

# MARKETPLACE ASSISTER TOOLKIT

## *Standard Operating Procedures Manual for Assisters in the Individual Federally-facilitated Marketplaces* **INTRODUCTION & INSTRUCTIONS FOR USE**





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## Introduction and Instructions for Use

### A. Welcome

The Centers for Medicare & Medicaid Services (CMS) aims to ensure that all consumers have access to high quality, affordable health coverage options through the Health Insurance Marketplace<sup>®i</sup>. Assisters play a critical role in meeting this goal, and CMS appreciates your support in this effort.

As an assister, you serve as a trusted resource to educate consumers and answer their questions about health coverage offered through a Federally-facilitated Marketplace (FFM).<sup>ii</sup> Assisters help to ensure that consumers have positive and successful experiences as they complete FFM eligibility and enrollment activities.

### B. Purpose of Manual

The Assister's Standard Operating Procedures (SOP) Manual is an instructional guide intended for assisters in the Federally-facilitated Marketplaces. The Center for Consumer Information & Insurance Oversight (CCIIO) within CMS maintains this Manual in its entirety as an online catalog of topic-specific assister SOPs at [Marketplace.cms.gov/technical-assistance-resources/the-assisters-sop-manual](https://Marketplace.cms.gov/technical-assistance-resources/the-assisters-sop-manual).

In this Manual, the term "assisters" refers to certified application counselors (CACs), Navigators, and non-Navigator assistance personnel who help consumers in the Federally-facilitated Marketplaces. The term "you" is also often used to refer to FFM assisters but is also sometimes used to refer to consumers [especially in Frequently Asked Questions (FAQs) sections]. This Manual contains SOPs for assister activities within a Federally-facilitated Marketplace for the individual market (also referred to in this document as an "Individual Federally-facilitated Marketplace," "Individual FFM," or "Individual Marketplace"). The SOPs reflect requirements, policies, and best practices under the Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (referred to collectively as the Affordable Care Act, or ACA), CMS regulations, and CMS guidance.

This Manual is not intended to take the place of the statutes, regulations, and formal policy guidance upon which it is based. It summarizes current policy and operations as of the date it was published. We encourage assisters to refer to these statutes, regulations, and interpretive guidance for complete and current information about the requirements that apply to them.

This Manual contains screenshots from [HealthCare.gov](https://www.healthcare.gov) that are intended only as an example of what you and/or the consumer may see when the consumer is completing an application at HealthCare.gov. All names and contact information used in the screenshots are fictional. The use of health insurer names and/or health plan names are for demonstration purposes only and should not be construed as an endorsement by CMS of any specific health insurer or health plan.



The instructions and information included in this Manual provide guidance on how to help consumers in an Individual FFM with key activities and issues discussed in the following sections of the Manual:

[Consumer Protections: Privacy and Security Guidelines](#)

[Consumer Protections: Fraud Prevention Guidelines](#)

[SOP 1 – Receive Consent Before Accessing Consumer PII](#)

[SOP 2 – Assess Consumers' Knowledge & Needs](#)

[SOP 3 – Create an Account](#)

[SOP 4 – Verify Identity and Resolve Potential Data Matching Issues](#)

[SOP 5 – Apply for Health Coverage](#)

[SOP 6 – Review Eligibility Results](#)

[SOP 7 – Lower Costs of Coverage](#)

[SOP 8 – Compare, Save, & Select Health Plans](#)

[SOP 9 – Pay Health Plan Premium](#)

[SOP 10 – Request a Marketplace Eligibility Appeal](#)

[SOP 11 – Exemptions](#)

[SOP 12 – Understanding Form 1095-A and Reconciling Advance Payments of the Premium Tax Credit](#)

[SOP 13 – Update a Federally-facilitated Marketplace Account](#)

[SOP 14 – Renew Health Coverage](#)

## C. Updates to the Manual

CCIIO may alter, delete, suspend, or discontinue the procedures detailed in various portions of this Manual in the future. Procedural changes will be communicated to assisters through the Assister Newsletter and assister webinars, as well as through federal regulations and guidance. CCIIO will also periodically update the Manual as relevant regulations, guidance, or policies are released and disseminate updated versions of the Manual to assister organizations. As an assister, you should refer to your assister organization's policies and guidelines for specific instructions on how to obtain new versions of the Manual.

