Serving Individuals with Disabilities

This job aid provides guidance for Navigators and certified application counselors (CACs) and non-Navigator personnel (collectively, assisters) who help individuals with disabilities, and individuals helping people with disabilities, in a state with a Federally-facilitated Marketplace.

Version 2.0 October 2023. This information is intended only for the use of entities and individuals certified to serve as Navigators, certified application counselors, or non-Navigator personnel in a Federally-facilitated Marketplace. The terms “Federally-facilitated Marketplace” and “FFM,” as used in this document, include FFMs where the state performs plan management functions. Some information in this manual may also be of interest to individuals helping consumers in State-based Marketplaces and State-based Marketplaces using the Federal Platform. This material was produced and disseminated at U.S. taxpayer expense.

Overview

Under federal disability rights laws, an individual with a disability is defined as a person who has a physical or mental impairment that substantially limits one or more major life activities. This includes people who have a record of an impairment, even if they do not currently have a disability.[i] The definition of "individual with a disability" also includes people who do not have a disability but are regarded as having an impairment. The Centers for Disease Control and Prevention (CDC) estimates that up to 26 percent of adults in the United States have some type of disability.[ii]

Assisters are required by federal disability rights laws and the Department of Health and Human Resources (HHS) Affordable Care Act (ACA) regulations to provide information and services in a manner accessible to individuals with disabilities. According to HHS regulations:

- Navigators are required to provide accessible services for individuals with disabilities, including those applying for coverage or seeking information, and those helping others obtain information or coverage.

- CACs may meet this requirement either directly or by providing an appropriate referral to another assister organization or to the Marketplace Call Center. When making referrals, CACs should consider whether the assister they are referring the consumer to is nearby and can be reached with minimal time and effort on the consumer's part, as well as whether the assister specializes in or can provide the disability access services the consumer might need or request. For example, calling the office and confirming with staff that these services are provided or alternately confirming availability of these services on the assisters' website.

Assisters should provide appropriate accommodations, auxiliary aids and services, and other resources to help ensure that individuals with disabilities have equal access to health coverage through the Health Insurance Marketplace®.[iii]

Statutes and Regulations

There are several laws prohibiting discrimination and requiring equal access for people with disabilities. These provisions affect how you work with people with disabilities.

Section 1557 of the Affordable Care Act (ACA)

Section 1557 of the ACA is a nondiscrimination law that prohibits discrimination based on disability, race, color, national origin (including limited English proficiency), sex (including sexual orientation and gender identity), and age in covered health programs and activities.

The Department of Health and Human Services (HHS) interprets and enforces Section 1557's prohibition on discrimination on the basis of sex to include: (1) discrimination on the basis of

sexual orientation; and (2) discrimination on the basis of gender identity, consistent with the Department's interpretation of Title IX of the Education Amendments of 1972 and the Supreme Court's decision in *Bostock v. Clayton County, GA* (140 S.Ct 1731 (2020)).

In 2022, HHS has proposed to revise the current (2020) Section 1557 regulation.

The current HHS regulation implementing Section 1557 of the ACA applies to:

- Health programs and activities, any part of which receives federal financial assistance (FFA) provided by HHS;
- Programs and activities administered by HHS under Title I of the ACA; and
- Programs and activities administered by an entity established under Title I of the ACA, like a Federally-facilitated Marketplace (FFM) and a State-based Marketplace (SBM).

Among other things, the HHS 1557 regulation requires covered entities to:

- With certain exceptions, make their programs, activities, and facilities physically accessible to individuals with disabilities, in compliance with applicable accessibility standards outlined in the Americans with Disabilities Act (ADA) and Section 504, if the facility was started on or after July 18, 2016.
- Make programs and activities provided through information and communication technology (ICT) accessible, including websites, unless doing so would result in undue financial and administrative burdens or a fundamental alteration in the nature of the program or activity.
- Take appropriate actions to ensure that communication with people with disabilities is as effective as it is with others, and provide auxiliary aids and services, like alternative formats (e.g., text to speech, large print, and braille) and sign-language interpreters, at no cost, when necessary for effective communication.
- Make reasonable modifications to policies and practices for people with disabilities when necessary to avoid discrimination, unless doing so would fundamentally alter the nature of the program or activity.

Other Laws and Regulations

- Section 504 of the Rehabilitation Act (45 CFR Parts 84 and 85) prohibits discrimination on the basis of disability in programs or activities operated under Title 1 of ACA. This includes Navigators and other assisters receiving FFA from HHS or those conducted by HHS.

