March Marketplace Update for Assisters

March 2018

Table of Contents

Reminder: Failure to File and Reconcile—Helping Consumers Understand and Take Action

Consumers are not eligible for advance payments of the premium tax credit (APTC) if APTC was previously paid on behalf of the tax filer for the application, but the tax filer did not file a federal income tax return for the year during which APTC was paid and/or did not reconcile the associated APTC.

Households who received APTC in a past year but whose tax filer did not file a tax return and reconcile past APTC are flagged by the Internal Revenue Service (IRS) as "failure to file and reconcile"—or FTR—when the Federally-facilitated Marketplace ("Marketplace") requests updated tax data. Starting with Open Enrollment for 2016, the Marketplace began discontinuing APTC for consumers whose tax filers had APTC paid on their behalf but did not file a tax return for that year. In 2018, the Marketplace also began ending APTC for enrollees whose tax filers did file a tax return but did not reconcile APTC (non-reconcilers).

Application Attestation:

Due to lags in IRS data updates, the Marketplace application contains a tax filing-related question (Figure 1) that allows enrollees who received APTC in the past to attest, under penalty of perjury, to having filed a tax return and reconciled APTC for any year during which APTC was paid on their behalf. This attestation allows enrollees to maintain APTC even if IRS' data has not yet reflected that they filed and reconciled.

Figure 1: Attestation Question on the Marketplace Application

FTR Recheck

Because the Marketplace gave consumers the option to attest to having filed and reconciled during the open enrollment period, it performs a recheck of IRS data to verify that those who attested actually filed and reconciled. In February 2018, the Marketplace checked the tax filing status of consumers:

1. Who are enrolled in a 2018 Marketplace plan with APTC; and
2. Who received APTC in 2016 but had not filed a 2016 tax return and/or reconciled 2016 APTC, according to IRS data.

Following this data recheck in February, the Marketplace sent two FTR warning notices that encouraged consumers to make sure their tax filer filed and reconciled for 2016, and if he or she did not, to file and reconcile immediately or their APTC will be removed. One notice was mailed to tax filers and one notice was addressed to the household contact for the application (which in most circumstances it the same as the tax filer).

What Assisters Can Do:

- Make sure enrollees know the process changed for 2018 coverage: enrollees are not eligible for APTC if their tax filer did not reconcile their past APTC using IRS Form 8962, even if they filed their 2016 taxes. These consumers must amend their 2016 tax returns and complete IRS Form 8962, or if the tax filer did not file a 2016 tax return at all, must file a 2016 return and include IRS Form 8962.
- Encourage enrollees who received APTC in 2016 to file (or amend) their 2016 federal income taxes and reconcile their APTC as soon as possible, even if they missed the filing deadline or they are within their filing extension period.
- Remind enrollees that even if they usually don't have to file an income tax return, if they received APTC, they must file a return for that year.
- Help enrollees who haven't filed their taxes understand what steps to take, including helping them access their Forms 1095-A and report any errors.

Answer to an Assister Question:

Assister Question: I assisted a consumer that showed me a letter from the Marketplace stating that he would lose his APTC unless the Marketplace received word from IRS that the he filed and reconciled his past taxes and APTC. He ended up losing his APTC and is paying full price for coverage. If he files and reconciles his past taxes and APTC now, would he be eligible for APTC instantly? Would he receive premium money back from his insurance company for the months that he was paying full price vs a lesser premium with the APTC applied?

Answer: It can take several weeks for a tax return to be processed by IRS and then for that filing status to be available to the Marketplace, so it's important to file as soon as possible upon receiving a warning notice, and to file and reconcile for all years APTC has been received. If an enrollee has already had his APTC discontinued, he can regain APTC prospectively after he files and reconciles, by updating his application and clicking "Yes" to the application question asking whether all past premium tax credits were reconciled. However, APTC will not be restored retroactively to the date it was discontinued, so no premium payments will be refunded from the issuer.

Coverage to Care Resources for Assisters and Consumers

What resources are available for consumers?

C2C consumer resources, many of which are available in different languages (English, Arabic, Chinese, Haitian Creole, Korean, Russian, Spanish, and Vietnamese) include:

- A Roadmap to Better Care and a Healthier You- The roadmap explains what health coverage is and how to use it to get primary care and preventive services you need.
- 5 Ways to Make the Most of Your Health Coverage – A quick reference on how to make the most of your health coverage.

