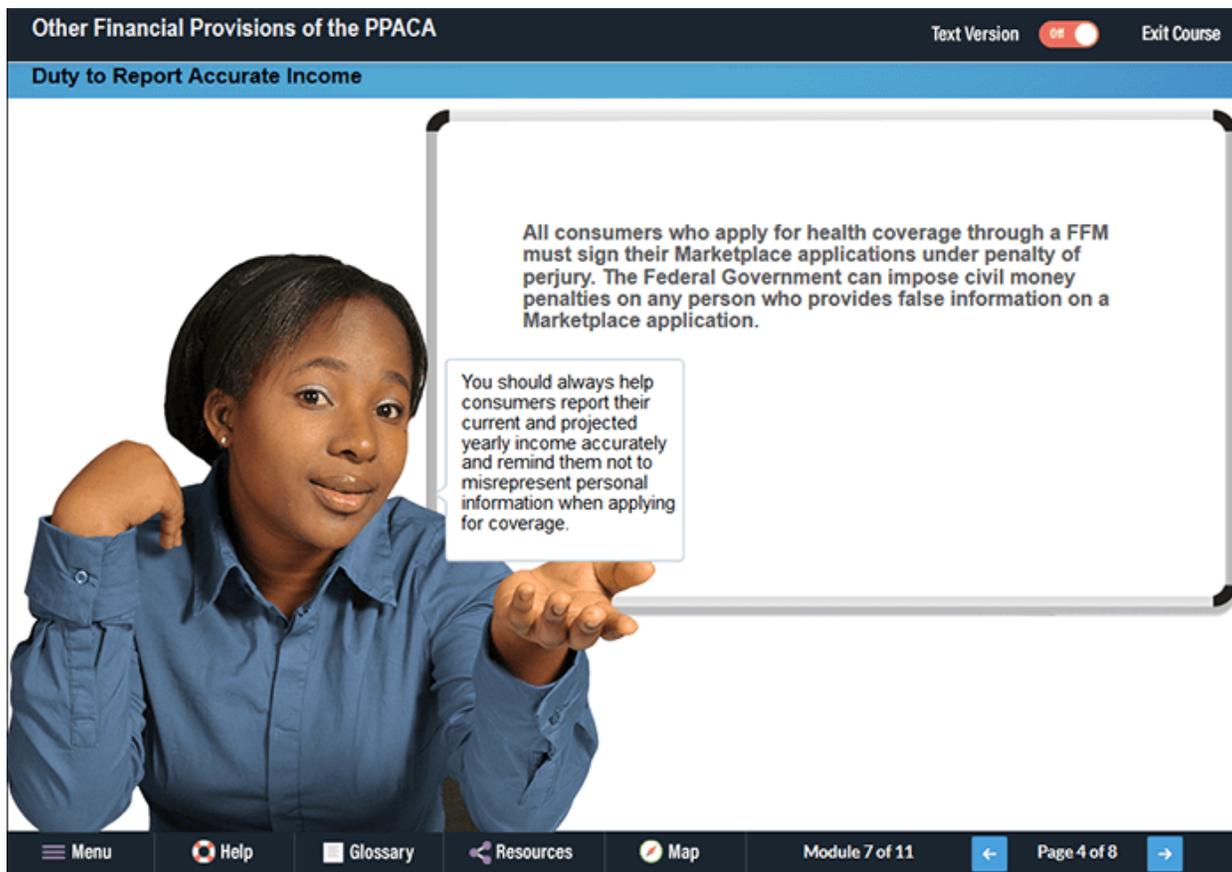
Text Version  Exit Course

Duty to Report Accurate Income

All consumers who apply for health coverage through a 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.

You should always help consumers report their current and projected yearly income accurately and remind them not to misrepresent personal information when applying for coverage.

Menu Help Glossary Resources Map Module 7 of 11 Page 4 of 8



You should always help consumers report their current and projected yearly income accurately and remind them not to misrepresent personal information when applying for coverage.

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# Medicaid Expansion

Other Financial Provisions of the PPACA Text Version  Exit Course

## Medicaid Expansion

The PPACA aims to significantly reduce the number of uninsured consumers by providing affordable coverage options through the Marketplaces, Medicaid, and CHIP. Under the law, some states have expanded their Medicaid programs to cover all people 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.

- **In all states:** Consumers can qualify for Medicaid based on income, household size, disability, family status, and other factors. Eligibility rules differ among states.
- **In states that have expanded Medicaid coverage:** Consumers who are adults age 19 through 64, not pregnant, and not entitled to or enrolled in Medicare can qualify for the adult group under the PPACA. If consumers' household income is below 133 percent of the FPL ([in practice](#), below 138 percent of the FPL) they generally qualify for Medicaid. A few states use a different income limit.

The Marketplaces help consumers receive a determination about whether they qualify based on these criteria. The tablet on this page shows how much consumers in states that have expanded Medicaid coverage can make and still qualify based on their household income. 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](#) for the next year is based on the new guidance once it's released.

Be sure you know whether the state you are 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 below to determine if your state or other states have expanded Medicaid.

Household Size	138% FPL, Which Is The Medicaid Eligibility Threshold In Most Expansion States
Individual:	\$17,609
Family of 2:	\$23,791
Family of 3:	\$29,974
Family of 4:	\$36,156
Family of 5:	\$42,338
Family of 6:	\$48,521
Family of 7:	\$54,703
Family of 8:	\$60,886

Menu Help Glossary Resources Map Module 7 of 11 Page 5 of 8

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

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Family of 6	\$48,521
Family of 7	\$54,703
Family of 8	\$60,886

**\*In Practice**

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

# Medicaid Expansion and the Marketplaces

Other Financial Provisions of the PPACA Text Version  Exit Course

## Medicaid Expansion and the Marketplaces



If your state has expanded its Medicaid program to cover low-income adults, you can help consumers apply for Medicaid through the Marketplace application process. If your state hasn't expanded Medicaid, consumers may 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 has not yet expanded Medicaid, OR
- They have been determined ineligible for Medicaid.

In all states, consumers with incomes below 100 percent of the FPL **generally** won't be eligible for insurance affordability programs through the Marketplaces. These consumers may remain without coverage and may apply for an exemption from the individual shared responsibility payment.

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

Menu Help Glossary Resources Map Module 7 of 11 Page 6 of 8

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

\*Lawfully present immigrants with incomes below 100 percent of the FPL can still qualify for insurance affordability programs through a Marketplace if they are ineligible for Medicaid because of their immigration status and they meet other eligibility requirements.

## Knowledge Check

Other Financial Provisions of the PPACA Text Version  Exit Course

**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 and makes \$60,000 a year. Easton is interested in learning more about the PPACA.

Which of the following are accurate statements that you should tell Easton about the law and its key provisions?

Choose **all that apply** and then select **Check Your Answer**.

- A. The PPACA created the Marketplaces, which are an easy way for Easton to shop for health coverage.
- 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.
- D. The PPACA lets Easton make apples-to-apples comparisons of QHPs.

Check Your Answer

Menu Help Glossary Resources Map Module 7 of 11 Page 7 of 8

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- C. Easton may be eligible for Medicaid if his state expanded its Medicaid program to cover low-income adults.
- D. The PPACA lets Easton make apples-to-apples comparisons of QHPs.

The correct answers are A, B, and D. 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, \$17,609 for a household of one in 2020.

## Key Points

Other Financial Provisions of the PPACA Text Version  Exit Course

### Key Points



- 01** 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.
- 02** Some states have expanded their Medicaid programs to cover all people with household incomes below a certain level. Others haven't.
- 03** The Federal Government can impose civil money penalties on any person who provides false information on a Marketplace application.

Menu Help Glossary Resources Map Module 7 of 11 Page 8 of 8

- 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.
- Some states have expanded their Medicaid programs to cover all people with household incomes below a certain level. Others haven't.
- The Federal Government can impose civil money penalties on any person who provides false information on a Marketplace application.

# Introduction to Medicaid

## Introduction

Introduction to Medicaid Text Version  Exit Course

### Introduction

Remember that the PPACA requires most individuals to obtain MEC or obtain an exemption from the individual shared responsibility requirement. Most Medicaid and CHIP coverage is considered MEC. Medicare Part A and Part C coverage are also considered MEC. Consumers who don't get MEC through these programs may find that the Marketplaces are an important option for getting coverage.

To provide optimal assistance to consumers, you should understand how these programs may interact with the PPACA and the Marketplaces. Let's start by reviewing the Medicaid program.

- 01 Benefits**  
State the mandatory Medicaid benefits
- 02 Types of Consumers**  
Identify the types of consumers eligible for Medicaid
- 03 Eligibility**  
Understand Medicaid eligibility and presumptive eligibility rules and requirements

Menu Help Glossary Resources Map Module 8 of 11 Page 1 of 12

Remember that the PPACA requires most individuals to obtain MEC or obtain an exemption from the individual shared responsibility requirement. Most Medicaid and CHIP coverage is considered MEC. Medicare Part A and Part C coverage are also considered MEC. Consumers who don't get MEC through these programs may find that the Marketplaces are an important option for getting coverage.