- The Centers for Medicare & Medicaid Services (CMS) Marketplace Regulations govern how assisters in FFMs should serve individuals with disabilities and avoid discrimination based on disability. Some of these regulations apply to FFMs. Some of these regulations

apply to Navigators in FFMs. These regulations apply regardless of whether an assister subject to them receives FFA. It prohibits against discrimination in certain areas such as service availability, accessibility, and delivery.

Health Coverage Options for Individuals with Disabilities

The Marketplace offers health coverage options to individuals with disabilities who may have previously faced barriers due to pre-existing conditions when seeking health coverage. Individuals with disabilities may also be eligible for Medicaid or the Children's Health Insurance Program (CHIP) and/or Medicare.

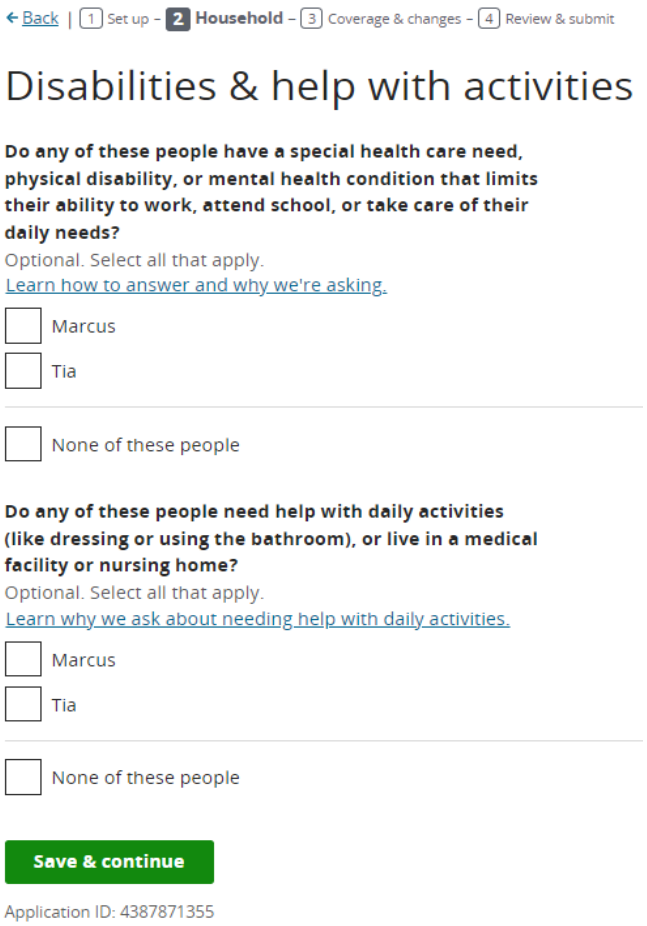
Marketplace and/or Medicaid Coverage

When individuals complete a Marketplace application for coverage with financial assistance, the Marketplace also evaluates individuals' eligibility for modified adjusted gross income (MAGI)-based Medicaid and CHIP.

Indicating a Disability on a Marketplace Application

The Marketplace application asks two questions about disabilities, shown in Exhibit 1. These questions help determine whether an individual might be eligible for coverage through their state's Medicaid program based on their disability (i.e., a non-MAGI basis).

Exhibit 1 – Questions about Disabilities on a Marketplace Application



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Disabilities & help with activities

Do any of these people have a special health care need, physical disability, or mental health condition that limits their ability to work, attend school, or take care of their daily needs?

Optional. Select all that apply.

Learn how to answer and why we're asking.

- ☐ Marcus
- ☐ Tia
- ☐ None of these people

Do any of these people need help with daily activities (like dressing or using the bathroom), or live in a medical facility or nursing home?

Optional. Select all that apply.

Learn why we ask about needing help with daily activities.

- ☐ Marcus
- ☐ Tia
- ☐ None of these people

Save & continue

Application ID: 4387871355

If an applicant (or other person completing the application) indicates that the answer to either of these questions is yes, or if other information they enter on the application suggests that they may qualify for Medicaid on a non-MAGI basis, such as due to a disability, the Marketplace securely transfers the application information to the state Medicaid agency to conduct a final eligibility determination for non-MAGI Medicaid.

- If the state Medicaid agency determines the consumer to be eligible for Medicaid that counts as minimum essential coverage (MEC) on a non-MAGI basis, the consumer will no longer be eligible for financial assistance to help pay for their share of a Marketplace plan premium and covered services and should act immediately to end their Marketplace coverage as soon as their Medicaid begins. For more information on next steps and information about how and when to end Marketplace coverage when a consumer is determined eligible for MEC Medicaid, please visit "Canceling a Marketplace plan when you get Medicaid or CHIP" at HealthCare.gov/medicaid-chip/cancelling-marketplace-plan.