## D. Instructions for Use

The Manual can either be used as electronic documents or as stand-alone paper documents. Key features of each individual SOP such as the Table of Contents and color coding allow for easy navigation of the documents in either format.

### 1. Electronic Document Use

When using the electronic versions of the Manual, select hyperlinked words underlined in blue font in the body of the Manual to navigate to a new section within the document or to open an external website. In the Table of

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Contents, hyperlinks appear as normal text. In all instances, hovering over a hyperlink changes the mouse pointer to indicate the hyperlink's presence.

## 2. Paper Document Use

When using the paper versions of the Manual, refer to the Table of Contents to navigate to the page containing the information you need. The Table of Contents provides an overview of the document by sections and subsections.



## Appendix A: Acronyms & Definitions

Exhibit 1 defines acronyms that you as assisters may encounter in Assister SOPs and other resources.

Exhibit 1 — Frequently Used Acronyms

Acronyms	Descriptions
APTC	Advance Payments of the Premium Tax Credit
CAP	Consumer Assistance Program
CCIO	Center for Consumer Information & Insurance Oversight
COBRA	Consolidated Omnibus Budget Reconciliation Act
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CSR	Cost-sharing Reduction
DHS	Department of Homeland Security
DMI	Data-matching Issue
EHB	Essential Health Benefits
FAQ	Frequently Asked Questions
FFM	Federally-facilitated Marketplace
FPL	Federal Poverty Level
HDHP	High Deductible Health Plan
HHS	Department of Health & Human Services
HMO	Health Maintenance Organization
HSA	Health Savings Account
ID	Identification
IHS	Indian Health Service
IRS	Internal Revenue Service
MAGI	Modified Adjusted Gross Income
MEC	Minimum Essential Coverage
PII	Personally Identifiable Information
QHP	Qualified Health Plan
SBC	Summary of Benefits and Coverage
SEP	Special Enrollment Period
SHIP	State Health Insurance Assistance Program
SHOP	Small Business Health Options Program
SOP	Standard Operating Procedure
SSI	Supplemental Security Income
SSN	Social Security Number
VA	Veterans Affairs
VHA	Veterans Health Administration

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## Appendix B: Definitions

The following is a list of terms from HealthCare.gov, CCIIO, and the Affordable Care Act explained in plain language that you may reference to assist consumers.

**Advance Payments of the Premium Tax Credit (APTC):** The Affordable Care Act provides a premium tax credit to help consumers afford health coverage purchased through a Marketplace. Consumers can receive and use the premium tax credit in advance— APTC—to lower their monthly premium costs. If consumers qualify, they may choose the amount of APTC they wish to apply toward their premium costs each month, up to a maximum amount. If the amount of APTC consumers get for the year is less than the premium tax credit they're due based on their annual household income determined when they file their federal income tax return for the coverage year, they'll get the difference as a refundable credit when they file their federal income tax return. If their APTC for the year are more than the amount of the premium tax credit for which they are eligible, they must repay the excess advance payments, subject to a limit for certain consumers, with their tax return. (Reference: [HealthCare.gov/glossary/advanced-premium-tax-credit](https://www.healthcare.gov/glossary/advanced-premium-tax-credit/))

**Affordable Care Act (ACA):** The health care reform law enacted in March 2010. Congress passed the law in two parts. The President signed the Patient Protection and Affordable Care Act into law on March 23, 2010, which was amended by the Health Care and Education Reconciliation Act of 2010 on March 30, 2010. The name "Affordable Care Act" refers to the amended version of the law (sometimes also known as ACA, PPACA, or "Obamacare"). (Reference: [HealthCare.gov/glossary/affordable-care-act](https://www.healthcare.gov/glossary/affordable-care-act/))

**Agent:** When registered with the Health Insurance Marketplace®, an individual or entity that helps individuals and businesses apply for and enroll in qualified health plans (QHPs) through the Marketplace and may assist in applying for advance payments of the premium tax credit and cost-sharing reductions. States grant licenses to agents to sell insurance in their respective jurisdictions. Agents may work for a single health insurance company. They may receive compensation from insurance companies with whom they have a contractual relationship to enroll consumers in a QHP (Reference: [Patient Protection and Affordable Care Act §1312\(e\)](https://www.fda.gov/oc/2013/03/20130314-aca-1312e) and [45 CFR §155.20](https://www.fda.gov/oc/2013/03/20130314-aca-1312e))