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### Benefits

State the mandatory Medicaid benefits

### Types of Consumers

Identify the types of consumers eligible for Medicaid

### Eligibility

Understand Medicaid eligibility and presumptive eligibility rules and requirements

# Medicaid Basics

Introduction to Medicaid Text Version  Exit Course

## Medicaid Basics

Medicaid is a health coverage program for low-income families and individuals, including:

- Parents and children
- Pregnant women
- Older consumers
- People with disabilities
- Other low-income adults, depending on the state

States have a great deal of flexibility in designing and administering their programs. Each state operates its own Medicaid program within federal guidelines to:

- Set eligibility standards
- Determine the type, amount, and scope of services provided
- Establish payment rates for Medicaid services



Menu Help Glossary Resources Map Module 8 of 11 Page 2 of 12

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- Pregnant women
- Older consumers
- People with disabilities
- Other low-income adults, depending on the state

States have a great deal of flexibility in designing and administering their programs. Each state operates its own Medicaid program within federal guidelines to:

- Set eligibility standards
- Determine the type, amount, and scope of services provided
- Establish payment rates for Medicaid services

# Mandatory Medicaid Benefits

The screenshot shows a slide from a course titled 'Introduction to Medicaid'. The slide is titled 'Mandatory Medicaid Benefits' and contains the following text and list:

Medicaid provides a wide range of benefits to eligible consumers. While all state Medicaid agencies are generally required to provide certain benefits to certain beneficiaries, some states may choose to provide additional benefits. You should be familiar with the benefits covered by your state's Medicaid program.

You can also review a [comprehensive list of mandatory and optional benefits at Medicaid.gov](#).

**Mandatory Medicaid benefits in all states include:**

- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Early and periodic screening, diagnostic, and treatment services for children (which includes health screenings for children and treatment if medical problems are identified)
- Inpatient hospital services
- Outpatient hospital services
- Nursing facility services
- Nurse midwife services
- Certified pediatric and family nurse practitioner services
- Freestanding birth center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

The slide also features a large blue cross icon on the left and a blue hand icon on the right. The bottom of the slide shows a navigation bar with 'Menu', 'Help', 'Glossary', 'Resources', 'Map', 'Module 8 of 11', 'Page 3 of 12', and navigation arrows.

Medicaid provides a wide range of benefits to eligible consumers. While all state Medicaid agencies are generally required to provide certain benefits to certain beneficiaries, some states may choose to provide additional benefits. You should be familiar with the benefits covered by your state's Medicaid program.

Mandatory Medicaid benefits in all states include:

- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Early and periodic screening, diagnostic, and treatment services for children (which includes health screenings for children and treatment if medical problems are identified)
- Inpatient hospital services
- Outpatient hospital services
- Nursing facility services
- Nurse midwife services
- Certified pediatric and family nurse practitioner services
- Freestanding birth center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

You can also review a [comprehensive list of mandatory and optional benefits at Medicaid.gov](#).

# Medicaid Eligibility Based on Categorical Requirements

Introduction to Medicaid Text Version  Exit Course

## Medicaid Eligibility Based on Categorical Requirements

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

- Pregnant women at or below a certain household income level
- Children and parents/caretaker relatives in households at certain income levels
- People with disabilities
- Certain low-income older adults

Some states choose to cover other groups of consumers called optional eligibility groups, which are those that federal law doesn't require states to cover under Medicaid. Common examples include:

- Medically-needy consumers
- Consumers with disabilities who are employed

Medicaid coverage for optional groups varies from state to state.  
It's important that you know which groups are covered by Medicaid and the household income requirements for each of them in your state.

You already learned that consumers must meet certain financial requirements to qualify for Medicaid. Nonfinancial requirements can also affect eligibility.



Menu Help Glossary Resources Map Module 8 of 11 Page 4 of 12

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# In All States: Mandatory Eligibility Groups

Introduction to Medicaid Text Version ON Exit Course

## In All States: Mandatory Eligibility Groups

Let's review each mandatory eligibility group in more detail. Select each to learn more.



### Low-Income Pregnant Women

In practice, all states must cover pregnant women whose yearly household income is at or below at least 138 percent of the FPL (e.g., \$36,156 for a family of four or \$23,791 for a family of two in 2020) and who meet all other eligibility criteria (e.g., state residency and immigration/citizenship requirements). Many states choose to set a **higher** household income level for pregnant women.

Once Medicaid eligibility is established, pregnant women remain eligible on the basis of their pregnancy during the postpartum period, which begins on the date the pregnancy terminates and ends on the last day of the month in which a 60-day period (beginning on the date the pregnancy terminates) ends. Pregnant women may be eligible for Medicaid on another basis after their eligibility as a pregnant woman expires but may be required to reapply for coverage on another basis.

States are also required to cover any children born to women who are enrolled in Medicaid or CHIP on the date of birth. The newborn children are then eligible for Medicaid or CHIP for the first year of life. If a woman is not enrolled in Medicaid or CHIP on the date of her child's birth, the parent(s) should be encouraged to submit an application for the child to the state Medicaid or CHIP agency as soon as possible. Newborn children can be found retroactively eligible for up to three months if they would have been eligible during that retroactive period.

Low-Income Pregnant WomenChildren in Low-Income HouseholdsLow-Income Parents or Caretaker RelativesElderly, Blind, or Disabled Individuals

MenuHelpGlossaryResourcesMapModule 8 of 11Page 5 of 12

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## Children in Low-Income Households

In practice, all states must cover children whose yearly family income is at or below at least 138 percent of the FPL and who meet all other eligibility criteria. All states have chosen to expand Medicaid coverage for most children beyond the minimum eligibility threshold. The average household income eligibility level for children is 187 percent of the FPL.

Additionally, states are required to cover:

- Children who are recipients of adoption assistance and foster care under Title IV-E of the Social Security Act.
- Former foster children (until age 26), as long as:

- They were in the state's foster care system and enrolled in Medicaid on their 18th birthday, and
- They aged out of the foster care system in the state while enrolled in Medicaid.

Additional help for low-income children and some pregnant women in families whose household income is too high to qualify for Medicaid may be available through CHIP.

### **Low-income Parents or Caretaker Relatives**

Low-income parents and other relatives (called "caretaker relatives") who take care of dependent children are covered by Medicaid in every state if they meet their state's income requirements:

- The upper income in non-expansion states varies by state. In the 48 contiguous states, it's as high as 216 percent of the FPL and as low as 18 percent of the FPL.
- States with a parent/caretaker eligibility level below 138% of the FPL that have expanded Medicaid will enroll parents and caretakers who are income-eligible in the adult group.

More information on [Medicaid and CHIP eligibility](#).

### **Elderly, Blind, or Disabled Individuals**

Medicaid is also available to aged, blind, and/or disabled individuals who:

- Receive SSI payments or are considered to be receiving such payments, OR
- Live in states that elect not to provide Medicaid to individuals receiving SSI payments but who meet eligibility rules that are more restrictive than those for SSI, OR
- Are eligible for Medicare and have limited household income and resources (also called "dual-eligible").

## In Some States: Optional Eligibility Groups

Introduction to Medicaid Text Version  Exit Course

**In Some States: Optional Eligibility Groups**

There are many optional eligibility groups that federal law doesn't require states to cover under Medicaid. A few examples include:

- Children at higher income levels
- "Medically *needy*" consumers
- Consumers living in medical institutions (e.g., nursing facilities) if their income is up to 300 percent of the [SSI federal benefit rate](#)
- Consumers with disabilities who are employed

Menu Help Glossary Resources Map Module 8 of 11 Page 6 of 12

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- Consumers living in medical institutions (e.g., nursing facilities) if their income is up to 300 percent of the SSI federal benefit rate\*\*
- Consumers with disabilities who are employed

### **\*Medically Needy**

"Medically *needy*" consumers are those whose income exceeds a state's regular Medicaid eligibility limit but who have high medical expenses (e.g., for nursing home care) that reduce their disposable income below the Medicaid eligibility limit. This process allows consumers to subtract or "spend down" their medical expenses from their income and other measurable financial resources to become eligible.

Consumers who are enrolled in a state Medicaid spend down program, or who have an application pending for spend down, may be eligible for APTC or CSRs if they apply for those programs and enroll in a QHP through their state's Marketplace.

### **\*SSI Federal Benefit Rate**

The SSI federal monthly benefit rate is \$783 for an eligible individual and \$1,175 for an eligible individual with an eligible spouse in 2020.

# Knowledge Check

Introduction to Medicaid Text Version  Exit Course

**Knowledge Check**



Which of the following groups of people are required by federal law to be covered by Medicaid?  
Choose **all that apply** and then select **Check Your Answer**.

- A. "Medically needy" consumers
- B. Pregnant women at or below a certain household income level
- C. Consumers living in nursing homes
- D. Children in low-income households

Check Your Answer

Menu Help Glossary Resources Map Module 8 of 11 Page 7 of 12

Which of the following groups of people are required by federal law to be covered by Medicaid?

