Plan Year 2022 Policy and Operations Updates

Centers for Medicare & Medicaid Services (CMS)
Center for Consumer Information & Insurance Oversight (CCIIO)

September 30, 2021
The information provided in this presentation is intended only as a general, informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, and formal policy guidance that it is based upon. This presentation summarizes current policy and operations as of the date it was presented. Links to certain source documents have been provided for your reference. We encourage audience members to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information about the requirements that apply to them. The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

This document generally is not intended for use in the State-based Marketplaces (SBMs) that do not use HealthCare.gov for eligibility and enrollment. Please review the guidance on our Agent and Broker Resources webpage (http://go.cms.gov/CCIIOAB) and Marketplace.CMS.gov to learn more.

Unless indicated otherwise, the general references to “Marketplace” in the presentation only include Federally-facilitated Marketplaces (FFMs) and State-based Marketplaces on the Federal Platform (SBM-FPs).

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Agenda

01 KEY POLICY CHANGES
Hear important updates on Marketplace policy and operations affecting agents and brokers.

02 HEALTHCARE.GOV UPDATE
Review changes to the HealthCare.gov application in advance of the PY 2022 Open Enrollment Period (OEP).

03 AUTO RE-ENROLLMENT REFRESHER
Understand what happens when a returning consumer does not select a new plan during OEP.

04 MARKETPLACE TO MEDICARE
Learn best practices for consumers transitioning between the Marketplace and other programs.

05 CALCULATING INCOME
Review tools available to assist consumers in estimating their PY 2022 income.

06 DATA MATCHING ISSUES
Get a refresher on helping consumers resolve data matching issues.

07 HELP ON DEMAND OVERVIEW
Check that you’re ready to receive referrals from the Marketplace.

08 AMERICAN RESCUE PLAN (ARP) OVERVIEW
Understand how the ARP expands affordability and access to coverage for consumers.

09 COMPLIANCE REMINDERS
Ensure you’re compliant with Marketplace policies during OE.

10 OPEN ENROLLMENT COMMUNICATIONS
Review the ways CMS communicates with agents, brokers, and consumers during OE.
REMINDER: Complete Marketplace Registration and Training

» The OEP for Plan Year (PY) 2022 is **November 1, 2021 - January 15, 2022**.

» All brokers planning to assist consumers with Marketplace coverage must complete PY 2022 Marketplace registration and training available through the CMS Enterprise Portal at [https://portal.cms.gov](https://portal.cms.gov) prior to enrolling them in coverage.

NEW AGENTS AND BROKERS

If you did not complete PY 2021 registration and training, you must:

» Take the full Individual Marketplace training for PY 2022

» Execute the Agent Broker General Agreement and the Individual Marketplace Privacy and Security Agreement via the Marketplace Learning Management System (MLMS)

» **Training for new agents and brokers will be available soon; CMS will announce when it is live**

RETURNING AGENTS AND BROKERS

If you completed PY 2021 registration and training:

» Take either the condensed or full Individual Marketplace training for PY 2022

» Execute the Agent Broker General Agreement and the Individual Marketplace Privacy and Security Agreement via the MLMS

» Complete registration by October 22 to avoid having Marketplace system access revoked and so issuers may provide compensation for your Marketplace enrollments

To learn how to complete Marketplace registration and training, read this [Frequently Asked Question](https://portal.cms.gov/).
Complete the Registration and Training Survey

» CMS will distribute a Registration and Training Survey every two weeks to those agents and brokers who have completed registration and training within that time period.

» The questionnaire seeks to collect timely feedback regarding the Agent and Broker program on topics such as:
  o Navigation and ease of use of the MLMS
  o Quality of the annual training modules
  o Improvements agents and brokers would like to see to the annual training

» CMS thanks you in advance for completing this survey.
Key Policy Changes and Operational Updates
Final Rule and 2022 Open Enrollment

» On September 17, 2021, CMS finalized a series of provisions that follow through on President Biden’s commitment to build on the Affordable Care Act (ACA), expand health coverage access for Americans and advance health equity. The provisions are the third installment of the payment notice for 2022.

2022 Open Enrollment

» The rule extends the annual individual market open enrollment period for 2022 and future benefit years to allow consumers more time to review plan choices, seek in-person assistance, and enroll in a plan that best meets their needs.

» The annual open enrollment period for all individual market Exchanges using the federal eligibility and enrollment platform and off-Exchange individual market plans in states with such Exchanges for 2022 and future benefit years will be **November 1 of the prior year through January 15 of the benefit year**. State Exchanges not using the federal eligibility and enrollment platform maintain flexibilities regarding effective date rules and open enrollment end dates, provided the Exchange’s open enrollment end date is no earlier than December 15 of the calendar year preceding the relevant benefit year.
To provide more opportunities for certain low-income consumers to access coverage with low or no premiums after advance payments of the premium tax credit (APTC), such as under the ARP, Exchanges will now have the option to provide a monthly SEP for APTC-eligible consumers with a projected annual household income no greater than 150% of the federal poverty level (FPL). The rule will permit Exchanges to provide a SEP for periods of time during which premium tax credits (PTCs) are available without the applicable taxpayer having to contribute toward their applicable portion of premiums before PTCs become available, such as those currently available under Section 9661 of the ARP. Exchanges on the Federal platform will implement this SEP by providing eligible consumers with a pathway through the HealthCare.gov application during such periods of time.
SEP Clarification

To ensure consistent application of SEPs based on APTC eligibility across the Exchanges, the final rule clarifies that, for purposes of the §155.420 SEPs, references to ineligibility for APTC refer to being ineligible for such payments, or being eligible for such payments, but for a maximum of $0 per month. That is, an enrollee with a maximum APTC amount of $0 is not considered APTC-eligible, and an enrollee is not considered newly APTC-eligible when they become eligible for $0 APTC after having previously been APTC-ineligible for another reason, such as having other minimum essential coverage.