**Applicant:** With respect to an Individual Marketplace, an applicant is an individual seeking eligibility for themselves through an application submitted to the Marketplace [or transmitted to the Marketplace by the state Medicaid or Children's Health Insurance Program (CHIP) agency]. Applicants must be seeking eligibility for at least one of the following: enrollment in a qualified health plan through the Marketplace (with or without advance payments of the premium tax credit and/or cost-sharing reductions) and/or enrollment in Medicaid or CHIP. (Reference: [45 CFR §155.20](https://www.fda.gov/oc/2013/03/20130314-aca-1312e) and [42 CFR §435.4](https://www.fda.gov/oc/2013/03/20130314-aca-1312e))

**Authorized Representative:** Someone whom consumers designate in writing to act on their behalf with the Marketplace, like a family member or other trusted person. (Reference: [45 CFR §155.227](https://www.fda.gov/oc/2013/03/20130314-aca-1312e))

**Benefits:** The health care items or services covered under a health plan. The health plan's coverage documents define the covered benefits and excluded services. In Medicaid or CHIP, the state program rules define covered benefits and excluded services. (Reference: [HealthCare.gov/glossary/benefits](https://www.healthcare.gov/glossary/benefits/))

**Benefit Year:** A calendar year for which a health plan provides coverage for health benefits. The benefit year for non-grandfathered individual market plans bought inside or outside the Marketplace generally begins January 1 of each year and ends December 31 of the same year. Unless terminated earlier, a consumer's individual market benefit year ends December 31 even if the coverage started after January 1. Any changes to benefits or rates of an individual market health insurance plan are generally made at the beginning of the calendar year. (Reference: [HealthCare.gov/glossary/benefit-year](https://www.healthcare.gov/glossary/benefit-year/))

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**Broker:** When registered with a Marketplace, an individual or entity that helps individuals and businesses apply for and enroll in a qualified health plan (QHP) through the Marketplace and may assist in applying for advance payments of the premium tax credit and cost-sharing reductions. States grant licenses to brokers to sell insurance in their respective jurisdictions. Brokers may represent several companies and they may receive compensation from an insurance company with whom they have a contractual relationship to enroll consumers into a QHP. (Reference: [Patient Protection and Affordable Care Act § 1312\(e\)](#) and [45 CFR §155.20](#))

**Catastrophic Health Plan:** Health plans that are subject to the health insurance market reform requirements applicable to individual health insurance coverage but that don't cover any benefits other than three primary care visits per year before the plan's annual limit on cost sharing is met and that comply with the requirement to cover certain preventive services without cost-sharing obligations. The premium amount consumers pay each month for Catastrophic health plans is generally lower than that for other plans, but out-of-pocket amounts are generally higher. To qualify for a Catastrophic health plan, consumers must be under 30 years old at the time of enrollment OR get an exemption because the Marketplace determined that they're unable to afford health coverage or have certain other hardships. (Reference: [HealthCare.gov/glossary/catastrophic-health-plan](#))

**Center for Consumer Information & Insurance Oversight (CCIIO):** A part of the Department of Health & Human Services that helps to implement many provisions of the Affordable Care Act, the health reform bill that became law in March 2010. CCIIO oversees the implementation of the provisions related to private health insurance. (Reference: [CMS.gov/CCIIO](#))

**Centers for Medicare & Medicaid Services (CMS):** The federal agency that runs Medicare, Medicaid and the Children's Health Insurance Program, and the Federally-facilitated Marketplaces. For more information, visit [CMS.gov](#). (Reference: [HealthCare.gov/glossary/centers-for-medicare-and-medicare-services](#))

**Certified Application Counselor (CAC):** In an FFM, an individual [affiliated with an organization designated by CMS as operator of the FFMs, otherwise known as a certified application counselor designated organization (CDO)] who is trained and able to help consumers as they look for health coverage options through the Marketplace, including helping them understand the eligibility and enrollment process. Their services are free to consumers. (Reference: [HealthCare.gov/glossary/certified-applicant-counselor](#))