- A. "Medically needy" consumers
- B. Pregnant women at or below a certain household income level
- C. Consumers living in nursing homes
- D. Children in low-income households

The correct answers are B and D. Federal law requires all states to cover pregnant women at or below a certain household income level and children in low-income households. States have the option to cover those designated as "medically needy" and consumers living in medical institutions (if their income is up to 300 percent of the SSI federal benefit rate).

# Presumptive Eligibility for Medicaid

Introduction to Medicaid Text Version  Exit Course

## Presumptive Eligibility for Medicaid

Presumptive eligibility is when certain "qualified entities" that provide Medicaid services screen individuals for Medicaid eligibility and temporarily enroll those who appear to be eligible on the spot without having to wait for their application to be fully processed.

The eligibility determination is based on household income, residency status, or other Medicaid requirements for certain groups of individuals (e.g., pregnant women and children).

You might encounter consumers who are receiving temporary Medicaid coverage through presumptive eligibility and who have not yet completed the Medicaid application process. Let these consumers know that they won't be able to keep their Medicaid coverage for an extended period of time if they don't complete the Medicaid application process.



The image shows two women sitting at a white table. The woman on the left is seen from the back, wearing a purple long-sleeved shirt and has her hair in a braid. The woman on the right is facing her, wearing a white long-sleeved shirt, and is holding a blue folder and a document. They appear to be in a professional setting, possibly a clinic or office, discussing the document.

Menu Help Glossary Resources Map Module 8 of 11 Page 8 of 12

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\*States can authorize entities such as hospitals, health clinics, or schools to temporarily enroll consumers and their families in Medicaid coverage if they appear eligible.

Not all hospitals are qualified to make presumptive eligibility decisions.

# Nonfinancial Requirements for Medicaid

Introduction to Medicaid Text Version  Exit Course

## Nonfinancial Requirements for Medicaid

If consumers belong to a mandatory or optional eligibility group in their state and meet applicable financial requirements, they must also meet certain nonfinancial verification requirements to be eligible for Medicaid. For example, these consumers may need to provide proof of the following:

- State residency
- Citizenship or immigration status
- Social Security Number (SSN)

Consumers with SSNs who apply for Medicaid coverage through a Marketplace must provide their SSN in the Marketplace application. If they don't, it will slow down the application process and they will have to provide it later.



Menu Help Glossary Resources Map Module 8 of 11 Page 9 of 12

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# Medicaid and Immigration Status

Introduction to Medicaid Text Version  Exit Course

## Medicaid and Immigration Status

You have learned the mandatory benefits available under Medicaid and the eligibility groups it covers. Some covered groups, such as immigrants, may only be eligible for limited Medicaid benefits. Let's review how immigration affects Medicaid eligibility.

Generally, immigrants must be **qualified noncitizens** for five years to be eligible for Medicaid. However, there are two noteworthy exceptions:

- All states are required to provide limited Medicaid coverage necessary for treatment of an **emergency medical condition** to noncitizens who qualify under the State plan but are not U.S. citizens or do not have satisfactory immigration status — including the cost of labor and delivery for new mothers. Therefore, certain immigrants who aren't eligible for traditional Medicaid or a QHP through a Marketplace may be able to get limited Medicaid coverage for emergencies even if they do not have a satisfactory immigration status. However, it may not be an ongoing coverage plan and they may need to apply for emergency medical assistance each time they need it.
- Many states choose to cover lawfully residing immigrant children under age 21 and pregnant women, including qualified non-citizens during the five-year waiting period, if they meet all other eligibility requirements.

Menu Help Glossary Resources Map Module 8 of 11 Page 10 of 12

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- Many states choose to cover lawfully residing immigrant children under age 21 and pregnant women, including qualified non-citizens during the five-year waiting period, if they meet all other eligibility requirements.

### Qualified Noncitizens

Qualified noncitizens are immigrants who reside legally in the U.S. and fall into a defined group, such as:

- Lawful permanent residents (LPRs/Green Card holders)
- Asylees
- Refugees
- Cuban/Haitian entrants
- U.S. parolees whose parole is expected to last at least one year
- Conditional entrants granted entry to the U.S. before 1980
- Battered non-citizens, spouses, children, or parents

- Victims of trafficking and their spouses, children, siblings, or parents— including individuals with a pending application for a victim of trafficking visa
- Individuals who are granted Withholding of Deportation or Withholding of Removal under immigration laws or under the Convention Against Torture (CAT)
- Member of a federally-recognized Indian tribe or American Indian born in Canada

### **Emergency Medical Condition**

An emergency medical condition is a condition that presents acute symptoms of sufficient severity, such as severe pain, that, without immediate medical attention, could reasonably be expected to result in the following:

- Placing the consumer's health in serious jeopardy
- Causing serious impairment to bodily functions
- Causing serious dysfunction of any bodily organ or part

Under emergency Medicaid, a heart attack, labor, and delivery are all examples of emergency medical conditions. States have some discretion on what conditions would be included under its definition of an emergency medical condition.

# Limited Medicaid Benefits

The screenshot shows a digital course slide. At the top, it says 'Introduction to Medicaid' and 'Text Version' with a toggle switch. The slide title is 'Limited Medicaid Benefits'. The main content is a list of Medicaid programs that don't count as MEC. A woman in a blue shirt and black skirt stands on the right, pointing to a callout box. The callout box contains text explaining the role of an assister. At the bottom, there is a navigation bar with 'Menu', 'Help', 'Glossary', 'Resources', 'Map', 'Module 8 of 11', and 'Page 11 of 12'.

Introduction to Medicaid Text Version  Exit Course

## Limited Medicaid Benefits

Limited Medicaid benefit programs that don't count as MEC **generally include:**

- Medicaid providing only family planning services
- Medicaid providing only tuberculosis-related services
- Medicaid providing only coverage limited to treatment of emergency medical conditions
- Some types of pregnancy-related Medicaid coverage
- Some types of medically needy coverage
- Some Section 1115 Medicaid demonstration projects

As an assister, you might help consumers who qualify for limited Medicaid benefits that are not considered MEC. You can help these consumers submit a Marketplace application. Individuals and families may also be eligible for insurance affordability programs (i.e., APTC or CSRs).

Menu Help Glossary Resources Map Module 8 of 11 Page 11 of 12

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\*These programs currently aren't classified as meeting MEC standards. However, to the extent that certain programs within these categories provide comprehensive coverage, the Department of the Treasury and/or the HHS may recognize these programs as MEC.

# Key Points

Introduction to Medicaid Text Version  Exit Course

## Key Points



- 01** Medicaid is a comprehensive health coverage program for low-income parents and children, pregnant women, older consumers, consumers with disabilities, and certain other adults (depending on the state).
- 02** All state Medicaid agencies are generally required to provide certain benefits to certain Medicaid beneficiaries while some states choose to provide additional benefits.
- 03** You can help consumers who receive limited Medicaid benefits submit a Marketplace application. Individuals and families may also be eligible for insurance affordability programs (i.e., APTC or CSRs).

Menu Help Glossary Resources Map Module 8 of 11 Page 12 of 12

- Medicaid is a comprehensive health coverage program for low-income parents and children, pregnant women, older consumers, consumers with disabilities, and certain other adults (depending on the state).
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# Introduction to CHIP

## Introduction

Introduction to CHIP Text Version  Exit Course

### Introduction

Many household members of consumers you assist will also qualify for CHIP, another public health coverage program. You should be familiar with CHIP and the eligibility requirements in your state.

- 01 Who Is Covered**  
State who is covered by the CHIP program
- 02 Benefits**  
Describe the benefits of CHIP
- 03 Eligibility**  
Identify CHIP eligibility and presumptive eligibility requirements

Menu Help Glossary Resources Map Module 9 of 11 Page 1 of 8

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### **Who Is Covered**

State who is covered by the CHIP program

### **Benefits**

Describe the benefits of CHIP

### **Eligibility**

Identify CHIP eligibility and presumptive eligibility requirements

# CHIP Basics

Introduction to CHIP Text Version  Exit Course

**CHIP Basics**

As is the case for Medicaid, states must follow federal guidelines and have flexibility to develop some aspects of their own CHIP programs (e.g., when setting eligibility standards).

**CHIP is a health coverage program for:**

- Uninsured children up to age 19 whose family income is too high for them to qualify for Medicaid
- Low-income pregnant women and/or newborns in some states who do not qualify for Medicaid

Menu Help Glossary Resources Map Module 9 of 11 Page 2 of 8

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- Low-income pregnant women and/or newborns in some states who do not qualify for Medicaid

# CHIP Benefits and Cost Sharing

Introduction to CHIP Text Version  Exit Course

## CHIP Benefits and Cost Sharing

At this point, you might be wondering what types of benefits are covered for children enrolled in CHIP.

Since CHIP varies by state, the exact benefits a particular state covers may differ from other states. However, all states provide comprehensive coverage including:

- ✓ Routine checkups
- ✓ Immunizations
- ✓ Doctor visits
- ✓ Prescriptions
- ✓ Dental and vision care
- ✓ Inpatient and outpatient hospital care
- ✓ Laboratory and X-ray services
- ✓ Emergency services

These benefits are similar to Medicaid services offered to consumers.