This clarification will mitigate the potential risk of inconsistent interpretation of this eligibility requirement across different Marketplaces. This clarification is especially important in light of the removal of the upper APTC eligibility limit on household income at 400% of the FPL for taxable years 2021 and 2022 under the ARP. While the ARP policy is in place, this clarification will ensure that Marketplaces appropriately find households eligible for an SEP if they newly gain or lose access to APTC, because their maximum APTC amount changed from $0 to more than $0, or vice versa.
The rule repeals the Exchange Direct Enrollment option. This option permitted a State Exchange, State-based Exchange on the Federal Platform (SBE-FP), or FFE state to facilitate enrollment of qualified individuals into individual market QHPs primarily through private-sector direct enrollment entities, including QHP issuers, web brokers, agents, and brokers, rather than the Exchange’s centralized website. Repeal of the Exchange Direct Enrollment option ensures that all available resources can be dedicated to support implementation of the health care provisions of the ARP and other new federal health care legislation, such as the consumer protections in the No Surprises Act, and aligns with recent executive actions designed to strengthen the ACA, increase enrollment in comprehensive coverage, and advance equity.

Note: Direct Enrollment (DE) and Enhanced Direct Enrollment (EDE) will be fully available for the upcoming OEP, and in 2022, for Federally-facilitated Exchange (FFE) states. There are no changes to the current operations of the federal DE and EDE pathways.
The FFE Navigator Program reaches vulnerable and underserved populations. This program is important to increase awareness of coverage options available through the Exchanges, help consumers find affordable coverage that meets their needs, and narrow health disparities. This final rule reinstates the requirement that FFE Navigators provide consumers with information and assistance on certain post-enrollment topics, such as the Exchange eligibility appeals process, the Exchange-related components of the PTC reconciliation process, and the basic concepts and rights of health coverage and how to use it. In addition, the rule expands the interpretation of what activities are encompassed in the duty to provide consumers with information and assistance related to the basic concepts and rights of health coverage and how to use it.
The Department of Health & Human Services (HHS) and the Department of the Treasury (collectively, the Departments) finalize modifications to regulations implementing section 1332 of the ACA governing waivers for state innovation (referred to as section 1332 waivers), including changes to many of the policies and interpretations of the statutory guardrails codified in part 1 of the 2022 Payment Notice final rule. The policies and interpretations in this rule supersede and replace those outlined in the October 2018 “State Relief and Empowerment Waivers” guidance (the 2018 guidance). This rule also repeals and replaces the previous codification of the 2018 guidance guardrail interpretations in part 1 of the 2022 Payment Notice final rule.

The Departments also modify regulations to set forth flexibilities in the public notice requirements and post-award public participation requirements for Section 1332 waivers under future emergent circumstances, if certain criteria are met. The rule also provides new information regarding the processes and procedures for amendments and extensions of approved Section 1332 waivers.
The Departments are of the view that rescinding the 2018 guidance, repealing the codification of its statutory guardrail interpretations in part 1 of the 2022 Payment Notice, and finalizing new policies and interpretations align with the Biden-Harris Administration’s goals to strengthen the ACA and increase enrollment in comprehensive coverage. These policies further advance the Biden-Harris Administration’s goal to expand coverage by empowering states to develop innovative health coverage options that best fit a state’s individual needs, expand coverage to its residents, and lower costs. This aligns with the Biden-Harris Administration’s commitment to protect and expand access to comprehensive, affordable health care, and to ensure that systemic barriers to opportunities and benefits for people of color and other underserved groups are not perpetuated. In addition, these policies further support the Biden-Harris Administration’s efforts to build on the ACA to meet the health care needs created by the COVID-19 public health emergency, reduce individuals’ health care costs, and make our health care system less complex to navigate.
Other Provisions

FFE and SBE-FP User Fees

For the 2022 benefit year, we finalize an increase of the FFE user fee rate to 2.75 percent of premiums and the SBE-FP user fee rate to 2.25 percent of premiums. This is an increase from the rates previously finalized in part 1 of the 2022 Payment Notice –2.25 percent and 1.75 percent, respectively. These rates account for funding for consumer information and outreach, including the FFE Navigator program. These rates are still lower than the current 2021 benefit year user fee rates.

Separate Billing

The rule repeals the separate billing regulation that required individual market QHP issuers to send a separate bill for that portion of a policyholder’s premium attributable to coverage for abortion services for which federal funding is prohibited. Specifically, we codify in its place the policy from the 2016 Payment Notice under which QHP issuers offering coverage of abortion services for which federal funding is prohibited have flexibility in selecting a method to comply with the separate payment requirement under Section 1303 of the ACA. We believe the changes offer issuers options for meaningful compliance with Section 1303 of the ACA without imposing the operational and administrative burdens of the separate billing policy, and without causing additional consumer confusion and unintended losses of coverage.
Other Provisions (continued)

Network Adequacy

» Following the court’s decision in City of Columbus v. Cochran, 2021 WL 825973 (D. Md. Mar. 4, 2021), HHS includes in this rule notice of its intent to implement the court’s decision with regard to network adequacy as soon as possible. HHS will not be able to implement those aspects of the court’s decision fully regarding network adequacy in time for issuers to design plans and for CMS to be prepared to certify such plans as QHPs for the 2022 plan year. HHS notes in preamble that it instead intends to address these issues in time for plan design and certification for PY 2023.

Provision of Essential Health Benefits (EHB)

» HHS is finalizing a technical amendment to requirements at §156.115(a)(3) pertaining to the provision of EHBs to include a cross-reference to the Public Health Service Act to make clear that health plans subject to EHB requirements must comply with all of the requirements under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and its implementing regulations, including any amendments to MHPAEA.
Under the ARP, if a taxpayer received or was approved to receive unemployment compensation for any week beginning in 2021, the taxpayer’s household income would be considered to be no higher than 133% of the FPL.