**Certified Application Counselor Designated Organization (CDO):** In an FFM, an organization designated by CMS, as operator of the FFMs, to certify staff members or volunteers to act as certified application counselors. (Reference: [45 CFR §155.225](#))

**Children's Health Insurance Program (CHIP):** Program jointly funded by state governments and the Federal Government that provides health coverage to low-income children and, in some states, pregnant women in families who earn too much income to qualify for Medicaid, up to certain income levels. (Reference: [HealthCare.gov/glossary/childrens-health-insurance-program-chip](#))

**Claim:** A request for payment that a consumer, their authorized representative, or their health care provider submits to the consumer's health insurer when the consumer receives items or services they think are covered. (Reference: [HealthCare.gov/glossary/claim](#))

**Coinsurance:** The consumer's share of the costs of a covered health care service calculated as a percent (for example, 20 percent) of the allowed amount for the service. Consumers pay coinsurance plus any deductibles they owe. For example, if the health insurance or plan's maximum allowed amount for a covered office visit is \$100 and the consumer has met the plan's deductible, the consumer's coinsurance payment of 20 percent would be \$20. The health insurance or plan pays the rest of the allowed amount. (Reference: [HealthCare.gov/glossary/co-insurance](#))

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**Consolidated Omnibus Budget Reconciliation Act (COBRA):** A federal law that may allow consumers to temporarily keep employer sponsored health coverage after their employment ends, they lose coverage as a dependent of the covered employee, or another qualifying event resulting in the loss of employer-sponsored health coverage. Consumers that elect COBRA continuation coverage pay up to 100 percent of the premiums, including the share the employer used to pay, plus a small administrative fee. (Reference: [HealthCare.gov/glossary/cobra/](https://www.healthcare.gov/glossary/cobra/))

**Copayment:** Also referred to as a copay, this is a fixed amount (for example, \$15) a consumer pays for a covered health care service, usually when they receive the service. The amount can vary by the type of covered health care service. (Reference: [HealthCare.gov/glossary/co-payment](https://www.healthcare.gov/glossary/co-payment/))

**Cost-sharing Reduction (CSR):** A discount that lowers the amount consumers have to pay out of pocket for deductibles, coinsurance, and copayments. Consumers also have a lower out-of-pocket maximum. Consumers are eligible for CSRs based on household income if they get health insurance through a Marketplace, meet household income requirements, enroll in a health plan in the Silver plan category (see Health Plan Categories), and meet other eligibility criteria. Consumers may also qualify for different cost-sharing reductions if they are a member of a federally recognized Tribe. (Reference: [HealthCare.gov/glossary/cost-sharing-reduction](https://www.healthcare.gov/glossary/cost-sharing-reduction/))

**Data Matching Issue (DMI):** A difference between information a consumer reports on their Marketplace health insurance application and information the Marketplace obtains from other trusted data sources.

If a DMI occurs, the Marketplace will ask consumers to submit documents to confirm their application information. These documents may include information about household income, citizenship, immigration status, eligibility for other types of health coverage, or other information on the application. If consumers don't submit acceptable documents by the deadline stated in their notice, they could lose their Marketplace plan, premium tax credits, and other help with costs. (Reference: [HealthCare.gov/glossary/data-matching-issue/](https://www.healthcare.gov/glossary/data-matching-issue/))

**Deductible:** The amount consumers owe for covered health care services before their health insurance or plan begins to pay. For example, if a consumer's deductible is \$1,000, the plan won't pay anything for covered health care services subject to the deductible until the consumer has paid \$1,000 for covered health services subject to the deductible. The deductible may not apply to all services. (Reference: [HealthCare.gov/glossary/deductible](https://www.healthcare.gov/glossary/deductible/))

**Eligibility Appeal:** In an Individual Marketplace, a request by an individual for a re-evaluation of a Marketplace eligibility decision or an eligibility decision by a state Medicaid or Children's Health Insurance Program agency. (Reference: [HealthCare.gov/can-i-appeal-a-marketplace-decision](https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/))