Some states charge small premiums and/or copayments for CHIP coverage. Families with children enrolled in CHIP aren't required to pay more than 5 percent of their yearly income for CHIP coverage – including out-of-pocket costs – but most programs charge premiums that are far lower. Cost sharing (e.g., deductibles, copayments, and coinsurance) isn't allowed for certain preventive services like well-baby or well-child visits.



Menu Help Glossary Resources Map Module 9 of 11 Page 3 of 8

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# CHIP Eligibility

Introduction to CHIP Text Version Exit Course

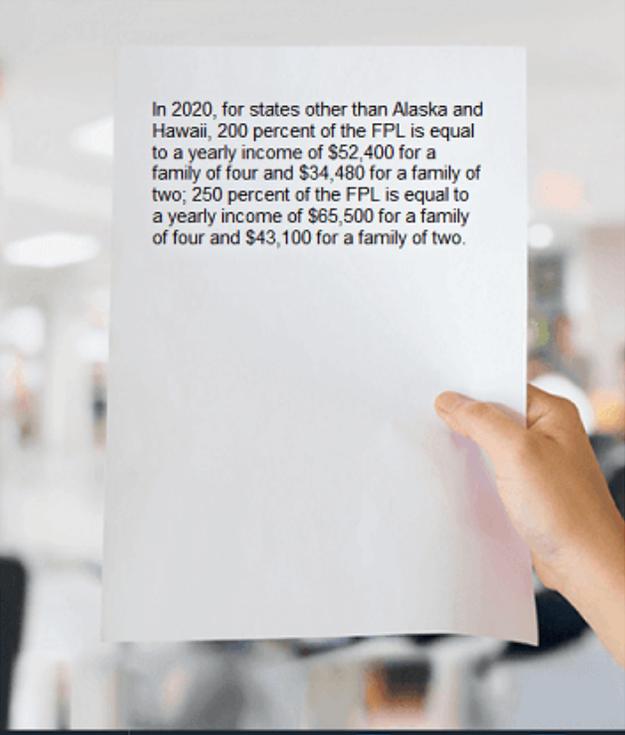
## CHIP Eligibility

CHIP provides low-cost health coverage to uninsured children up to age 19 in families whose income is too high for them to qualify for Medicaid. Some states require that children be uninsured for up to 90 days before they can enroll in CHIP.

Remember, MAGI is used to calculate consumers' financial eligibility for CHIP. Each state has its own rules about who qualifies for CHIP:

- Most states cover children in families with incomes up to at least 200 percent of the FPL.
- Nearly half of these states offer coverage to children whose household income is at or above 250 percent of the FPL.
- Other states allow children with higher income levels to pay higher premiums and buy into CHIP.

Remember, states also have the option to provide CHIP coverage to some low-income pregnant women. In a few states, CHIP provides coverage to women for the duration of their pregnancy. Infants born to women enrolled in Medicaid or CHIP are automatically eligible for Medicaid or CHIP up to one year of age. Under the Patient Protection and Affordable Care Act, new mothers who lose access to healthcare services provided through unborn child CHIP coverage following the birth of their child may qualify for an SEP 60 days before or after their loss of coverage if they are otherwise eligible to enroll in a QHP through a Marketplace. The PPACA also gives states the option to extend CHIP eligibility to the children of state employees who were previously excluded from CHIP coverage.



In 2020, for states other than Alaska and Hawaii, 200 percent of the FPL is equal to a yearly income of \$52,400 for a family of four and \$34,480 for a family of two; 250 percent of the FPL is equal to a yearly income of \$65,500 for a family of four and \$43,100 for a family of two.

Menu Help Glossary Resources Map Module 9 of 11 Page 4 of 8

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# CHIP Eligibility and Presumptive Eligibility

Introduction to CHIP Text Version  Exit Course

## CHIP Eligibility and Presumptive Eligibility

Just like for Medicaid, states can authorize "qualified entities" – including health care providers, schools, Head Start programs, and other community-based organizations – to screen for CHIP eligibility and immediately enroll children who appear to be eligible. Presumptive eligibility allows children to get access to CHIP services without having to wait for their application to be fully processed.

If individuals are enrolled temporarily under presumptive eligibility, they and their families must complete the application process later to keep their coverage.

It's important to know if the state you are working in has presumptive eligibility. If so, resources may be available to help consumers complete the application process. [More information on which states provide presumptive eligibility.](#)



Menu Help Glossary Resources Map Module 9 of 11 Page 5 of 8

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# CHIP Eligibility and Immigration Status

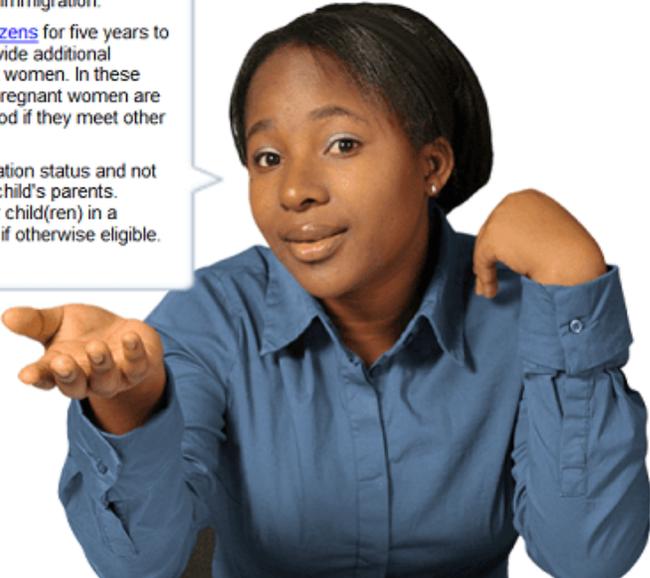
Introduction to CHIP Text Version  Exit Course

## CHIP Eligibility and Immigration Status

Medicaid and CHIP are also similar in terms of immigration.

Generally, immigrants must be [qualified noncitizens](#) for five years to be eligible for CHIP. However, some states provide additional benefits for immigrant children and/or pregnant women. In these states, lawfully residing immigrant children or pregnant women are eligible for CHIP without a [five-year](#) waiting period if they meet other eligibility requirements.

Eligibility for CHIP is based on a child's immigration status and not on the citizenship or immigration status of the child's parents. Parents may also have the option to enroll their child(ren) in a separate child-only plan through a Marketplace if otherwise eligible.



Menu Help Glossary Resources Map Module 9 of 11 Page 6 of 8

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Generally, immigrants must be [qualified noncitizens](#) for [five years](#) to be eligible for CHIP. However, some states provide additional benefits for immigrant children and/or pregnant women. In these states, lawfully residing immigrant children or pregnant women are eligible for CHIP without a five-year waiting period if they meet other eligibility requirements.

### Qualified Noncitizens

Qualified noncitizens are immigrants who legally reside in the U.S. and fall into a defined group, such as:

- Lawful permanent residents (LPRs/Green Card holders)
- Asylees
- Refugees
- Cuban/Haitian entrants
- U.S. parolees whose parole is expected to last at least one year
- Individuals who are granted Withholding of Deportation or Withholding of Removal under immigration laws or under the Convention Against Torture (CAT)

Eligibility for CHIP is based on a child's immigration status and not on the citizenship or immigration status of the child's parents. Parents may also have the option to enroll their child(ren) in a separate child-only plan through a Marketplace if otherwise eligible.

# Knowledge Check

Introduction to CHIP Text Version  Exit Course

## Knowledge Check



CHIP coverage varies by state, so the exact benefits that a particular state covers in CHIP may also differ from other states. However, all states provide comprehensive coverage, including which of the following?

Choose **all that apply** and then select **Check Your Answer**.

- A. Immunizations
- B. Prescriptions
- C. Orthodontic care
- D. Laboratory and X-ray services

Check Your Answer

Menu Help Glossary Resources Map Module 9 of 11 Page 7 of 8

CHIP coverage varies by state, so the exact benefits that a particular state covers in CHIP may also differ from other states. However, all states provide comprehensive coverage, including which of the following?

- A. Immunizations
- B. Prescriptions
- C. Orthodontic care
- D. Laboratory and X-ray services

The correct answers are A, B, and D. CHIP benefits for all states include: immunizations, prescriptions, and laboratory and X-ray services.

## Key Points

Introduction to CHIP Text Version Off Exit Course

### Key Points



- 01** CHIP covers uninsured children up to age 19 in low-income families with incomes too high for them to qualify for Medicaid.
- 02** Although covered CHIP benefits vary by state, all states must provide comprehensive coverage that includes immunizations, doctor visits, and prescription drugs.
- 03** Eligibility for CHIP is based on a child's U.S. citizenship or immigration status and state residency — not on the U.S. citizenship or immigration status of the child's parents.