- How to Maximize Your Health Coverage – This short animated video is available in English and Spanish to demonstrate why using health coverage is important and where to begin. Watch, download, or share.
- A Roadmap to Behavioral Health is a companion guide to the Roadmap to Better Care and a Healthier You with vital information about mental health and substance use disorder services, finding a behavioral health provider, defining behavioral health terms, receiving services, and following up on care.

C2C Partner Resources include:

- Manage Your Health Care Costs is a guide for assisters to help consumers understand health insurance costs and terms, know their own specific health insurance costs, plan for health care costs, and know how to pay their premium.
- Partner Toolkit - This toolkit provides ideas on how to partner, including ready-to-use language and social media graphics, in both English and Spanish, to help you share C2C resources with people in your community.
- A Roadmap to Better Care and a Healthier You — Customizable This file allows you to create your own custom version of the Roadmap, and includes fillable fields where you can add information that could be helpful to your community, such as your own contact information or other local resources.

How can my organization use *From C2C* materials?

Please use the resources available on the C2C website go.cms.gov/c2c at community outreach events. Assisters can distribute the materials or use the fillable PDF of the Roadmap to customize our Roadmap with your information so consumers can contact you directly if they have questions about accessing care. All resources can be downloaded from the website or printed copies can be ordered at no cost to your organization from the CMS Product Ordering Website (http://productordering.cms.hhs.gov/).

How can I become a C2C partner?

Assisters may easily become a partner by downloading the Partner Toolkit and begin sharing information. The Partner Toolkit contains a web badge you can use to link to our site, a drop-in newsletter article, a blog post, social media posts and graphics, and information about the program. Assisters can download it on the C2C website: go.cms.gov/c2c To receive updates on new products and other C2C information, Assisters may also sign up for updates directly from C2C by signing up for the C2C listserv.

Summary of Webinar presentation on “Marketplace Eligibility Appeals”

The Friday, February 16, 2018 assister webinar included a presentation on the Marketplace eligibility appeals process. Once consumers apply for coverage in the Marketplace, they will get an eligibility notice that explains what they qualify for. If consumers do not agree with a decision

made by the Health Insurance Marketplace, they may be eligible to file an appeal.

Here are some highlights from the presentation:

WHEN can a consumer file a Marketplace appeal?

- Consumers have 90 days from the date of their eligibility notice to start an appeal of that eligibility determination.

WHAT kinds of Marketplace decisions can consumers appeal?

- Whether they're eligible to buy a Marketplace plan
- Whether they can enroll in a Marketplace plan outside the regular Open Enrollment Period
- Whether they're eligible for lower costs based on their income
- The amount of savings they're eligible for
- In certain states, whether they're eligible for Medicaid or the Children's Health Insurance Program (CHIP) (in other states, these determinations must be appealed directly to the state agency for Medicaid or CHIP)
- Whether they are eligible for an exemption from the individual responsibility requirement

HOW can consumers file a Marketplace eligibility appeal? Here are the 2 ways consumers can request an appeal:

- Consumers may mail a letter or their state's appeal request form to:

  Health Insurance Marketplace
  Attn: Appeals
  465 Industrial Blvd
  London, KY 40750-0061

- Consumers may fax an appeal request (letter or state-specific form) to this secure fax line: 1-877-369-0129

*Note: Depending on the state and consumers' eligibility results, consumers' may be able to appeal through the Marketplace or they **may have to file an appeal with their state Medicaid or CHIP agency**. The consumers' eligibility notice will explain.

THEN what happens?

Once consumers submit their eligibility appeal, the Marketplace Appeals Center will review their request. They'll get a letter in the mail letting them know that the Marketplace Appeals Center received the appeal. The Marketplace Appeals Center will contact consumers to discuss the appeal and, if possible, will work with consumers to **resolve the appeal informally**. If consumers have questions about their eligibility appeal, they can call the Marketplace Appeals Center at 1-855-231-1751. TTY users should call 1-855-739-2231. If consumers are not satisfied with the outcome of the informal resolution of their eligibility appeal, they have **the right**

to a hearing. A hearing is a more formal way for consumers to present their case and get a decision on their appeal. If consumers want a hearing, a federal hearing officer will conduct it, usually by phone. Generally, consumers will get a letter in the mail at least 15 days before their hearing with the date, time, and instructions on how to call into the hearing.

If consumers don't show up for their hearing, their appeal will be dismissed. If a consumer's appeal is dismissed, it's the same as if the appeal had never filed an appeal, and the consumer's last Marketplace eligibility determination will remain in effect.