**Employer-sponsored Health Plan (Group Health Plan):** Also referred to as employer-sponsored coverage or job-based coverage. A group health plan or health coverage offered by an employer, which may be a governmental plan or any other plan, and which may be insured by purchasing coverage offered in the small- or large- group marketplace within a state. (Reference: [IRC §5000A\(f\)\(2\)](https://www.irs.gov/irm/part40/40010101_0101_01))

**Enrollee:** In an Individual Marketplace, a qualified individual enrolled in a qualified health plan through the Marketplace. (Reference: [45 CFR §155.20](https://www.ecfr.gov/current/title-45--chapter-155--section-20))

**Essential Health Benefits (EHB):** A set of health care service categories in which certain plans must cover items and services. The Affordable Care Act ensures that non-grandfathered health insurance plans offered in the individual and small-group markets, both inside and outside of the Marketplace, offer a comprehensive package of items and services, known as essential health benefits. EHB must include items and services within at least the following ten categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and

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wellness services and chronic disease management; and pediatric services, including oral and vision care. Insurance policies must cover these categories of benefits to be certified as qualified health plans that can be offered in the Marketplace. Alternative benefit plans offered under state Medicaid plans (which must be offered to the new adult population), must also cover EHB. (Reference: [HealthCare.gov/glossary/essential-health-benefits](https://www.healthcare.gov/glossary/essential-health-benefits))

**Exemption:** Consumers who are 30 or older and want to purchase a Catastrophic health plan must apply for a hardship or affordability exemption to qualify, which means that they are not required to pay a tax penalty for not having health coverage. Beginning with coverage year 2019, consumers no longer need an exemption to avoid the tax penalty, otherwise known as the individual shared responsibility payment, if they don't have minimum essential coverage. The fee for not having health insurance no longer applies. (Reference: [HealthCare.gov/health-coverage-exemptions/exemptions-from-the-fee](https://www.healthcare.gov/health-coverage-exemptions/exemptions-from-the-fee) and [HealthCare.gov/health-coverage-exemptions/exemptions-catastrophic-coverage](https://www.healthcare.gov/health-coverage-exemptions/exemptions-catastrophic-coverage))

**Federal Poverty Level (FPL):** FPL represents a threshold level of household income used by the Federal Government to determine an individual's eligibility to participate in certain federal programs or qualify for advance payments of the premium tax credit or cost-sharing reductions in a Marketplace when enrolling in a qualified health plan. Poverty guidelines are available at [ASPE.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines](https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines). (Reference: [HealthCare.gov/glossary/federal-poverty-level-fpl](https://www.healthcare.gov/glossary/federal-poverty-level-fpl))

**Health Coverage:** Consumers' legal entitlement to payment or reimbursement for their health care costs for covered services or items, generally under a contract with a health insurance company, a group health plan offered in connection with employment, or a government program like Medicare, Medicaid, or the Children's Health Insurance Program. (Reference: [HealthCare.gov/glossary/health-coverage](https://www.healthcare.gov/glossary/health-coverage))

**Health Insurance:** A contract that requires a consumer's health insurer to pay some or all of the consumer's health care costs in exchange for a premium. (Reference: [HealthCare.gov/glossary/health-insurance](https://www.healthcare.gov/glossary/health-insurance))

**Health Insurance Issuer (Issuer):** An insurance company, insurance service, or insurance organization that must have a license to engage in the business of insurance in a state and that is subject to state laws that regulate insurance. (Reference: [45 CFR §144.103](https://www.ecfr.gov/current/title-45--chapter-144--section-103))

**Health Plan Categories:** The Individual Marketplace generally separates health plans into four health plan categories — Bronze, Silver, Gold, or Platinum — based on the amount the plan can be expected to pay of the average overall cost of providing essential health benefits to members. The plan category a consumer chooses affects the total amount the consumer will likely spend for essential health benefits during the year but has nothing to do with quality of care. For the four metal category plans, the percentages the plans will spend on average are 60 percent (Bronze), 70 percent (Silver), 80 percent (Gold), and 90 percent (Platinum). This is not the same as coinsurance in which a consumer pays a specific percentage of the cost of a specific service. (Reference: [HealthCare.gov/glossary/health-plan-categories](https://www.healthcare.gov/glossary/health-plan-categories))

**High Deductible Health Plan (HDHP):** A plan that features higher deductibles than traditional insurance plans. Consumers may combine high deductible health plans with a health savings account or a health reimbursement arrangement to allow them to pay for qualified medical expenses on a pre-tax basis. (Reference: [HealthCare.gov/glossary/high-deductible-health-plan](https://www.healthcare.gov/glossary/high-deductible-health-plan))

**Health Reimbursement Arrangement (HRA):** Employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. Unused amounts may be rolled over to be used in subsequent years. The employer funds and owns the arrangement. (Reference: [HealthCare.gov/glossary/health-reimbursement-account-hra](https://www.healthcare.gov/glossary/health-reimbursement-account-hra)).