Menu Help Glossary Resources Map Module 9 of 11 Page 8 of 8

- CHIP covers uninsured children up to age 19 in low-income families with incomes too high for them to qualify for Medicaid.
- Although covered CHIP benefits vary by state, all states must provide comprehensive coverage that includes immunizations, doctor visits, and prescription drugs.
- Eligibility for CHIP is based on a child's U.S. citizenship or immigration status and state residency — not on the U.S. citizenship or immigration status of the child's parents.

# Introduction to Medicare

## Introduction

Introduction to Medicare Text Version  Exit Course

### Introduction

Now that we've reviewed the most common types of coverage you'll help consumers get, let's make sure you know how to help older consumers or certain other consumers who might have Medicare or become eligible for Medicare soon.

- 01 Eligibility**  
State the eligibility requirements for Medicare
- 02 Enrollment**  
Describe Medicare enrollment scenarios
- 03 Benefits**  
State the benefits available from Medicare
- 04 Medicare & the Marketplaces**  
Describe the relationship between Medicare and the Marketplaces

Menu Help Glossary Resources Map Module 10 of 11 Page 1 of 14

Now that we've reviewed the most common types of coverage you'll help consumers get, let's make sure you know how to help older consumers or certain other consumers who might have Medicare or become eligible for Medicare soon.

### **Eligibility**

State the eligibility requirements for Medicare

### **Enrollment**

Describe Medicare enrollment scenarios

### **Benefits**

State the benefits available from Medicare

### **Medicare & the Marketplaces**

Describe the relationship between Medicare and the Marketplaces

# Medicare Basics

Introduction to Medicare Text Version  Exit Course

## Medicare Basics

Medicare is a health coverage program made up of different parts and benefits. You should bring up Medicare in discussions with consumers who:

- Are age 65 or over,
- Have end-stage renal disease (ESRD), or
- Have a disability, regardless of age.

You should have a general idea of how both Medicare and Marketplace coverage work for these consumers so you can provide them with fair, accurate, and impartial information about their health coverage options.



Menu Help Glossary Resources Map Module 10 of 11 Page 2 of 14

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## Medicare Basics (cont'd)

Introduction to Medicare Text Version  Exit Course

**Medicare Basics (cont'd)**



Medicare isn't part of the Marketplaces. However, consumers who have Medicare Part A or Part C have qualifying health coverage called MEC.

You should tell consumers who have Medicare coverage that the Marketplaces won't affect their Medicare choices or benefits. As long as consumers get original Medicare Part A (with or without Part B) or a Part C Medicare Advantage plan (e.g., an HMO or PPO), they won't have to make any changes.

The eligibility requirements for Medicare are complex. Generally, it's a good idea to refer consumers to their State Health Insurance Assistance Program (SHIP) if they have specific questions about Medicare.

Menu Help Glossary Resources Map Module 10 of 11 Page 3 of 14

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The eligibility requirements for Medicare are complex. Generally, it's a good idea to refer consumers to their State Health Insurance Assistance Program (SHIP) if they have specific questions about Medicare.

## Referring Consumers to Other Organizations for Help with Medicare

Introduction to Medicare Text Version  Exit Course

### Referring Consumers to Other Organizations for Help with Medicare

Remember that Navigators and CACs in FFM must provide information in a fair, accurate, and impartial manner. All assisters must provide information that assists consumers with submitting Marketplace eligibility applications, clarifies distinctions among health coverage options including QHPs, and helps consumers make informed decisions during the health coverage selection process. Navigators in FFM must acknowledge other health programs – including Medicare – when providing this information. Sometimes it might be helpful to refer consumers to other organizations when they need assistance that falls outside the scope of your authorized assister functions related to the FFM.

It is a best practice to refer consumers who may be eligible for Medicare to their SHIP or other resources in their area for in-depth information. Remember to follow [CMS guidance](#) when working with (or referring consumers to) organizations that are not other FFM assister organizations or HHS entities.

**Select** the resource to learn more about how it can help consumers who may be eligible for Medicare:

- [State Health Insurance Assistance Program \(SHIP\)](#)



Menu Help Glossary Resources Map Module 10 of 11 Page 4 of 14

Remember that Navigators and CACs in FFM must provide information in a fair, accurate, and impartial manner. All assisters must provide information that assists consumers with submitting Marketplace eligibility applications, clarifies distinctions among health coverage options including QHPs, and helps consumers make informed decisions during the health coverage selection process. Navigators in FFM must acknowledge other health programs – including Medicare – when providing this information. Sometimes it might be helpful to refer consumers to other organizations when they need assistance that falls outside the scope of your authorized assister functions related to the FFM.

It is a best practice to refer consumers who may be eligible for Medicare to their SHIP or other resources in their area for in-depth information. Remember to follow [CMS guidance](#) when working with (or referring consumers to) organizations that are not other FFM assister organizations or HHS entities.

### **State Health Insurance Assistance Program (SHIP)**

A program in every state that offers one-on-one Medicare counseling and assistance to consumers and their families. Consumers with questions about Medicare can be referred to their local SHIP at [www.shiptacenter.org](http://www.shiptacenter.org)

# Medicare Benefits: Different Parts

Introduction to Medicare Text Version Exit Course

## Medicare Benefits: Different Parts

The different parts of Medicare help cover specific services. Refer to the graphic to learn more about each part.

As an assister, it's a good idea for you to be familiar with the coverage options available to consumers that are eligible for Medicare. Let's review the different parts of Medicare and how they might affect consumers who come to you for more information about the Marketplaces.

Note: In certain situations, consumers may have Medicare and also enroll in Marketplace coverage. You will learn about some of these situations in this module.

**Counts as MEC**

**Medicare Part A (Hospital Insurance)**  
Part A covers inpatient hospital stays, care in skilled nursing facilities, hospice care, and some home health care. Most consumers have Medicare Part A without a premium, but other consumers may have to pay a premium for Part A.

**Does not count as MEC if used alone**

**Medicare Part B (Medical Insurance)**  
Part B covers certain doctors' services, outpatient care, home health care, durable medical equipment and supplies, preventive services, and other services. There's generally a premium for Part B.

**Medicare Part C (Medicare Advantage)**  
Medicare Advantage 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 Medicare Advantage Plans also offer prescription drug coverage (Part D) and some offer additional benefits that Parts A, B, and D don't cover. Consumers with a Medicare Advantage Plan pay a Part B premium and usually pay an additional monthly premium amount for other benefits that the plan covers.

**Medicare Part D (Prescription Drug Coverage)**  
Part D covers prescription drugs. Health insurance companies approved by Medicare offer Part D coverage. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans. There's generally a premium for Part D.

Visit [Medicare.gov](https://www.Medicare.gov) for more information about Medicare benefits and enrollment processes.

Menu Help Glossary Resources Map Module 10 of 11 Page 5 of 14

The different parts of Medicare help cover specific services.

As an assister, it's a good idea for you to be familiar with the coverage options available to consumers that are eligible for Medicare. Let's review the different parts of Medicare and how they might affect consumers who come to you for more information about the Marketplaces.

Note: In certain situations, consumers may have Medicare and also enroll in Marketplace coverage. You will learn about some of these situations in this module.

### Medicare Part A (Hospital Insurance)

Part A covers inpatient hospital stays, care in skilled nursing facilities, hospice care, and some home health care. Most Medicare beneficiaries have Medicare Part A without a premium, but others may have to pay a premium for Part A.

### Medicare Part B (Medical Insurance)

Part B covers certain doctors' services, outpatient care, home health care, durable medical equipment and supplies, preventive services, and other services. There's generally a premium for Part B.

### Medicare Part C (Medicare Advantage Plans)

Medicare Advantage 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 Medicare Advantage Plans also offer prescription drug coverage (Part D) and some offer additional benefits that Parts A, B, and D don't cover. Consumers with a Medicare Advantage Plan pay a Part B premium and usually pay an additional monthly premium amount for other benefits that the plan covers.

### Medicare Part D (Prescription Drug Coverage)

Part D covers prescription drugs. Health insurance companies approved by Medicare offer Part D coverage. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans. There's generally a premium for Part D.

Visit [Medicare.gov](https://www.Medicare.gov) for more information about Medicare benefits and enrollment processes.

# Premium-Free Part A Medicare and Eligibility

Introduction to Medicare Text Version ON Exit Course

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## Premium-Free Part A Medicare and Eligibility

Now that we've reviewed the different parts of Medicare, let's discuss eligibility for Part A. In general, consumers who paid Social Security and Medicare taxes for at least 10 years (or at least 40 quarters) are entitled to premium-free Part A Medicare. Those already receiving Social Security benefits are automatically enrolled in premium-free Part A (when they become entitled), but others have to apply for premium-free Part A.

Consumers who have Medicare generally can't enroll in QHPs through a Marketplace. It is against the law for a private insurer to sell a Marketplace plan to a consumer when the insurer knows the consumer has Medicare coverage. This is generally true even if a consumer has only Part A or only Part B coverage.

Additionally, if a consumer has been determined eligible for or is enrolled in Medicare that counts as MEC (i.e., Part A or Part C), the consumer is not eligible to receive financial assistance — that is, APTC or CSRs — to help pay for a Marketplace plan.