IF AN APPEAL IS URGENT, consumers can request an expedited appeal.

Consumers can file a request for an expedited (faster) appeal if the time needed for the standard appeal process would jeopardize the consumer's life or ability to attain, maintain, or regain maximum function.

Consumers' requests to expedite their appeal should specifically explain how a standard appeal would jeopardize their life or their ability to attain, maintain, or regain maximum function.

Consumers' requests to expedite their appeals will be processed as quickly as possible. A final appeal decision will be made as quickly as possible.

THE MARKETPLACE CAN HELP. Consumers can visit www.healthcare.gov/marketplace-appeals/getting-help/ to get more information on how to get help filing an appeal. If consumers want to get help in a language other than English, they have the right to get help and information about appeals and other Marketplace issues in their language at no cost. To talk to an interpreter, consumers can call 1-800-318-2596.

SHOP MARKEPLACE DECISIONS CAN ALSO BE APPEALED. Consumers can visit https://www.healthcare.gov/marketplace-appeals/shop-decisions/ to get more information on how to appeal a SHOP Marketplace decision. Starting with Plan Year 2018, SHOPs will only be required to determine employer eligibility to participate in a SHOP, and will not be required to determine employer group members' eligibility to enroll in SHOP.

Therefore, SHOPs will only be required to handle appeals as they relate to an employer's eligibility. Employer group members (i.e. employees) must now appeal an eligibility determination directly with the insurance company. The employee can however still file a complaint with the SHOP, and/or take advantage of any other appeal mechanisms under Federal or State law.

Additional Resources:

- HealthCare.gov – "How to appeal a Marketplace decision"
- Fact sheet and instructions - Appeals: Eligibility & Health Plan Decisions in the Health Insurance Marketplace
- How to Appeal a Marketplace Decision versus a Health Plan Decision
- What to Do if your Marketplace Appeal is Invalid

Q&A from the Marketplace Appeals Presentation

Q1: How can consumers request an expedited appeal?

A1: To resolve a case more quickly, consumers must tell the Marketplace Appeals Center on their appeal form why an appeal request needs to be expedited. Appeals can be expedited if the appellant has an immediate need for health services, and a delay could seriously jeopardize their life, health, or ability to attain, maintain, or retain maximum function. If an appellant's health status changes after he or she has filed their appeal (which did not include a request for an expedited appeal), they can call the Marketplace Appeals Center and ask for an expedited appeal, explaining why they need one.

Q2: How can consumers appeal decisions made by their insurance company?

A2: These types of appeals should be pursued through the consumer's insurance company, not through the Marketplace Appeals Center. Please refer to plan documents or contact the insurance company for further information about their complaint and appeal processes.

Q3: Where can we find the form consumers can use to designate an authorized representative?

A3: The authorized representative form can be found in the middle of the page here: https://www.healthcare.gov/marketplace-appeals/getting-help/

Q4: Why does it take 90 days for the Marketplace Appeals Center to process appeal requests?

A4: Oftentimes, the appeals process takes that amount of time when the Marketplace Appeals Center needs additional documentation from the consumer. All appeals are processed as timely as possible.

Refresher: Reporting a Life Change

When consumers have life events, it is essential that they report them to the Marketplace. This is because certain life events could impact both consumers' eligibility for coverage as well as the level of financial assistance (APTC or CSRs) that they may qualify for. Certain life changes could also result in consumers' being determined or assessed as eligible for Medicaid or CHIP, which could lead to additional cost savings or covered benefits for them or their family. That is why reporting a life change is so important.

Consumers are required to report changes affecting eligibility information on their application within **30 days** of the change.

Certain life changes may also make consumers eligible for a Special Enrollment Period (SEP) that may allow them to make changes to their coverage. If consumers are eligible for an SEP they generally have **60 days** from the date of the life change to make changes to their coverage.

For more SEP information, visit:

- https://marketplace.cms.gov/technical-assistance-resources/sep-preenrollment-verification-overview.pdf
- https://marketplace.cms.gov/outreach-and-education/special-enrollment-periods-available-to-consumers.pdf

Consumers can report life changes in one of two ways:

1. Online: Consumers can visit HealthCare.gov and log in to their Marketplace account (or create an account if they don't have one). Select their submitted application; then, select **"Report a life change**" from the menu on the left.
2. By phone: Contact the Marketplace Call Center at 1-800-318-2596. TTY users should call 1-855-889-4325.