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**Health Savings Account (HSA):** A medical savings account available to taxpayers who are enrolled in a high deductible health plan. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Consumers must use funds to pay for qualified medical expenses. Unlike a Flexible Spending Account (FSA), funds roll over year to year if consumers do not spend them. (Reference: [HealthCare.gov/glossary/health-savings-account-HSA](https://www.healthcare.gov/glossary/health-savings-account-HSA))

**Individual Coverage Health Reimbursement Arrangement (ICHRA):** A type of Health Reimbursement Arrangement (HRA) that reimburses medical expenses, like monthly premiums, and requires eligible employees and dependents to have individual health insurance coverage or Medicare Parts A (Hospital Insurance) and B (Medical Insurance) or Part C (Medicare Advantage) for each month they are covered by the individual coverage HRA. An employer can offer an ICHRA instead of traditional group health plan coverage. Employees and dependents with an ICHRA offer qualify for premium tax credits (see Premium Tax Credits) only if the employer's offer doesn't meet minimum standards for affordability and they opt out of ICHRA coverage. (Reference: [HealthCare.gov/glossary/individual-coverage-hra](https://www.healthcare.gov/glossary/individual-coverage-hra))

**Individual Marketplace:** The Marketplace for individuals to purchase health insurance plans for themselves or their families other than through an employer-sponsored group health plan. (Reference: [Patient Protection and Affordable Care Act §1304\(a\)\(2\)](#))

**Individual Shared Responsibility Payment (also referred to as a “penalty,” “fee,” “fine,” “or “individual mandate”):** For tax years prior to 2019, taxpayers must report minimum essential coverage (MEC), qualify for an exemption, or pay an individual shared responsibility payment.

Beginning with coverage year 2019, individuals who do not have MEC are no longer required to make a shared responsibility payment. Although tax reform legislation enacted in December 2017 reduces the individual shared responsibility payment to \$0 for months beginning after December 31, 2018, individuals may still have reason to seek other types of exemptions, like an affordability or hardship exemption, for purposes of obtaining Catastrophic health coverage for 2019 and future years. (References: [HealthCare.gov/glossary/fee](https://www.healthcare.gov/glossary/fee) and [Patient Protection and Affordable Care Act - HHS Notice of Benefit and Payment Parameters for 2019](#))

**Insurance Affordability Program:** A program that is one of the following: a Medicaid program; the Children's Health Insurance Program; or a program that makes QHPs available with advance payments of the premium tax credit and cost-sharing reductions. (Reference: [45 CFR §155.300](#))

**Marketplace:** A marketplace for health insurance, also known as an “Exchange,” operated by a governmental agency or non-profit entity that meets applicable government standards. A Marketplace makes qualified health plans available to qualified individuals and/or qualified employers. Generally, in CMS documents, this term is often used to refer both to Marketplaces serving the individual market for qualified individuals and to Small Business Health Options Program (SHOP) Marketplaces serving the small group market for qualified employers and is often used regardless of whether a Marketplace is established and operated by a state or by HHS. However, in this document, the term Marketplace generally is used to refer only to the Federally-facilitated Marketplaces (FFMs) and frequently is used to refer only to the FFMs for the individual market. (Reference: [45 CFR §155.20](#))

**Marketplace Service Area:** The geographic area in which a Marketplace is certified to operate. (Reference: [45 CFR §155.20](#))

**Medicaid:** A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and, in some states, other adults. The Federal Government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in



how they design their programs; therefore, Medicaid can vary state by state and may have a different name in your state. (Reference: [HealthCare.gov/glossary/medicaid/](https://www.healthcare.gov/glossary/medicaid/))