If the taxpayer met other eligibility criteria, this means that the taxpayer could be eligible for a PTC that covers the entire premium cost for the benchmark Marketplace plan for the whole household, regardless of the taxpayer’s actual household income amount.

If anyone in the household received or was approved to receive unemployment compensation for any week beginning in 2021, the household may also qualify for cost-sharing reductions (CSRs) if they enroll in a silver-level plan. In both cases households that in the past have not qualified for APTC or CSR due to income below 100% of the FPL are considered to have household incomes of 100% FPL for purposes of APTC and/or CSR.

This benefit is available for the remainder of 2021 and consumers who are not currently enrolled in Marketplace coverage and who attest to receiving or being approved to receive unemployment compensation for any week beginning in 2021 can still be eligible for the benefits, and may qualify for a 2021 SEP.

Note: These extra savings aren’t available on 2022 Marketplace plans.
Expiration of Unemployment Compensation Benefits: Consumer Impacts

» Starting with Open Enrollment for 2022, consumers who received these extra Marketplace savings and lower costs in 2021 due to their receipt of unemployment compensation may notice changes to their financial assistance amounts when they shop and re-enroll for PY2022 plans.

» Their eligibility for financial assistance will be based on their projected household income for 2022, unlike in 2021 when unemployment compensation recipients may have received more financial assistance without regard to their household income amount.

» However, consumers with household income from 100% through 150% FPL may remain eligible for a tax credit that covers the entire monthly premium cost for the benchmark Marketplace plan and continue to qualify for CSRs.

» Other consumers may experience significant changes – such as an increase in their share of the premium or less CSRs.
Expiration of Unemployment Compensation Benefits: Consumer Impacts

» For example, consumers who qualified for and accessed the ARP unemployment compensation benefits in 2021 may experience one of the following situations:

» Consumers with incomes **above 150% FPL** ($39,750 for a family of four) may be eligible for **lower APTC and CSR amounts** on their PY2022 plan, meaning their premium and cost sharing owed would be higher.

» Consumers with incomes **above 250% FPL** ($66,250 for a family of four) **will no longer be eligible for income-based CSRs*** on their PY2022 coverage.
  
  o  *Note*: Tribal CSR benefits are unaffected.

» Consumers with **higher incomes** may now have to **pay the full cost** of their Marketplace premium due to being eligible for a $0 APTC amount on their PY2022 plan. Even though the ARP lifted the 400% FPL income limit for 2021 and 2022, consumers with higher incomes may still not receive a tax credit if the premiums available to them are low enough to be below 8.5% of their household income.
Expiration of Unemployment Compensation Benefits: Consumer Impacts

For example, consumers who qualified for and accessed the ARP unemployment compensation benefits in 2021 may experience one of the following situations:

- Consumers with household incomes **under 100% FPL** ($26,500 for a family of four) and who are ineligible for Medicaid (i.e. consumers in the “Medicaid gap”) may now be **ineligible for APTC and CSR** benefits in PY2022 due to their household income being under 100% FPL, with the exception of certain immigrant consumers.

- Consumers at any income level may see new Data Matching Issues (DMIs) associated with their PY2022 coverage, and should follow standard processes to submit documents online or via mail to resolve their DMIs.
Expiration of Unemployment Compensation Benefits: Consumer Messaging

» It’s important that consumers who are receiving the ARP unemployment compensation benefits in 2021 understand those one-time extra savings aren’t available in 2022 and their financial assistance may be changing.

» Impacted consumers will see special language in their Marketplace Open Enrollment Notice and new content is being added to HealthCare.gov to explain the change.

» Consumers who don’t return to HealthCare.gov to update their Marketplace application during Open Enrollment and are automatically re-enrolled into PY2022 coverage will also receive notices with special language that the ARP unemployment compensation benefits aren’t available for 2022.

» Encourage consumers to visit HealthCare.gov to update their Marketplace application, shop for 2022 coverage, and submit any required documents to make sure they’re getting the right coverage and savings.

On July 23, 2021, CMS, together with the Internal Revenue Service (IRS), released guidance to ensure consumers continue to receive the tax credits they are eligible for through their Marketplace plan.

For plan years 2021 and 2022, **CMS will not end** the financial help consumers enrolled through the Health Insurance Marketplace®¹ receive to pay for their health coverage if IRS data indicates the consumer did not file a federal income tax return(s) and reconcile a previous year’s PTC.

Consumers are generally still required to file and reconcile PTCs with the IRS for their federal income tax returns, with the exception of consumers who received excess PTCs in plan year 2020.

In response to this change, CMS will be removing the application attestation for consumers to verify they have reconciled PTCs received during previous years.

¹ Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.
**Other Enrollment Updates**

**One HealthCare.gov Application**

» Agents and brokers using HealthCare.gov to assist consumers to enroll in coverage will generally only see a single streamlined application during PY 2022 OEP.

**Asynchronous Submissions**

» CMS rolled out new functionality allowing consumers to complete application submission and enrollment even when a connection to the IRS is not available.

» For applications submitted when IRS services are unavailable and where IRS information is needed for income verification, consumers will be able sign and submit their application and enroll in a plan (or update their enrollment if already enrolled). The Marketplace willretry IRS services after submission and complete income verification when IRS services becomes available.

» These applications will generally have annual income verified or an annual income DMI created within 24 hours or less. When they submit their application, impacted consumers will receive a message on their eligibility results page that lets them know that they should check back later to see if they have an income DMI. If an income DMI is created after application submission, consumers will receive an email notification or an additional notice in the mail.
Other Enrollment Updates

COBRA SEP

» COBRA premium assistance ended on September 30, 2021, and so consumers can enroll in a Marketplace plan with an SEP. To enroll, consumers can report a September 30 "loss of coverage" on their application. Consumers can’t qualify for a premium tax credit while they’re enrolled in COBRA, so if they want to change to Marketplace coverage, make sure that their COBRA coverage ends on the last day before their Marketplace coverage starts. Learn more about COBRA premium assistance.