After a consumer reports a life change, he or she will receive a new eligibility notice that explains whether they qualify for an SEP. The eligibility notice will also explain both their coverage options and whether they are eligible for lower costs based on their reported Life Change.

Steps to Report a Life Change

To report a life change, consumers should take the following steps to update their application online.

1. Log into their HealthCare.gov account.
2. Choose the application they want to update.
3. Click "**Report a life change**" on the left-hand menu.
4. Read through the list of changes and click "**Report a life change**" to get started.
5. Select the kind of change they want to report.
6. Navigate through their application and report any changes to their income, household members, address, new health coverage offers, and other information.

For more information about reporting life changes, visit Healthcare.gov:

- https://www.healthcare.gov/reporting-changes/when-you-move/
- https://www.healthcare.gov/reporting-changes/why-report-changes/
- https://www.healthcare.gov/reporting-changes/how-to-report-changes/
- https://www.healthcare.gov/reporting-changes/which-changes-to-report/

Notices Were Mailed to Consumers Who May Be Enrolled in Marketplace Coverage AND Medicare (also called Medicare Periodic Data Matching)

Key Takeaway: Recently, the Federally-facilitated Marketplace (FFM) mailed paper notices to the household contacts of consumers who may be enrolled in a Marketplace plan and Medicare that qualifies as minimum essential coverage (MEC). The notices include instructions on what to do next. Generally, consumers determined eligible for MEC Medicare are not eligible for a Marketplace plan with APTC or CSRs. If consumers who receive this notice contact assisters with questions, assisters can help them understand the notice and complete the necessary next steps.*

**Medicare Parts A and C are considered MEC. Medicare Parts B and D are not considered MEC.*

Overview

The FFM confirms MEC Medicare enrollment for Marketplace enrollees receiving APTC through a Medicare Periodic Data Matching (PDM) process. During this round of Medicare PDM, the Marketplace identified all consumers who are enrolled in MEC Medicare and Marketplace coverage with APTC (i.e., "dually enrolled" consumers). If the FFM confirms that the Marketplace enrollee has MEC Medicare, these consumers may be at risk for a tax liability if they are receiving APTC for their Marketplace coverage. Therefore, all consumers who are identified as enrolled in MEC Medicare should return to their application to end their APTC and may consider ending their Marketplace coverage.

Recently, as part of Medicare PDM, the FFM mailed paper notices to the household contact for all consumers found to be dually enrolled in MEC Medicare and Marketplace coverage with and without APTC. The notices included:

- Names of consumers who were found to be dually enrolled;
- A recommendation that individuals who are found to be enrolled in MEC Medicare should not be enrolled in Marketplace coverage and are not eligible for APTC/CSR through the Marketplace;
- Instructions on the correct action to take on Marketplace coverage (for consumers enrolled in MEC Medicare); and
- Contact information to confirm if they are enrolled in Medicare or if they have any questions.

Q&A: How to help consumers who receive the notice.

Q1: If a consumer is 65, but doesn't have enough quarters to qualify for premium-free Medicare Part A and can't afford premium Part A, do they have to enroll in Part B and can they stay on their Marketplace plan?

A1: For consumers who must pay a premium for Medicare Part A, we recommend that they compare their Marketplace benefits and premiums to Medicare to see what best fits their needs and budget. In this scenario, they would not have to take Part B.

Q2: Shouldn't consumers dually enrolled in MEC Medicare and Marketplace coverage end their Marketplace coverage right away? Won't they have to pay back any APTCs?

A2: They may be liable to pay back all or some of the APTC paid on their behalf during months of overlapping coverage. We strongly encourage that they end their Marketplace coverage only after they have confirmation of their Medicare Part B enrollment to avoid gaps in coverage.

Q3: What if a person is of Medicare age but does not qualify for premium-free Medicare Part A or Part B and does not obtain Medicare coverage? Can she still enroll through the Marketplace?

A3: Yes, as long as she is otherwise eligible (e.g. she is lawfully present, etc.), she can still enroll in a Marketplace plan.

Q4: Are there special instructions for those who are dually enrolled and entitled to Medicare due to an end-stage renal disease (ESRD) diagnosis?

A4: Consumers with a diagnosis of ESRD generally can choose between enrolling in Medicare or Marketplace coverage at the time of their ESRD diagnosis. But if a consumer with ESRD does choose to enroll in Medicare Part A, we highly recommend that they enroll in Medicare Part B as well to ensure their medical costs associated with their ESRD diagnosis are covered.