**Medicare:** A federal health insurance program for people who are age 65 or older and certain younger people with disabilities. It also covers people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). (Reference: [HealthCare.gov/glossary/medicare/](https://www.healthcare.gov/glossary/medicare/))

**Minimum Essential Coverage (MEC):** Any insurance plan that meets the Affordable Care Act requirement for having health coverage. Types of coverage that meet MEC requirements include the following: Individual Marketplace policies, certain employer-sponsored coverage, Medicare Part A or C, Children's Health Insurance Program (CHIP) coverage (including CHIP buy-in programs that provide identical coverage to the state's Title XXI CHIP program), Peace Corps, most Medicaid, TRICARE, Veterans Affairs (VA) health care program plans, and certain other coverage designated by the Secretary of HHS. (Reference: [HealthCare.gov/glossary/minimum-essential-coverage/](https://www.healthcare.gov/glossary/minimum-essential-coverage/))

**Minimum Value:** A health plan meets this standard if it is designed to pay at least 60 percent of the total allowed cost of benefits under the plan and the benefits under the plan include substantial coverage of inpatient hospital services and physician services. Individuals eligible for minimum essential coverage, including employer-sponsored coverage that provides minimum value and that is affordable, are not eligible to receive a premium tax credit. (Reference: [45 CFR §156.145](https://www.ecfr.gov/current/title-45--chapter-156--section-145))

**Modified Adjusted Gross Income (MAGI):** The figure used to determine eligibility for lower costs in the Marketplace and for some Medicaid and Children's Health Insurance Program applicants. Generally, MAGI is an individual's adjusted gross income plus any tax-exempt Social Security, interest, or foreign income the individual has. (Reference: [HealthCare.gov/glossary/modified-adjusted-gross-income-magi/](https://www.healthcare.gov/glossary/modified-adjusted-gross-income-magi/))

**Navigator:** An individual or organization that receives a grant from the Marketplace and that is trained and able to help consumers as they look for health coverage options through the Marketplace, including helping them complete the eligibility and enrollment process. These individuals and organizations are required to be unbiased. Their services are free to consumers. (Reference: [HealthCare.gov/glossary/navigator/](https://www.healthcare.gov/glossary/navigator/))

**Open Enrollment Period (OEP):** The period of time during which individuals who are eligible to enroll in a qualified health plan can enroll in a plan through the Individual Marketplace. The OEP in Marketplaces using the federal eligibility and enrollment platform will run from November 15 – January 15 each year. Individuals may also qualify for Special Enrollment Periods if they experience certain qualifying events outside of the OEP. Consumers can apply for Medicaid or Children's Health Insurance Program coverage at any time of the year. (Reference: [HealthCare.gov/glossary/open-enrollment-period/](https://www.healthcare.gov/glossary/open-enrollment-period/))

**Out-of-pocket Costs:** The expenses for health care services that plans and issuers do not reimburse. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that are not covered. (Reference: [HealthCare.gov/glossary/out-of-pocket-costs/](https://www.healthcare.gov/glossary/out-of-pocket-costs/))

**Plan Year:** A consecutive twelve-month period during which a health plan provides coverage for health benefits. A plan year may be a calendar year. (Reference: [45 CFR §155.20](https://www.ecfr.gov/current/title-45--chapter-155--section-20))

**Premium:** The amount that consumers or employers pay for health insurance or employer-sponsored coverage. Premiums are paid by the consumer and/or employers on a monthly, quarterly, or yearly basis. (Reference: [HealthCare.gov/glossary/premium/](https://www.healthcare.gov/glossary/premium/))

**Premium Tax Credit (PTC):** PTC is a refundable credit that helps eligible individuals and families cover the premiums for their health insurance purchased through the Health Insurance Marketplace®. To receive this



credit, an individual must meet certain requirements and file a tax return with Form 8962, Premium Tax Credit. (Reference: [IRS.gov/affordable-care-act/individuals-and-families/the-premium-tax-credit-the-basics](https://www.irs.gov/affordable-care-act/individuals-and-families/the-premium-tax-credit-the-basics))

**Qualified Health Plan (QHP):** Under the Affordable Care Act, an insurance plan that is certified by a Marketplace, provides essential health benefits, follows established limits on cost sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. Each QHP is certified by the Marketplace through which the plan is offered. (Reference: [HealthCare.gov/glossary/qualified-health-plan/](https://www.healthcare.gov/glossary/qualified-health-plan/))