**Your payment would be about**  
**\$1,986 a month**  
at full retirement age

WANDA WORKER  
456 ANYWHERE AVENUE  
MAINTOWN, USA 11111-1111

May 1, 2020

### Your Social Security Statement

Are you thinking about retirement? Are you ready for retirement? We have tools that can help you!

- Estimate your future retirement benefits at [socialsecurity.gov/estimator](https://socialsecurity.gov/estimator)
- Apply for retirement, spouse's, Medicare, or disability benefits at [socialsecurity.gov/applyforbenefits](https://socialsecurity.gov/applyforbenefits)
- And once you receive benefits, manage your benefits at [myaccount.socialsecurity.gov](https://myaccount.socialsecurity.gov)

Your Social Security Statement tells you about **how much you or your family would receive** in disability, survivor, or retirement benefits. It also includes our record of your lifetime earnings. Check out your earnings history, and **let us know right away if you find an error**. This is important because we base your benefits on our record of your lifetime earnings.

Social Security benefits are **not intended to be** your only source of income when you retire. On average, Social Security will replace about 40 percent of your annual pre-retirement earnings. You will need other savings, investments, pensions, or retirement accounts to live comfortably when you retire.

To see your Statement online anytime, create a **my Social Security** account at [myaccount.socialsecurity.gov](https://myaccount.socialsecurity.gov).

*Social Security Administration*

Follow the Social Security Administration at these social media sites.   

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Menu Help Glossary Resources Map Module 10 of 11 Page 6 of 14

Now that we've reviewed the different parts of Medicare, let's discuss eligibility for Part A. In general, consumers who paid Social Security and Medicare taxes for at least 10 years (or at least 40 quarters) are entitled to premium-free Part A Medicare. Those already receiving Social Security benefits are automatically enrolled in premium-free Part A (when they become entitled), but others have to apply for premium-free Part A.

Consumers who have Medicare generally can't enroll in QHPs through a Marketplace. It is against the law for a private insurer to sell a Marketplace plan to a consumer when the insurer knows the consumer has Medicare coverage. This is generally true even if a consumer has only Part A or only Part B coverage.

Additionally, if a consumer has been determined eligible for or is enrolled in Medicare that counts as MEC (i.e., Part A or Part C), the consumer is not eligible to receive financial assistance — that is, APTC or CSRs — to help pay for a Marketplace plan.

# Premium Part A Medicare and Eligibility

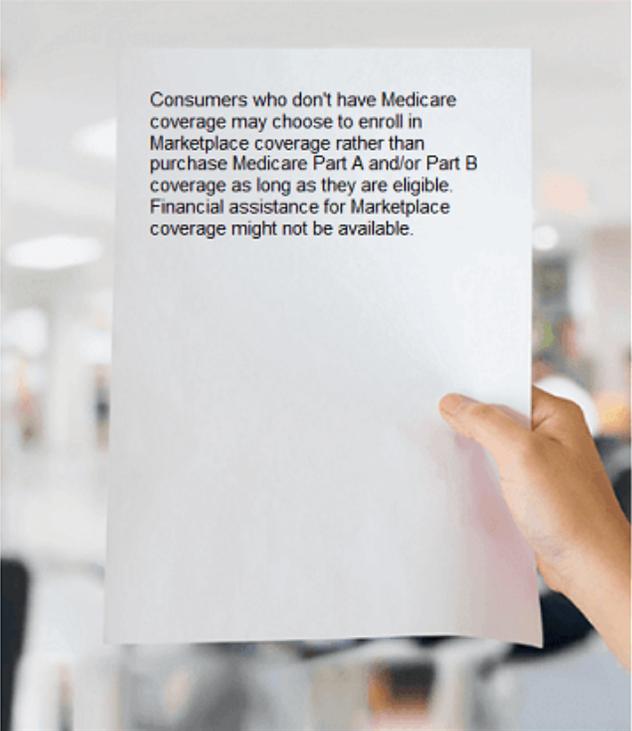
Introduction to Medicare Text Version  Exit Course

## Premium Part A Medicare and Eligibility

In general, consumers ages 65 and older who are not entitled to premium-free Part A Medicare (because they haven't earned enough quarters of coverage) may choose to purchase Medicare Part A coverage by filing an application at a Social Security office. Because these consumers will need to pay monthly premiums, this type of Medicare coverage is called **Medicare premium Part A**.

Older consumers who want to get Medicare premium Part A can apply for coverage only during a prescribed enrollment period and must also enroll in (or already be enrolled in) Medicare Part B. To purchase Medicare premium Part A, consumers must also live in the U.S. AND be U.S. citizens or lawful permanent residents of the U.S. for at least five consecutive years.

You can help consumers find more information about Medicare benefits at [www.Medicare.gov](http://www.Medicare.gov). Remember, consumers can also search for their local SHIP for detailed information about Medicare at [www.shiptacenter.org](http://www.shiptacenter.org).



Consumers who don't have Medicare coverage may choose to enroll in Marketplace coverage rather than purchase Medicare Part A and/or Part B coverage as long as they are eligible. Financial assistance for Marketplace coverage might not be available.

Menu Help Glossary Resources Map Module 10 of 11 Page 7 of 14

In general, consumers ages 65 and older who are not entitled to premium-free Part A Medicare (because they haven't earned enough quarters of coverage) may choose to purchase Medicare Part A coverage by filing an application at a Social Security office. Because these consumers will need to pay monthly premiums, this type of Medicare coverage is called Medicare premium Part A.

Older consumers who want to get Medicare premium Part A can apply for coverage only during a prescribed enrollment period and must also enroll in (or already be enrolled in) Medicare Part B. To purchase Medicare premium Part A, consumers must also live in the U.S. AND be U.S. citizens or lawful permanent residents of the U.S. for at least five consecutive years.

You can help consumers find more information about Medicare benefits at [www.Medicare.gov](http://www.Medicare.gov). Remember, consumers can also search for their local SHIP for detailed information about Medicare at [www.shoptacenter.org](http://www.shoptacenter.org).

Consumers who don't have Medicare coverage may choose to enroll in Marketplace coverage rather than purchase Medicare Part A and/or Part B coverage as long as they are eligible. Financial assistance for Marketplace coverage might not be available.

# Transition to Medicare and Interaction with Marketplace Coverage

Introduction to Medicare Text Version ON Exit Course

## Transition to Medicare and Interaction with Marketplace Coverage

	If consumers...	Then consumers...	And...
<p>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.</p> <div style="border: 1px solid orange; padding: 5px; margin: 10px 0;"> <p>Consumers who don't sign up for Medicare during their Initial Enrollment Period (IEP) and do not have job-based coverage based on current employment, including coverage through a Small Business Health Options Program (SHOP) Marketplace, may have to pay higher premiums when they sign up for Medicare later.</p> </div> <p>Mouse over each item in the first column on this page for 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.</p>	<p>Are receiving Social Security Retirement or Social Security Disability benefits,</p> <p>Are newly eligible for Medicare and don't get Social Security benefits yet,</p> <p>Have job-based coverage based on current employment, including coverage through a SHOP Marketplace,</p> <p>Are eligible for programs to lower their QHP costs through a Marketplace (i.e., APTC and CSRs),</p> <p>Want help to pay for some of their health care costs that their original Medicare plan doesn't cover,</p>	<p>Will have an IEP to sign up for Medicare Part A and Part B and should apply for Part D at that time if they want prescription drug coverage.</p>	<p>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 job-based coverage (including coverage through a SHOP Marketplace), they may:</p> <ul style="list-style-type: none"> <li>Become uninsured.</li> <li>Have to make the individual shared responsibility payment for not having MEC.</li> </ul>

Menu
Help
Glossary
Resources
Map
Module 10 of 11
Page 8 of 14

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 do not have job-based coverage based on current employment, including coverage through a Small Business Health Options Program (SHOP) Marketplace, may have to pay higher premiums when they sign up for Medicare later.

Here is some information you should tell these consumers depending on their circumstances.

If consumers... Are receiving Social Security Retirement or Social Security Disability benefits,

Then consumers... Will get information about Medicare a few months before they're automatically enrolled in Medicare Part A and Part B.

And... They should consider signing up for Medicare Part D at the beginning of their IEP so they will have prescription drug coverage on their first day of eligibility.

If consumers... Are newly eligible for Medicare and don't get Social Security benefits yet,

Then consumers... Will have an IEP to sign up for Medicare Part A and Part B and should apply for Part D at that time if they want prescription drug coverage.

And... 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 job-based coverage (including coverage through a SHOP Marketplace), they may:

- Become uninsured.
- Have to make the individual shared responsibility payment for not having MEC.

If consumers... Have job-based coverage based on current employment, including coverage through a SHOP Marketplace,

Then consumers... Should sign up for premium-free Medicare Part A (if eligible) when their IEP begins and consider delaying enrollment in Part B until the job-based coverage or the current employment ends, whichever occurs first.

If consumers...Are eligible for programs to lower their QHP costs through a Marketplace (i.e., APTC and CSRs),

Then consumers...Will lose eligibility for APTC and CSRs through a Marketplace when they become eligible for Medicare premium-free Part A based on their age or when their Medicare Part A coverage starts, regardless of the basis for their eligibility for Medicare. 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.