- If an individual qualifies for Medicaid that doesn't count as MEC on a non-MAGI basis, which could include a state's optional "Medically Needy" program—which serves individuals who have high medical expenses and who would be eligible for Medicaid except that their income exceeds Medicaid thresholds—they may still be eligible to enroll in a Marketplace plan and receive financial assistance unless and until the individual has been determined eligible for MEC Medicaid. Note the Medicaid Buy-in plans may qualify as MEC.

Reporting Disability-related Income on a Marketplace Application

Individuals applying for coverage through the Marketplace who indicate that they would like help paying for coverage will need to provide their income information. When projecting annual income, disability-related income is often misreported. The following table lists the disability-related income applicants should and should not report on their application.

Report This Income	Do not Report This Income
▪ Social Security Disability Insurance (SSDI)	▪ Supplemental Security Income (SSI) SSI is separate from Social Security, even though they sound alike. It is designed to help persons who are aged, blind, or disabled or who are very low income and have limited assets. SSI is not taxed and does not count towards MAGI. ▪ Veterans' disability payments ▪ Worker's compensation payments

For a full list of what to include as income on a Marketplace application, visit HealthCare.gov/income-and-household-information/income.

In most states, individuals with disabilities who receive SSI payments automatically qualify for Medicaid coverage. If an individual is not automatically eligible for Medicaid, they will have to meet other criteria for their state's Medicaid program, which could include income, assets, and disability. Because Medicaid programs vary from state to state, assisters should refer individuals to the state Medicaid program for more specific information. To review Medicaid Eligibility for SSI recipients, by Type of State visit Crsreports.congress.gov/product/pdf/R/R46111, page 13.

Individuals who get SSDI benefits and are in a 24-month waiting period before getting Medicare may need to obtain other health coverage. These individuals may be able to get Medicaid coverage while they wait for their Medicare coverage to start. If they are eligible for Medicaid, their Medicaid eligibility may continue even after they enroll in Medicare. If they are not eligible for Medicaid, they may qualify for a Marketplace qualified health plan (QHP) and may qualify for financial assistance.

Some individuals may have household incomes that are too high to qualify for CHIP or MAGI-based Medicaid. These individuals may choose to purchase health coverage through the

Marketplace if eligible and may also be eligible for financial assistance to reduce their health coverage costs.

Medicare

Some individuals with disabilities are also Medicare beneficiaries. Individuals who have received SSDI for at least 24 months are automatically enrolled in Medicare Part A. These individuals may choose to enroll in Part B and are also eligible to enroll in a Medicare Part D prescription drug plan. In addition, Medicare beneficiaries who have limited resources and income may be eligible for the Extra Help program (SSA.gov/medicare/part-d-extra-help) to help pay for the costs related to a Medicare Part D prescription drug plan (e.g., monthly premiums, annual deductibles, prescription co-payments). Individuals should review their current health coverage and health coverage needs during Medicare Open Enrollment to determine if they want to make a change to how they receive their Medicare. Individuals should visit Medicare.gov to make sure they are looking at available Medicare options, not Marketplace plans. **It is against the law to knowingly sell a Marketplace plan that duplicates Medicare benefits to a Medicare beneficiary**.[iv]

Individuals who are not entitled to benefits under Part A or enrolled under Part B can still enroll in a Marketplace plan, if otherwise eligible. Individuals already enrolled in a Marketplace qualified health plan (QHP) when they become entitled to Medicare coverage can generally keep their Marketplace plan after Medicare coverage starts, but they will no longer be eligible for financial assistance. Medicare beneficiaries generally must visit the Marketplace to terminate financial assistance for which they are no longer entitled or, if they choose, terminate their Marketplace plan enrollment entirely.

Policy Updates

Assisters should be familiar with the following policy updates:

- Individuals who are enrolled in employer-sponsored coverage (ESC) may qualify for a Special Enrollment Period (SEP) if they are determined newly eligible for APTC because their ESC no longer offers affordable coverage, and they drop their employer coverage. This applies to individuals whose coverage is no longer affordable due to the change in IRS rules that went into effect on January 1, 2023 (“the family glitch”). Under this new rule, if an individual has an offer of employer coverage that extends to their family members, the affordability of employer coverage for those family members will be based on the family premium amount, not the self-only employee premium cost. Individuals can access this SEP by attesting “Yes” to the application question that asks about losing qualifying health coverage and providing the date they can end their employer coverage or the date they lost it in the past.