**Qualified Individual:** An individual who has been determined eligible to enroll in a qualified health plan through an Individual Marketplace. (Reference: [45 CFR §155.20](https://www.ecfr.gov/current/title-45--chapter-155--section-20))

**Qualified Small Employer Health Reimbursement Arrangement (QSEHRA):** Small employers who don't offer group health coverage to their employees can help employees pay for medical expenses through a QSEHRA. If your employer offers you a QSEHRA, you can use it to help pay your household's health care costs (like your monthly premium) for [qualifying health coverage](#). (Reference: [HealthCare.gov/glossary/qsehra/](https://www.healthcare.gov/glossary/qsehra/))

**Special Enrollment Period (SEP):** In the individual Marketplace, a period during which a qualified individual or enrollee who experiences certain qualifying events may enroll or change enrollment in a qualified health plan through the Marketplace outside of the annual individual market Open Enrollment Period. For example, individuals who lose employer-sponsored health coverage or who lose Medicaid coverage because of an increase in income would be eligible for an SEP to enroll in a Marketplace plan, if they otherwise qualify. Other triggering events include marriage, divorce, and the birth or adoption of a child. (Reference: [45 CFR §155.20](https://www.ecfr.gov/current/title-45--chapter-155--section-20))

**Summary of Benefits and Coverage (SBC):** An easy-to-read summary that lets consumers make apples-to-apples comparisons of costs and coverage between health plans. Consumers can compare options based on price, benefits, and other features that may be important to them. Consumers will receive the SBC when they shop for coverage on their own or through their job, renew or change coverage, or request an SBC from the health insurance company. (Reference: [HealthCare.gov/glossary/summary-of-benefits-and-coverage](https://www.healthcare.gov/glossary/summary-of-benefits-and-coverage/))

**Tax Dependent:** A child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction. Under the Affordable Care Act, individuals may be able to claim a premium tax credit to help cover the cost of coverage for themselves and their tax dependents. (Reference: [HealthCare.gov/glossary/dependent](https://www.healthcare.gov/glossary/dependent/))

**TRICARE:** A health care program for active-duty and retired uniformed services members and their families. (Reference: [HealthCare.gov/glossary/tricare/](https://www.healthcare.gov/glossary/tricare/))

**Veterans Affairs Health Care Benefits:** Health care benefits for which veterans who served in the active military, naval, or air service and were separated under any condition other than dishonorable may qualify. For more information on how the Affordable Care Act affects veterans' health benefits, visit [VA.gov/health/aca/](https://www.va.gov/health/aca/).



### Appendix C: Support Resources

If consumers require assistance that is outside of assister activities, refer consumers to other organizations and resources as appropriate. Exhibit 2 provides a list of external resources.

Exhibit 2—External Resources

Resource	Contact Information	What does this resource do?	How should consumers use this resource?
Center for Consumer Information & Insurance Oversight (CCIIO)	<a href="https://www.cms.gov/ccio">CMS.gov/ccio</a>	This entity implements many provisions of the Affordable Care Act, the health reform bill signed into law in March 2010. CCIIO oversees the implementation of the provisions related to private health insurance.	<ul style="list-style-type: none"> <li>• To gather more information on the Affordable Care Act by referencing detailed fact sheets, FAQs, and other resources.</li> </ul>
HealthCare.gov	<a href="https://www.healthcare.gov">HealthCare.gov</a>	This website allows consumers to access information about the Affordable Care Act and to enroll in health coverage through an FFM.	<ul style="list-style-type: none"> <li>• To find out about health coverage options available through an FFM.</li> <li>• To apply for health coverage online.</li> <li>• To get real-time answers to questions using the online chat function.</li> </ul>

<sup>i</sup> Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health and Human Services.

<sup>ii</sup> The terms “Federally-facilitated Marketplace” and “FFM,” as used in this document, include FFMs where the state performs plan management functions and certain State-based Marketplaces using the federal platform (SBM-FPs). The terms “Health Insurance Marketplace®” and “Marketplace,” as used in this document, generally refer to an FFM and frequently refer to an Individual FFM.