If consumers... Want help to pay for some of their health care costs that their original Medicare plan doesn't cover,

Then consumers... Should consider purchasing a Medicare Supplement Insurance (Medigap) policy.

And...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 Medicare Part A and Part B.

Note: Medicare Part C (called Medicare Advantage or MA) is not a type of Medigap policy. Consumers cannot enroll in a Medigap policy if they have MA 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](https://www.medicare.gov).

## Transition to Medicare and Interaction with Marketplace Coverage (cont'd)

Introduction to Medicare Text Version Exit Course

**Transition to Medicare and Interaction with Marketplace Coverage (cont'd)**

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 Medicare Part A and Part B without an application if they are getting Social Security or Railroad Retirement Board benefits at the time they meet the entitlement or eligibility requirements for Medicare.
- 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 talk 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 Medicare Part A and Medicare Advantage count as MEC just like Marketplace plans do. However, you should talk to these consumers about 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 are not eligible to receive financial assistance from a Marketplace to help lower the costs of coverage (i.e., APTC and CSRs) if they are 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.

Menu Help Glossary Resources Map Module 10 of 11 Page 9 of 14

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

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### Automatically Enrolled in Medicare and Have Marketplace Coverage

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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.

# Help With Medicare Costs

Introduction to Medicare Text Version  Exit Course

## Help With Medicare Costs

Consumers with Premium-free Part A Medicare might also be eligible for help with paying Medicare costs under these other programs:

- Extra help with Medicare Prescription Drug costs
- Medicare Savings Programs (MSPs) for help with Medicare Part A and Part B costs, which include:
  - Qualified Medicare Beneficiary (QMB) program
  - Specified Low-income Medicare Beneficiary (SLMB) program
  - Qualifying Individual (QI) program
  - Dual eligibility for Medicare and Medicaid coverage

Note: Eligible consumers who have Medicare or are considering enrolling in Medicare can also access MSPs and Extra Help for Medicare Part D to help pay for Medicare costs.

More information on eligibility and coverage is available in the Resources section.

What could you tell consumers who have premium-free Part A Medicare since they aren't eligible for APTC and/or CSRs through a Marketplace?



Menu Help Glossary Resources Map Module 10 of 11 Page 10 of 14

What could you tell consumers who have premium-free Part A Medicare since they aren't eligible for APTC and/or CSRs through a Marketplace?

Consumers with Premium-free Part A Medicare might also be eligible for help with paying Medicare costs under these other programs:

- Extra help with Medicare Prescription Drug costs
- Medicare Savings Programs (MSPs) for help with Medicare Part A and Part B costs, which include:
  - Qualified Medicare Beneficiary (QMB) program
  - Specified Low-income Medicare Beneficiary (SLMB) program
  - Qualifying Individual (QI) program
  - Dual eligibility for Medicare and Medicaid coverage

Note: Eligible consumers who have Medicare or are considering enrolling in Medicare can also access MSPs and Extra Help for Medicare Part D to help pay for Medicare costs.

More information on eligibility and coverage is available in the **Resources** section.

## Knowledge Check

Introduction to Medicare Text Version  Exit Course

### Knowledge Check



It's time for a Knowledge Check to review how you might assist an older consumer. Eduardo, who is 71 years old, comes to your office for more information about his health coverage options. He's currently enrolled in Medicare premium-free Part A and Medicare Part B. He wants to know more about other options that might be available to help lower his costs.

Which of the following discussions would be appropriate to have with Eduardo?  
Choose **all that apply** and then select **Check Your Answer**.

- A. Tell him you can't help him and that he should contact his local State Health Insurance Assistance Program to find out if he qualifies for state-based financial assistance to lower his Medicare costs.
- B. Tell him that he can keep his current Medicare premium-free Part A and Medicare Part B and apply for programs through a Marketplace to help him with Medicare premium costs.
- C. Tell him that he can keep his current Medicare premium-free Part A and Medicare Part B and apply for a Medicare Savings Program (MSP) to see if he's eligible to get help paying for his Medicare costs.
- D. Tell him that because he's enrolled in Medicare premium-free Part A and Medicare Part B, insurers currently cannot sell him a QHP through the Marketplace if they know it will duplicate his Medicare benefits. However, if he wants to enroll in a QHP, he could contact the Social Security office to learn about stopping his Medicare coverage. If he stops his Medicare coverage, he might become eligible to purchase coverage through a Marketplace.

Check Your Answer

MenuHelpGlossaryResourcesMapModule 10 of 11Page 11 of 14

It's time for a Knowledge Check to review how you might assist an older consumer. Eduardo, who is 71 years old, comes to your office for more information about his health coverage options. He's currently enrolled in Medicare premium-free Part A and Medicare Part B. He wants to know more about other options that might be available to help lower his costs.

Which of the following discussions would be appropriate to have with Eduardo?

- A. Tell him you can't help him and that he should contact his local State Health Insurance Assistance Program to find out if he qualifies for state-based financial assistance to lower his Medicare costs.
- B. Tell him that he can keep his current Medicare premium-free Part A and Medicare Part B and apply for programs through a Marketplace to help him with Medicare premium costs.
- C. Tell him that he can keep his current Medicare premium-free Part A and Medicare Part B and apply for a Medicare Savings Program (MSP) to see if he's eligible to get help paying for his Medicare costs.
- D. Tell him that because he's enrolled in Medicare premium-free Part A and Medicare Part B, insurers currently cannot sell him a QHP through the Marketplace if they know it will duplicate his Medicare benefits. However, if he wants to enroll in a QHP, he could contact the Social Security office to learn about stopping his Medicare coverage. If he stops his Medicare coverage, he might become eligible to purchase coverage through a Marketplace.

The correct answers are C and D. You should tell Eduardo about the various programs that might help him lower his Medicare costs. If he wants to compare his Medicare costs with the possible cost of enrolling in a QHP through a Marketplace, you should help Eduardo fill out a Marketplace application to see if he's eligible to enroll in a QHP and/or if he qualifies for APTC/CSRs. When Eduardo gets his eligibility determination notice, you can review it with him to make sure he has the information he needs – including financial considerations – to decide whether he should: 1) keep his Medicare premium-free Part A coverage and apply for an MSP; or 2) opt out of Medicare premium-free Part A by contacting the Social Security office to end his Medicare coverage and enroll in a QHP through a Marketplace.

# Knowledge Check

Introduction to Medicare Text Version  Exit Course

## Knowledge Check



Here is the last Medicare knowledge check.

Which of the following is usually the best option for older consumers enrolled in a QHP through a Marketplace for individuals and families if they are about to become entitled to Medicare premium-free Part A?

Choose the **correct answer** and then select **Check Your Answer**.

- A. Apply for Medicare immediately or as soon as their Initial Enrollment Period begins.
- B. Stay enrolled in their current QHP.
- C. Wait until after they become eligible for Medicare to decide whether to apply for Medicare.
- D. Switch to another QHP with health coverage options similar to what Medicare provides.

 **Check Your Answer**

MenuHelpGlossaryResourcesMapModule 10 of 11Page 12 of 14

Which of the following is usually the best option for older consumers enrolled in a QHP through a Marketplace for individuals and families if they are about to become entitled to Medicare premium-free Part A?

- A. Apply for Medicare immediately or as soon as their Initial Enrollment Period begins.
- B. Stay enrolled in their current QHP.
- C. Wait until after they become eligible for Medicare to decide whether to apply for Medicare.
- D. Switch to another QHP with health coverage options similar to what Medicare provides.

The correct answer is A. If consumers are about to become eligible for Medicare, their best option is usually to enroll in Medicare immediately or as soon as their Initial Enrollment Period begins. They may experience increased costs, fees, and gaps in coverage if they don't sign up for Medicare when they first become eligible.

# Medicare Eligibility and Immigration Status

Introduction to Medicare Text Version  Exit Course

## Medicare Eligibility and Immigration Status

Generally, consumers must be U.S. citizens or lawful permanent residents and live in the U.S. continuously for the past five years preceding the month in which they submit an application for Medicare Part B. Medicare claims under Part A or Part B will not be paid for consumers who are not lawfully present in the U.S., even if they earned enough quarters of coverage to qualify.

You can learn more about Medicare eligibility for immigrants in the course on Serving Vulnerable and Underserved Populations in this training.

Consumers who are not U.S. citizens can contact the [Social Security Administration](#) for more information about Medicare eligibility requirements.

Menu Help Glossary Resources Map Module 10 of 11 Page 13 of 14

Generally, consumers must be U.S. citizens or lawful permanent residents and live in the U.S. continuously for the past five years preceding the month in which they submit an application for Medicare Part B. Medicare claims under Part A or Part B will not be paid for consumers who are not lawfully present in the U.S., even if they earned enough quarters of coverage to qualify.

You can learn more about Medicare eligibility for immigrants in the course on Serving Vulnerable and Underserved Populations in this training.

Consumers who are not U.S. citizens can contact the [Social Security Administration](#) for more information about Medicare eligibility requirements.