- A temporary Unwinding SEP is available to individuals who submit a new application or update an existing application between March 31, 2023, and July 31, 2024, and attest to a last date of Medicaid or CHIP coverage within the same time period. Individuals will have 60 days from the date they submit their application to select a Marketplace plan with coverage that starts the first day of the month after they select a plan.

- Beginning with Plan Year 2024, for individuals who qualify for the loss of qualifying coverage SEP and who select a plan within the 60 days prior to losing coverage, their coverage effective date is the first day of the month after loss of coverage or, at the option of the Exchange, if a plan is chosen before the last day of the month preceding the loss of coverage, the first of the month in which the loss of coverage occurs.

- The SEP available to individuals who have an estimated annual household income at or below 150 percent of the FPL in their state and are APTC-eligible allowing them to enroll in Marketplace coverage or change their Marketplace coverage once per month, if they so choose, continues to be available under the enhanced PTC amounts in the Inflation Reduction Act of 2022.

- Effective January 1, 2024, or earlier if an Exchange chooses to do so, Exchanges will now have the option to permit Medicaid or CHIP coverage loss attestations either 60 days before or 90 days (or greater than 90 days if a State Medicaid Agency provides for or allows a reconsideration period greater than 90 days) after a consumer loses Medicaid or CHIP coverage that counts as MEC to enroll in a Marketplace plan.

Scenario

Rose, a 58-year-old woman, lives by herself and has no dependents. She has type 2 diabetes and hypertension and recently went blind after experiencing diabetes-related vision problems. She just quit her job due to her vision impairment and cannot afford her existing health insurance plan. What should Rose consider when selecting new health coverage?

a) **Medicaid Eligibility**: Rose may be eligible for Medicaid on a MAGI basis and/or on a non-MAGI basis, like disability. In most states, if Rose is under sixty-five and is receiving SSI, she will automatically be considered to have a disability and may be eligible for Medicaid. In addition, if Rose receives SSDI, assisters should advise her of her potential current or future eligibility for Medicare and provide her with information about the program.

b) **Marketplace Savings Eligibility**: If Rose's annual household income is between 100 percent and 400 percent of the federal poverty level (FPL) and she is not eligible for Medicaid or other MEC, she may be eligible for lower costs on Marketplace coverage. For coverage effective in 2023, this means that if Rose is the only person in her household, her annual income must fall between $14,580 and $58,320 (higher in Alaska

and Hawaii) to be potentially eligible for lower costs. Note, for APTC, coverage in 2024 will use the 2023 FPL.

Note: The American Rescue Plan Act of 2021 expanded eligibility to include household income above 400 percent of the FPL and capped how much of a family's household income the family would pay towards the premiums for a benchmark plan at 8.5 percent. The Inflation Reduction Act (IRA) signed into law on August 16, 2022, extended the enhanced tax credits through Plan Year 2025.

c) **Prescription Drug Coverage**: If Rose chooses to enroll in a Marketplace plan, assisters should encourage her to consider her prescription drug coverage needs. Assisters should help Rose evaluate prescription drug formularies, as well as the tier placement and any utilization management policies for her medication and find a coverage option that covers her medication and best fits her needs, whether it is a QHP through the Marketplace or Medicaid (if eligible).

d) **Provider Network**: If Rose chooses to enroll in a Marketplace plan, assisters should encourage her to check the provider network to determine whether her endocrinologist, ophthalmologist, and other specialists she may need to see are part of the plan's network. Assisters should also encourage Rose to call the providers to confirm that they are accepting new or existing patients enrolled in that plan, since information provided in directories is not always up-to-date or accurate. If Rose's current providers are out of network, she may not be able to continue to receive services from them or may face higher out-of-pocket costs if she does.

e) **Future Health Care Needs**: Assisters should discuss what health care services are covered by a specific health plan. Rose's condition may require her to receive physical therapy, specialized therapy services, or mobility devices. Assisters should help Rose select a plan that will cover these services in the future, if needed. A plan with more expensive monthly premiums may reduce overall costs if the consumer requires multiple provider visits or services. Assisters should point out to Rose which documents from plans contain this information and where in plan documents she can locate details on number of permitted visits, authorization processes for mobility devices, cost-sharing, etc.