» When consumers apply for Marketplace coverage, they should indicate they’ve lost qualifying health coverage, and provide the last day that they had COBRA coverage with premium assistance (generally, September 30, 2021).

» If consumers decide to keep COBRA without premium assistance, they can qualify for a special enrollment period based on the end date of their COBRA coverage, which is usually 18 to 36 months after it started.
Auto Re-enrollment Refresher and Ability to End QHP coverage by Opting-Out of Auto-reenrollment Following Medicaid/CHIP Eligibility Determination
Each year, the Marketplace must redetermine a consumer’s eligibility for Marketplace coverage and financial assistance (45 CFR §155.335).

» Enrollees are encouraged to return to the Marketplace during the OEP (November 1, 2021 through January 15, 2022) to update their application and receive an updated eligibility determination ("active re-enrollees").

» Enrollees who do not return to the Marketplace and select a plan during the OEP are automatically re-enrolled into the same Qualified Health Plan (QHP), or if unavailable, another QHP intended to be similar ("passive re-enrollees").

» The Marketplace does not redetermine eligibility for Medicaid or CHIP on behalf of consumers who do not submit an updated application during the OEP.
What is Auto Re-enrollment?

» Auto re-enrollment is the process the Marketplace uses to ensure that current enrollees who do not make an active plan selection by December 15, 2021 will retain coverage on January 1, 2022.

» **Active re-enrollment, where an applicant updates the application and plan selection, is always preferred.**
  
  o Active re-enrollment ensures the enrollee receives a more accurate financial assistance eligibility determination and that the re-enrollment QHP reflects qualities that are important to the enrollee (e.g., cost, provider network, prescription drug formulary).
  
  o Some enrollees will lose their financial assistance unless they actively re-enroll. The Marketplace Open Enrollment Notice sent to them by the Marketplace will include special language noting the need to actively apply.
Auto Re-enrollment Frequency

Auto re-enrollment will run in two rounds:

» **Round 1 - October 13** (approximate): All enrollees eligible for re-enrollment who are re-enrolled in a QHP offered by the same issuer or matched to an alternate QHP from a different issuer by CMS or a state Department of Insurance (DOI). Goal is to complete this round before the OEP begins.

» **Round 2 - December 16** (approximate): New 2022 enrollees who enrolled after Round 1; enrollees whose auto re-enrollment is updated because the enrollee reported, or the Marketplace otherwise obtained, new eligibility information after Round 1.

**NOTE:** The auto-re-enrollment plan is not visible in consumers’ accounts until approximately December 16; however, enrollees can find their auto-re-enrolled plan highlighted in Plan Results after submitting an application during the OEP.
Medicaid/CHIP Eligibility During the OEP

» When updating an application during the OEP, an existing QHP enrollee may be found newly eligible for Medicaid or CHIP, particularly if the enrollee’s income or household size changed or the state recently expanded Medicaid.

» Depending on the state, the Marketplace will either “determine” or “assess” the consumer as eligible for Medicaid or CHIP, as applicable; for consumers determined or assessed to be Medicaid or CHIP-eligible, the Marketplace sends their application information via a secure electronic process to the state Medicaid/CHIP agency for additional evaluation and/or enrollment, as applicable.

DETERMINATION STATES
The Marketplace makes the final eligibility determination for Medicaid and CHIP coverage, consistent with federal Medicaid and CHIP regulations and state-specific policies.

ASSESSMENT STATES
The Marketplace makes a preliminary assessment of Medicaid/CHIP eligibility; state Medicaid/CHIP agencies make the final eligibility determination, consistent with federal Medicaid and CHIP regulations and state-specific policies.

The decision as to whether a state is an assessment or determination state is made by the state Medicaid/CHIP agency, and applies to all applications for coverage and financial assistance that are submitted to the Marketplace for that state.
Question: The assister helps a current enrollee submit an application for the upcoming plan year. The QHP enrollee’s eligibility notice says he or she is now eligible for Medicaid or CHIP. Will the enrollee be automatically re-enrolled in Marketplace coverage next year?

Answer: Whether the enrollee will be automatically re-enrolled in Marketplace coverage depends on whether there are other people in the enrollee’s household, and whether those people are still eligible for enrollment in a QHP and actively choose a plan during the OEP.*

*NOTE: As a reminder, a QHP enrollee who doesn’t return to actively apply and enroll during the OEP receives an auto-determination that does not re-evaluate whether the enrollee is Medicaid-eligible.
If the members of the enrollee’s household have mixed eligibility after actively applying (meaning some are QHP-eligible and others are now eligible for Medicaid/CHIP):

» An enrollee who is newly eligible for Medicaid/CHIP will not be automatically re-enrolled in QHP coverage if other QHP-eligible enrollees on the application proceed through Plan Compare and choose a plan.

» Continuing through Plan Compare and selecting a plan enrolls the QHP-eligible family members into Marketplace coverage, and cancels the future-year QHP coverage for the newly Medicaid/CHIP-eligible enrollee.

If the members of the consumer’s household are all Medicaid/CHIP-eligible:

» There is no option to continue through Plan Compare to cancel the future coverage if the entire household is eligible for Medicaid/CHIP, so all enrollees will get re-enrolled into QHP coverage for the future year unless they opt-out of auto re-enrollment.
If the Medicaid/CHIP-eligible enrollees do not cancel their future-year QHP coverage:

- Enrollees who are actively determined* newly eligible for Medicaid/CHIP are auto-reenrolled into 2022 coverage without APTC.
- Enrollees who are assessed eligible for Medicaid/CHIP are auto re-enrolled in 2022 coverage, but remain eligible for APTC (since the state makes the final determination).

*NOTE: This includes final determinations only, meaning those for which citizenship/immigration status and income, for example, have been verified.
The Marketplace Eligibility Results Page will display an option for households with existing QHP enrollees in Medicaid determination states* that are all determined eligible for Medicaid and/or CHIP to opt-out of future year Marketplace coverage.