# Key Points

Introduction to Medicare Text Version  Exit Course

## Key Points



- 01** Consumers who already have Medicare Part A and/or Part B generally can't enroll in QHPs through a Marketplace because it's against the law for a private insurer to sell a Marketplace plan to someone who has Medicare coverage when the insurer knows the plan will provide duplicate benefits.
- 02** If consumers are enrolled in QHPs and get financial assistance through a Marketplace, they'll lose their eligibility for Marketplace-based financial assistance when their Medicare Part A coverage begins or when they become eligible for premium-free Medicare Part A due to age. However, consumers with premium-free Part A Medicare typically pay less for health coverage than they would for Marketplace coverage.
- 03** Consumers who don't have Medicare coverage (and who are not eligible for premium-free Part A due to age) may be able to enroll in a QHP through a Marketplace and may be eligible for APTC and CSRs.
- 04** Consumers who have Medicare Part B only or Medicare premium Part A and Part B may be eligible to enroll in a QHP through a Marketplace, but an insurer that knows its plan will duplicate a consumer's Medicare coverage can only sell them a QHP after they voluntarily end all their Medicare coverage.
- 05** Additional programs for lowering consumers' costs may be available through Medicare.

Menu Help Glossary Resources Map Module 10 of 11 Page 14 of 14

- Consumers who already have Medicare Part A and/or Part B generally can't enroll in QHPs through a Marketplace because it's against the law for a private insurer to sell a Marketplace plan to someone who has Medicare coverage when the insurer knows the plan will provide duplicate benefits.
- If consumers are enrolled in QHPs and get financial assistance through a Marketplace, they'll lose their eligibility for Marketplace-based financial assistance when their Medicare Part A coverage begins or when they become eligible for premium-free Medicare Part A due to age. However, consumers with premium-free Part A Medicare typically pay less for health coverage than they would for Marketplace coverage.
- Consumers who don't have Medicare coverage (and who are not eligible for premium-free Part A due to age) may be able to enroll in a QHP through a Marketplace and may be eligible for APTC and CSRs.
- Consumers who have Medicare Part B only or Medicare premium Part A and Part B may be eligible to enroll in a QHP through a Marketplace, but an insurer that knows its plan will duplicate a consumer's Medicare coverage can only sell them a QHP after they voluntarily end all their Medicare coverage.
- Additional programs for lowering consumers' costs may be available through Medicare.

# The Coverage Gap

## Introduction

The Coverage Gap

Text Version  Exit Course

**Introduction**

At this point, you might be wondering how you can help consumers who do not qualify for Medicaid, CHIP, or Medicare if they do not qualify for programs to help lower their costs through a Marketplace or if other private health coverage is unaffordable for them.

**01**  
**Coverage Gap**  
Define the coverage gap

**02**  
**Coverage Exemptions**  
Help consumers who fall in the coverage gap obtain Marketplace exemptions

**03**  
**Consumer Options**  
State options available to consumers in a coverage gap

Menu Help Glossary Resources Map Module 11 of 11 Page 1 of 4

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### **Coverage Gap**

Define the coverage gap

### **Coverage Exemptions**

Help consumers who fall in the coverage gap obtain Marketplace exemptions

### **Consumer Options**

State options available to consumers in a coverage gap

# Low-Income Consumers Who Don't Qualify for Public Coverage and Can't Afford Private Coverage

The Coverage Gap Text Version Off Exit Course

## Low-Income Consumers Who Don't Qualify for Public Coverage and Can't Afford Private Coverage

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

**Coverage Exemptions**  
Consumers in a coverage gap may be eligible to receive an exemption from the individual shared responsibility payment during 2018 for the period they were without coverage or did not meet the requirement to have MEC. Generally, you can assist consumers in a coverage gap with the process of applying for exemptions granted through the Marketplaces.

Individuals who choose to go without insurance are not subject to making individual shared responsibility payments for tax years 2019 and later because the fee is reduced to \$0 for those years. You might also find it helpful to refer them to other resources. Remember, you can show consumers where to access tax forms but you cannot help them fill out tax forms in your role as an assister.

Note: Individuals age 30 and above must continue to obtain and report an [exemption](#) if they wish to purchase Catastrophic health coverage.

Menu Help Glossary Resources Map Module 11 of 11 Page 2 of 4

## What is a coverage gap?

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Note: Individuals age 30 and above must continue to obtain and report an [exemption](#) if they wish to purchase Catastrophic health coverage.

## Options for Consumers that Fall into a Coverage Gap

The Coverage Gap Text Version Exit Course

### Options for Consumers that Fall into a Coverage Gap

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

- Obtain health care services at federally qualified community health centers (FQHCs).** These centers provide services on a sliding scale depending on a consumer's income. Use the following tool to find a community health center near the consumer: [HealthCare.gov/community-health-centers/](https://www.healthcare.gov/community-health-centers/).
- Purchase Catastrophic health coverage.** Catastrophic plans are available through the Marketplaces for consumers under 30 years old and consumers who are 30 years old or older and are granted a hardship exemption. Catastrophic plans usually have lower monthly premiums than comprehensive plans but cover consumers only if they need a lot of care. They protect consumers from worst-case scenarios like serious accidents or illnesses. For more information, visit: [HealthCare.gov/choose-a-plan/catastrophic-health-plans/](https://www.healthcare.gov/choose-a-plan/catastrophic-health-plans/).
- See what pharmaceutical assistance programs may be available.** Some pharmaceutical companies offer assistance programs for the drugs they manufacture. You can help consumers see if assistance is available for the medications they take by visiting: [Medicare.gov/Pharmaceutical-Assistance-Program](https://www.medicare.gov/Pharmaceutical-Assistance-Program).
- Obtain a short-term plan.** Consumers may enroll in short-term, limited-duration insurance policies designed for people who experience a temporary gap in health coverage.

You should always follow [CMS guidance](#) when working with or referring consumers to organizations that are not other FFM assister organizations or HHS entities.

Menu Help Glossary Resources Map Module 11 of 11 Page 3 of 4

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- **See what pharmaceutical assistance programs may be available.** Some pharmaceutical companies offer assistance programs for the drugs they manufacture. You can help consumers see if assistance is available for the medications they take by visiting: [Medicare.gov/Pharmaceutical-Assistance-Program](https://www.medicare.gov/Pharmaceutical-Assistance-Program).
- **Obtain a short-term plan.** Consumers may enroll in short-term, limited-duration insurance policies designed for people who experience a temporary gap in health coverage.

You should always follow [CMS guidance](#) when working with or referring consumers to organizations that are not other FFM assister organizations or HHS entities.

# Key Points

The Coverage Gap Text Version ON Exit Course

## Key Points



- 01 Some consumers may fall into a coverage gap.
- 02 Consumers in a coverage gap are not subject to making individual shared responsibility payments for tax years 2019 and later because the fee is reduced to \$0 after December 31, 2018. However, if they wish to purchase Catastrophic health coverage, individuals age 30 and above must continue to obtain and report an affordability or hardship exemption through the Marketplace.
- 03 You can refer consumers in a coverage gap to other sources for care, including FQHCs, Catastrophic health plans, pharmaceutical assistance programs, and short-term, limited-duration insurance policies.

Menu Help Glossary Resources Map Module 11 of 11 Page 4 of 4

- Some consumers may fall into a coverage gap.
- Consumers in a coverage gap are not subject to making individual shared responsibility payments for tax years 2019 and later because the fee is reduced to \$0 after December 31, 2018. However, if they wish to purchase Catastrophic health coverage, individuals age 30 and above must continue to obtain and report an affordability or hardship exemption through the Marketplace.
- You can refer consumers in a coverage gap to other sources for care, including FQHCs, Catastrophic health plans, pharmaceutical assistance programs, and short-term, limited-duration insurance policies.

# Conclusion

Text Version  Exit Course

Conclusion



Congratulations! You have learned about the key features of the PPACA, 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 successfully completed this course.  
Select **Exit Course** to leave the course and take the Patient Protection and Affordable Care Act Basics exam. Good luck!

Menu Help Glossary Resources Map

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You've successfully completed this course.

# Resources

## Patient Protection and Affordable Care Act Basics Resources

**More Information on Immigration Status:** Information about immigration status requirements for consumers in a Marketplace. <https://www.healthcare.gov/immigration-status-and-the-marketplace/>

**Incarcerated Consumers:** Explanation of incarceration status in relation to eligibility for coverage through a Marketplace. <https://www.healthcare.gov/incarceration/>

**Medicaid Expansion:** Official resource at HealthCare.gov that provides information for consumers who live in states that did not expand Medicaid. <https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/>

**More Information about the PPACA:** The text of the Patient Protection and Affordable Care Act can be accessed through this link at HealthCare.gov. <https://www.healthcare.gov/where-can-i-read-the-affordable-care-act/>

**Federal Poverty Guidelines:** Official HHS guidance on FPL levels for 2020. <https://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. <https://www.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. <https://marketplace.cms.gov/technical-assistance-resources/fast-facts-medicaid-chip.pdf>