Providing Appropriate and Accessible Assistance

CMS expects all assisters and assister organizations to have a basic level of disability literacy. Assisters should not define individuals by their disabilities or make assumptions about what they are capable of doing or understanding. When you interact with individuals with disabilities, remember they should not be treated any differently from individuals without disabilities. Individuals with disabilities are independent and capable, so it is important that you always be respectful of individuals and their specific needs. Assisters should be aware of the accommodations and auxiliary aids individuals with disabilities may require so they can

effectively communicate with them, ensure they understand their health coverage options, and help them enroll in a plan that best fits their needs and budgets.

The following table lists reminders Assisters can use when working with or referring to individuals with disabilities.

Assisters should:	Assisters should not:
▪ Be respectful and avoid referring to individuals by their disabilities. Also avoid stigmatizing terminology such as “special” or describing wheelchair users as “wheelchair-bound.” ▪ Use “people first” language (e.g., “person with a disability” rather than “disabled person”). ▪ Speak directly to individuals, not to the person accompanying them or a translator, unless requested by the consumer. ▪ Ask individuals about their goals and priorities. ▪ Help individuals identify the unique health care services and benefits they may require (e.g., habilitation, rehabilitation, durable medical equipment, prosthetics) and then help them choose coverage that meets those needs. ▪ Maintain the capacity and accommodations to help individuals understand and compare insurance options, including resources in braille, screen-reading and enlarging software and devices, or having sign-language interpreters, captioning and other translation services. ▪ Be considerate, patient, and take your time. Because of the complexity of health insurance, you may have to repeat information multiple times or in different ways for the individuals to understand.	▪ Assume a consumer needs assistance. Offer assistance if it seems to be needed or if a consumer requests it (e.g., do not touch someone’s wheelchair or other assistive technology without first asking for their permission). ▪ Make assumptions about what a consumer is or is not capable of doing or understanding. ▪ Use stigmatizing terminology like “wheelchair-bound” that treats adaptive equipment as limiting rather than empowering, or “special.”

The following table lists suggestions[v] for providing accessible assistance to individuals with different types of disabilities.

Impairment Type	Accessible Assistance Suggestions
Physical	▪ Remove physical barriers to accessing assister facilities and install appropriate signage. ▪ Provide wheelchair-accessible locations, which includes addressing accessibility of entrances and exits, seating areas within the office space, restrooms, and parking. ▪ Provide access to assistance via modified computer, assistive technology, or telecommunication services, such as alternative keyboards, speech recognition software, and speakerphones.
Hearing	▪ Qualified in-person interpreters. ▪ Video teleconference capabilities (VTC) with sign-language interpreters ▪ Two-way texting devices ▪ Clear and understandable speech ▪ Willingness to repeat information as needed. ▪ Pen and paper to help with communication

Visual	▪ Written information in braille
	▪ Access to information via:
	  ▪ Voice or large-print materials
	  ▪ Clear black print on white or pale-yellow paper
	  ▪ Videos with audio description
	  ▪ Screen-reading (Text-to-Speech) software

Impairment Type	Accessible Assistance Suggestions
Cognitive or Intellectual	▪ Use simple, plain language, as well as illustrations and simple infographics to represent basic information. ▪ Support a consumer's choice to use an authorized representative to help them make health care decisions. ▪ Communicate with individuals' representatives, guardians, family members, or support persons, if requested by individuals. ▪ Refer individuals to additional resources and entities that may be able to provide specialized assistance.

Additional Resources

- Administration for Community Living: ACL.gov
- Medicaid.gov
- Medicare.gov
- National Council on Disability: NCD.gov

While CMS does not endorse information from outside entities, assisters may find the information on the following websites useful:

- National Disability Navigator Resource Collaborative Disability Guide: Nationaldisabilitynavigator.org/ndnrc-materials/disability-guide/
- National Disability Resource Navigator Collaborative Fact Sheets: Nationaldisabilitynavigator.org/ndnrc-materials/fact-sheets

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[i] 42 U.S.C. §12102.
[ii] Refer to the "Disability Impacts All of Us" Fact Sheet available at CDC.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html
[iii] Assisters should be familiar with any specific accessibility requirements that apply to their assister type under HHS regulations. Independent of these obligations, certain federal civil rights laws may also apply to assisters and consequently may require such assisters to provide information and services in a manner that is accessible to individuals with disabilities. Health Insurance Marketplace® is a registered service mark of the Department of Health & Human Services.
[iv] SSA.gov/OP_Home/ssact/title18/1882.htm
[v] These suggestions are examples only and are not intended to take the place of the statutes, regulations, and formal policy guidance upon which they are based.