- This opt-out capability will only be available for applications where all applying members have been determined Medicaid- or CHIP-eligible, as these consumers do not have the ability to continue to Plan Compare and update their existing enrollment.

This update will allow the consumer to more easily terminate his or her policy that is eligible for re-enrollment at the end of the year and will cancel any policies that already exist for the future year.

Allowing new Medicaid/CHIP-eligible consumers to easily cancel their future QHP coverage before they are re-enrolled provides a better consumer experience and will reduce requests for retroactive terminations in January.

Households enrolled in a state that is transitioning to a state-based Marketplace for the next coverage year will not have the option to opt-out on the Marketplace. They will see messaging to opt-out with their state.

*NOTE: Alabama, Alaska, Louisiana, Montana, Virginia, West Virginia, Wyoming
Marketplace to Medicaid and Medicare
When Consumers Should End Marketplace Coverage

» Consumers should end their Marketplace plan the day before their Medicare coverage begins. Consumers should select the date they want to end coverage. Generally, they can set a date for their Marketplace coverage to end.

» Most consumers will want to end Marketplace coverage when they become eligible for Medicare or when they know their Medicare start date.

» In some cases, consumers will need to end their Marketplace coverage by calling the Marketplace Call Center. In other cases, consumers can end their coverage on HealthCare.gov.

» This depends on:
  o If everyone on the application is ending their coverage, or just some people; and
  o If the person who is ending their Marketplace coverage is the household contact (subscriber) on the application. There may be circumstances when the person who is ending their Marketplace coverage is the household contact under which other enrollees in that person’s coverage who want to continue their coverage will need to select the same or a new plan and may have their accumulators (such as deductible or annual limit on cost sharing) reset.
How Consumers Should End Marketplace Coverage (Continued)

» When the person transitioning from Marketplace coverage to Medicare is the household contact, they should call the Marketplace Call Center to:
  o End the household contact’s Marketplace coverage.
  o Designate a new household contact.
  o Ensure that those remaining on their Marketplace plan don’t lose their coverage.

» **Note:** Don’t try to change or remove the household contact online unless you’re ending coverage for everyone on the plan.

Calculating Income
HealthCare.gov offers an Income Calculation Tool that assists applicants in estimating previous, current, and future income for a given year.

The tool can collect multiple types of income throughout different periods of the year to calculate the consumer’s total estimated annual income, which can be printed or saved as a PDF.

Within the Video Learning Center for agents and brokers, CMS offers a walkthrough of the Income Calculation Tool, demonstrating how to add income from previous employment; unemployment benefits, including federal pandemic unemployment compensation; and estimated future employment.
Refresher: Helping Consumers Resolve Data Matching Issues
What Is a Data Matching Issue (DMI)?

Agents and brokers can play a vital role in helping consumers understand and follow the correct process to resolve DMIs.

» At the conclusion of eligibility verification, if there are inconsistencies between information in the consumer’s application and the information contained in the trusted electronic sources, the Marketplace produces an initial eligibility notice that includes a temporary 90-day eligibility determination*, a list of any DMIs, and instructions on how they can be resolved.

» If the consumer does not resolve the DMI, he or she may lose eligibility for enrollment through the Marketplace, may lose eligibility for APTC and/or CSR, or may have a modification of APTC and/or CSR, if applicable.

» A DMI is created when a consumer’s data is missing or does not match information from trusted data sources.

» Information may not match because a trusted data source may not have data for a consumer.

DMI EXAMPLES

» Missing or incorrect Social Security number
» Incorrect household income
» Name differs from citizenship or other document
» Missing immigration document numbers and ID numbers

*For immigration-related DMIs, the timeframe is 95 days.
Consumers will receive 90, 60, and 30 day notices, advising them to submit requested information to resolve their DMIs.

Consumers Who Submit Documents Get Additional Outreach*
Steps to Help Resolve DMIs

ASSISTING CONSUMERS IN DMI RESOLUTION

» Help confirm if the consumer has a verification issue through My Account and notices.

» Help the consumer go back to the application to confirm the information that is included is correct.

» Help the consumer submit document(s) online or by mail to resolve the verification issues.

DOCUMENTATION

» Consumers will need to send different documents based on what they are asked to verify.

» More information on the DMI process and a list of acceptable documents to resolve DMIs can be found in the Helping Consumers Resolve DMIs presentation and the Consumer Guide for Annual Data Matching Issues.
Tips for Preventing DMIs

01 COMPLETENESS
Assist consumers in completing all possible application fields.

02 ACCURACY
Double check that the information on the application is complete and free of errors or typos.

03 VERIFY IDENTIFICATION
Ensure the consumer’s name exactly matches documents such as his or her Social Security card.

04 PROVIDE SSN
Non-applicants in the household are strongly encouraged to provide a Social Security number if they have one.
Help On Demand Overview
Help On Demand is a consumer assistance referral system that connects consumers seeking assistance with Marketplace-registered, state-licensed agents and brokers in their area who can provide immediate assistance with Marketplace plans and enrollments.

- Help On Demand is a CMS-contracted service developed and hosted by Help On Demand.

Only agents and brokers who have completed Marketplace registration and training for the applicable PY are eligible to participate in Help On Demand.


- If you are already registered to participate in Help On Demand and have completed the Marketplace registration requirements for the applicable PY, you can log into your account at [https://marketplace.helpondemand.com](https://marketplace.helpondemand.com).

- For more information and resources on Help On Demand, visit the [Help On Demand Resources Page](http://go.cms.gov/CCIOAB), which is accessible via the “Help On Demand” link under “Resources” on the right side of the Agent and Broker Resources webpage.
Improvements to Help On Demand for Plan Year 2022

Referral Page Re-Design

» To improve clarity, the referral page will now have three updated column headers:
  o Contact Information, Referral Assigned, Referral Expires
Logging into Help On Demand Just Got Easier!

» Use Face ID or Touch ID for faster access to the Help On Demand mobile application.

» Remember to download the most up-to-date version of the application on your phone to take advantage of this enhancement.
ARP Overview
For PYs 2021 and 2022, the ARP makes PTCs available to consumers with household income above 400 percent FPL and caps how much of household income the family will pay toward the premiums for a benchmark plan at 8.5 percent.

The ARP reduces the percentage of household income consumers at all income levels are expected to contribute to their monthly premiums for a benchmark plan:

- Consumers with household incomes between 100-150 percent FPL may be eligible for coverage options with $0 premiums.
- Four out of five enrollees will be able find a plan for $10 or less after APTC.
- Over 50 percent of enrollees will be able to find a Silver plan for $10 or less after APTC.

For 2021, the ARP made available additional PTCs and CSRs to otherwise eligible households that received unemployment compensation. These benefits were only available during 2021. Consumers may see a reduction in their tax credit amount or CSRs for 2022 coverage because the benefits are no longer available.
Compliance Reminders
You must personally obtain consumer consent prior to providing assistance with Marketplace coverage and may not enroll a consumer based solely on information gathered by a third party. If an agency or brokerage will be servicing your clients after enrollment, you should also obtain consumer consent for the agency or brokerage to access your client’s sensitive information (i.e. their contact and other household information, etc.).

The Marketplace standards of conduct specify that agents and brokers must obtain consumer consent prior to assisting with Marketplace transactions, including conducting searches for consumer applications using approved Classic Direct Enrollment/Enhanced Direct Enrollment websites and ongoing account/enrollment maintenance.

If you are aware of an agent or broker who is conducting a search for consumer applications using approved Classic Direct Enrollment/Enhanced Direct Enrollment websites, enrolling consumers in Marketplace coverage without their consent, or inappropriately accessing CMS systems, report it to the Agent/Broker Email Help Desk at EPProducer-AssisterHelpDesk@cms.hhs.gov.
Consent Reminders

- Consumer accounts should only have the consumer’s (or his or her legally authorized representative’s) email and mailing addresses.

- Never enter your own agent or broker professional or company email or mailing address on a consumer’s application.

- You also should not create or use dummy addresses in place of the consumer’s email or mailing address.

- Do not maintain access to a client’s account or associated email account.

- Ensure your clients are reporting accurate income when completing or updating the eligibility application. Reinforce that it is in their best interest to report the most accurate income estimate, not the estimate that maximizes the amount of PTC for which they may be eligible.

- If a client may be eligible for Medicare, direct him or her to Medicare for a determination before you assist that client with enrolling in a QHP.
Open Enrollment Communications
Marketplace OEP Communications

» The Marketplace communicates regularly with consumers via email, SMS, and autodial throughout the OEP to remind them to take action and complete steps along the way from creating an account, applying, enrolling, and paying their first premium.

» Consumers can unsubscribe from Marketplace emails within the email itself and can also opt-out through their account.

» The Marketplace sends consumers MOENs toward the end of September and beginning of October that provide reminders about the upcoming OEP dates and important actions they may need to take to re-enroll in coverage.

» Before the OEP starts, issuers may begin contacting current consumers by sending a re-enrollment notice and indicating any plan changes for the upcoming year. Communication during OEP encourages consumers to update their information with the Marketplace.
Other Marketplace Reminders
Every year, CMS establishes scheduled maintenance windows for HealthCare.gov. Like other IT systems, these scheduled maintenance windows are how we update and improve our systems to run optimally and are the normal course of business. Consumer access to HealthCare.gov will be limited while systems are updated. Maintenance will only occur when deemed necessary to provide consumers with a better shopping experience. The purpose in scheduling these times is to minimize any consumer disruption.

Similar to the last several years, in order to allow agents, brokers, assisters, and states to plan in advance of Open Enrollment, we are sharing the maximum potential windows of scheduled maintenance on HealthCare.gov for the upcoming OEP.

It is important to note that these times are the maximum windows for scheduled maintenance activities that require limiting or restricting consumer access to HealthCare.gov. Consistent with past years, CMS anticipates the actual maintenance periods may be shorter. As with all IT systems, there is a possibility that unscheduled work will be needed, in which case CMS will use existing channels to notify stakeholders.

Potential/maximum scheduled HealthCare.gov maintenance windows for this upcoming OEP are:

- **Monday, November 1, 2021**, early morning to make final preparations ahead of the start of the OEP
- **Sundays, November 14, December 5, and December 19**, 12:00am to 7:00am
Marketplace Circle of Champions

» The Marketplace Circle of Champions is an annual recognition program for Marketplace-registered agents and brokers who assist with at least 20 active enrollments in Marketplace coverage during the OEP.

» There are **three Circle of Champions recognition levels** for agents and brokers.

**Circle of Champions**  
Agents and brokers who complete 20-99 active enrollments

**Elite Circle of Champions**  
Agents and brokers who complete 100-499 active enrollments

**Elite Plus Circle of Champions**  
Agents and brokers who complete 500+ active enrollments
Race and Ethnicity Questions in the Marketplace Application

» CMS routinely analyzes data on who is signing up for coverage and how Exchange applicants move through the online work flows in order to measure Marketplace effectiveness and determine whether there is a need for policy, operational, or outreach/marketing updates.

» One of the barriers to making informed decisions is that consumers, or individuals filling out applications on consumers’ behalf, often do not provide attestations to the optional race and ethnicity questions in the FFE application.

» We encourage all agents and brokers to take the time to ask consumers to respond to these questions. This information will help CMS reduce health disparities, prevent discrimination, promote equity for all communities and FFE consumers, and better follow its mission to improve health care coverage. CMS asks this question in order to ensure outreach is reaching all communities and that the application process does not create barriers for individuals or groups.

» CMS will use this data to identify possible application, enrollment, or coverage barriers and disparities for all communities seeking coverage through the FFE. In addition, the question about language preference will help CMS assess language needs of the populations being served and help CMS and insurers have language services ready for you.
Reaching Underserved and Underinsured Communities

Following the Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, CMS has been engaging in initiatives to understand and better address health disparities and advance equity in health coverage access.

If you would like to learn more about how to reach underserved and/or underinsured communities and help them enroll in health coverage, we encourage you to check out these resources:

- CMS Diverse Community Panel Data Slides
- Resources by language
- Health Equity Technical Assistance Program
- Outreach and Education for Special Populations
Find Local Help

» Consumers can access the Find Local Help tool by visiting https://www.healthcare.gov/find-assistance/ or by clicking the “Find Local Help” button on www.healthCare.gov.

» To use the Find Local Help tool to find help in their area, consumers can search by city and state or ZIP code to view a list of local organizations (assisters) and/or individuals (agents and brokers) who can help them apply, pick a plan, and enroll.

» Search Find Local Help to confirm your listing is accurate at https://localhelp.healthcare.gov/.

» Fix any issues by updating your MLMS profile or contact FFMProducer-AssisterHelpDesk@cms.hhs.gov for assistance.

» It may take up to three business days for MLMS profile updates to appear on Find Local Help.
Upcoming Webinars and Office Hours

Register for upcoming webinars and office hours by visiting [https://www.regtap.info/](https://www.regtap.info/) and following the instructions below:

1. Log in to REGTAP. If you are new to REGTAP, select "Register as a New User." You will receive an email to confirm your account.

2. Select "Training Events" from "My Dashboard."

3. Click the "View" icon next to the webinar topic/title you wish to register for.

4. Click the “Register Me” button.

5. If you require further assistance logging in to REGTAP or registering for a webinar, contact the Registrar at 1-800-257-9520 or registrar@REGTAP.info. Assistance is available Monday through Friday from 9:00 AM - 5:00 PM ET. **Note: Registration closes 24 hours prior to each event.**

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
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<tbody>
<tr>
<td>Plan Year 2022 Marketplace Registration and Training for New Agents and Brokers</td>
<td>Tuesday, October 5, 2021</td>
</tr>
<tr>
<td>Help On Demand Overview</td>
<td>Thursday, October 7, 2021</td>
</tr>
<tr>
<td>Helping Consumers Apply and Enroll</td>
<td>Thursday, October 21, 2021</td>
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<tr>
<td>Agent and Broker Office Hours</td>
<td>Thursday, November 4, 2021</td>
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<td>Agent and Broker Office Hours</td>
<td>Thursday, November 18, 2021</td>
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<tr>
<td>Agent and Broker Office Hours</td>
<td>Thursday, December 2, 2021</td>
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<tr>
<td>Agent and Broker Office Hours</td>
<td>Thursday, December 16, 2021</td>
</tr>
<tr>
<td>Agent and Broker Office Hours</td>
<td>Thursday, January 6, 2021</td>
</tr>
</tbody>
</table>
Check out these technical assistance videos for Marketplace agents and brokers at the **Agent and Broker Video Learning Center (VLC)!** The VLC features a variety of topics to help you navigate the Marketplace, including:

- Marketplace application walkthrough videos for various consumer scenarios
- How to retrieve your user ID and reset your password
- How to use the income calculation tool on HealthCare.gov
- A guide to 2022 Marketplace updates for agents and brokers

The Agent and Broker Frequently Asked Questions (FAQs) website provides answers to commonly asked questions about working in the Health Insurance Marketplace®, selling SHOP insurance, and helping clients enroll in and maintain coverage.

» This self-service resource is available online at your convenience.

» Visit https://www.agentbrokerfaq.cms.gov/s/ and search by question category, keyword, or part of your question. Most responses also include links to additional resources to help you when assisting your clients.
# Frequently Used Agent/Broker Marketplace Help Desks and Call Centers

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone # and/or Email Address</th>
<th>Types of Inquiries Handled</th>
<th>Hours (Closed Holidays)</th>
</tr>
</thead>
</table>
| **Marketplace Service Desk** | 1-855-CMS-1515               | • CMS Enterprise Portal password resets and account lockouts  
• Other CMS Enterprise Portal account issues or error messages  
• General registration and training questions (not related to a specific training platform)  
• Login issues on the Direct Enrollment agent/broker landing page  
• Technical or system-specific issues related to the MLMS  
• User-specific questions about maneuvering in the MLMS site, or accessing training and exams | Monday-Friday  
8:00 AM–8:00 PM ET  
October–November only: Saturday-Sunday  
10:00 AM–3:00 PM ET |
| **Agent/Broker Email Help Desk** | FFMProducer-AssisterHelpDesk@cms.hhs.gov | • General enrollment and compensation questions  
• Manual identity proofing/Experian issues  
• Escalated general registration and training questions (not related to a specific training platform)  
• Agent/Broker Registration Completion List issues  
• Find Local Help listing issues  
• Help On Demand participation instructions or questions  
• Report concerns that a consumer or another agent or broker has engaged in fraud or abusive conduct | Monday–Friday  
8:00 AM–6:00 PM ET |
| **Marketplace Call Center Agent/Broker Partner Line** | 1-855-788-6275  
Note: Enter your NPN to access this line.  
TTY users 1-855-889-4325 | Specific consumer application questions related to:  
• Password reset for a consumer HealthCare.gov account,  
• SEP not available on the consumer application, or  
• Consumer specific eligibility and enrollment questions | Monday–Sunday  
24 hours/day |
| **SHOP Call Center** | 800-706-7893  
TTY users 1-888-201-6445 | • Inquiries related to SHOP eligibility determinations on HealthCare.gov  
• Contact the health insurance issuer for most questions about SHOP plans, such as applications, enrollment, renewal, or changing or updating coverage. | Monday–Sunday  
24 hours/day |
| **Marketplace Appeals Center** | 1-855-231-1751  
TTY users 1-855-739-2231 | • Status of a Marketplace eligibility appeal  
• How to appoint an Authorized Representative to request Marketplace eligibility appeal on a consumer’s behalf | Monday–Friday  
7:00 AM–8:30 PM ET |

A full list of Agent/Broker Help Desks and Call Centers is available from the Agent and Broker Resources webpage (http://go.cms.gov/CCIIOAB) under Quick Links.
Dedicated Agent/Broker Support Available for Complex Consumer Cases

» Complex consumer-specific cases are cases where a consumer has submitted an eligibility application for coverage and/or has enrolled in coverage and requires assistance in making a change.

» In this situation, you must first attempt to resolve the case by contacting the Marketplace Consumer Call Center or the EDE partner (if applicable).

» If you are unsuccessful in resolving the case with the Marketplace Call Center or EDE partner (if applicable) and still require assistance, contact the FFM Agent/Broker Email Help Desk (FFMProducer-AssisterHelpDesk@cms.hhs.gov) and provide the following information:
  o Full name, email address, and phone number of the agent or broker assisting the consumer
  o The consumer’s Marketplace application ID
  o The state in which the consumer resides
  o Summary of the case and what you are requesting
  o Whether the case is medically urgent (and if so, when a response is needed)
  o Indicate that you have already called the Marketplace Call Center or EDE partner and provide the date of the call

» The Help Desk will refer the information you provide to representatives from our Complex Case Help Center (CCHC) so they can respond to your issue. A member of the CCHC team will contact you via phone for additional information or to communicate the outcome of the case.
## Agent and Broker Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Link</th>
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<tbody>
<tr>
<td>Agents and Brokers Resources webpage</td>
<td><a href="http://go.cms.gov/CCIIOAB">http://go.cms.gov/CCIIOAB</a></td>
</tr>
<tr>
<td>Agent and Broker FFM Registration Completion List</td>
<td><a href="https://data.healthcare.gov/ffm_ab_registration_lists">https://data.healthcare.gov/ffm_ab_registration_lists</a></td>
</tr>
<tr>
<td>Agent and Broker Marketplace Registration Tracker</td>
<td><a href="https://data.healthcare.gov/ab-registration-tracker/">https://data.healthcare.gov/ab-registration-tracker/</a></td>
</tr>
<tr>
<td>Find Local Help Tool</td>
<td><a href="https://www.healthcare.gov/find-assistance/">https://www.healthcare.gov/find-assistance/</a></td>
</tr>
<tr>
<td>Help On Demand</td>
<td><a href="https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-">https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-</a></td>
</tr>
<tr>
<td></td>
<td>Marketplaces/Help-On-Demand-for-Agents-and-Brokers.html</td>
</tr>
<tr>
<td>Agent and Broker NPN Search Tool</td>
<td><a href="http://www.nipr.com/PacNpnSearch.htm">www.nipr.com/PacNpnSearch.htm</a></td>
</tr>
<tr>
<td>Issuer &amp; Direct Enrollment Partner Directory</td>
<td><a href="https://data.healthcare.gov/issuer-partner-lookup">https://data.healthcare.gov/issuer-partner-lookup</a></td>
</tr>
<tr>
<td>Agent and Broker Frequently Asked Questions website</td>
<td><a href="https://www.agentbrokerfaq.cms.gov/s/">https://www.agentbrokerfaq.cms.gov/s/</a></td>
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## Acronym Definitions

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ACA</td>
<td>Affordable Care Act</td>
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<tr>
<td>APTC</td>
<td>Advance Payments of the Premium Tax Credit</td>
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<tr>
<td>ARP</td>
<td>American Rescue Plan of 2021</td>
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<tr>
<td>CCHC</td>
<td>Complex Case Help Center</td>
</tr>
<tr>
<td>CCIIO</td>
<td>Center for Consumer Information &amp; Insurance Oversight</td>
</tr>
<tr>
<td>CHIP</td>
<td>Children’s Health Insurance Program</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>COFA</td>
<td>Compact of Free Association</td>
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<tr>
<td>CSR</td>
<td>Cost-sharing Reduction</td>
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<tr>
<td>DC</td>
<td>District of Columbia</td>
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<tr>
<td>DE</td>
<td>Direct Enrollment</td>
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<tr>
<td>DMI</td>
<td>Data Matching Issue</td>
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<tr>
<td>DOI</td>
<td>Department of Insurance</td>
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<tr>
<td>EDE</td>
<td>Enhanced Direct Enrollment</td>
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<tr>
<td>EHB</td>
<td>Essential Health Benefit</td>
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<tr>
<td>FFE</td>
<td>Federally-facilitated Exchange</td>
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<tr>
<td>FFM</td>
<td>Federally-facilitated Marketplace</td>
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<tr>
<td>FPL</td>
<td>Federal Poverty Level</td>
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<tr>
<td>HHS</td>
<td>Department of Health &amp; Human Services</td>
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<tr>
<td>IRS</td>
<td>Internal Revenue Service</td>
</tr>
<tr>
<td>MHPAEA</td>
<td>Mental Health Parity and Addiction Equity Act of 2008</td>
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<tr>
<td>MLMS</td>
<td>Marketplace Learning Management System</td>
</tr>
<tr>
<td>OEP</td>
<td>Open Enrollment Period</td>
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<tr>
<td>PTC</td>
<td>Premium Tax Credit</td>
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<tr>
<td>QHP</td>
<td>Qualified Health Plan</td>
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<tr>
<td>SBE-FP</td>
<td>State-based Exchange on the Federal Platform</td>
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<tr>
<td>SBM</td>
<td>State-based Marketplace</td>
</tr>
<tr>
<td>SBM-FP</td>
<td>State-based Marketplaces on the Federal Platform</td>
</tr>
<tr>
<td>SEP</td>
<td>Special Enrollment Period</td>
</tr>
</tbody>
</table>
Agents and brokers are valued partners to all of us at CMS for the vital role you play in enrolling consumers in qualified health coverage.

We thank you for the trusted advice, support, and assistance you provide throughout the year and wish you continued success during the upcoming OEP and beyond!