Final Notices have been sent to consumers who were found to be dually-enrolled in Marketplace coverage with financial help *and* MEC Medicaid or CHIP: Consumer Action Suggested

Key Takeaway: In February 2018, the Marketplace[1] sent an initial warning notice to consumers who were found to be enrolled in Medicaid or the Children's Health Insurance Program (CHIP) that counts as qualifying coverage (also known as minimum essential coverage, or MEC)[2] and were also enrolled in Marketplace coverage with advance payments of the premium tax credit (APTC) and/or income-based cost-sharing reductions (CSRs). The initial warning notices requested that consumers take the appropriate action by a specific date. Consumers who did

[1] References to the "Marketplace" throughout refer to the Federally-Facilitated Marketplaces (including State Partnership Marketplaces) and State-Based Marketplaces using the federal eligibility and enrollment platform.

[2] Most Medicaid is considered qualifying coverage. Some forms of Medicaid cover limited benefits (like Medicaid that only covers emergency care, family planning or pregnancy-related services) and aren't considered qualifying coverage. (For more information on which Medicaid programs count as qualifying coverage, visit: HealthCare.gov/medicaid-limited-benefits/). Most CHIP coverage is considered qualifying coverage.

not do so are being sent a final notice this spring, informing them that: (a) the Marketplace has ended any APTC/CSRs being paid on their behalf, (b) their Marketplace coverage will continue without financial help, and (c) eligibility for APTC/CSRs for anyone else on the Marketplace application has been redetermined, if applicable. **Dually-enrolled consumers who do not want to pay full cost for their share of the Marketplace plan premium and covered services will need to end their Marketplace coverage immediately.** Assisters can help affected consumers understand the notice and complete the necessary next steps.

Overview

Consumers who are determined eligible for or are enrolled in Medicaid or CHIP that counts as qualifying coverage are ineligible for APTC and CSRs to help pay for the cost of their Marketplace plan premium and covered services.[3, 4] Medicaid/CHIP PDM is the process the Marketplace uses to identify consumers who are enrolled in Marketplace coverage with APTC/CSRs and Medicaid or CHIP (i.e. "dually-enrolled" consumers). In February 2018, following the most recent data match with state Medicaid and CHIP agencies, the Marketplace sent an initial warning notice to the household contact for dually-enrolled consumers,[5] stating that if they did not take action by the date in the notice, the Marketplace would end any APTC/CSRs being paid on affected consumers' behalf, and their Marketplace coverage would continue without financial help.[6] The notice told consumers to do one of the following (and provided instructions) by a specified date: end their Marketplace coverage with APTC/CSRs if they were enrolled in Medicaid or CHIP; OR update their Marketplace application to tell the Marketplace that they're not enrolled in Medicaid/CHIP. The notice was mailed and/or posted to the household contact's Marketplace account, depending on what they selected as their communication preference.

This spring, a **final notice** is being sent to the household contact for consumers who did not respond by the date specified in the initial warning notice, letting them know that affected consumers are still enrolled in a Marketplace plan but will no longer receive financial help for their coverage. Consumers who choose to remain in full-cost Marketplace coverage should notify their state Medicaid or CHIP agency of their Marketplace enrollment. If they choose to remain enrolled in full-cost Marketplace coverage, they may no longer be eligible for CHIP. For anyone else on the application who is still enrolled in a Marketplace plan, their coverage will

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[3] Generally, consumer who is eligible for income-based CSRs will also be eligible for APTC. However, not all consumers who are eligible for APTC will be eligible for income-based CSRs.

[4] In accordance with recent guidance from the Internal Revenue Service (IRS), if a Marketplace makes a determination or assessment that an individual is ineligible for Medicaid or CHIP and eligible for APTC when the individual enrolls in Marketplace coverage, the individual is treated as not eligible for Medicaid or CHIP for purposes of the premium tax credit while they are enrolled in Marketplace coverage for that year. For more information, visit: https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Questions-and-Answers-on-the-Premium-Tax-Credit, question 29.

[5] Due to technical limitations, dually-enrolled consumers in Ohio did not receive notices in this round of Medicaid/CHIP PDM. Consumers in these states will not be affected by this round of Medicaid/CHIP PDM.

[6] If a consumer still wants a Marketplace plan after having been determined eligible for Medicaid or CHIP that counts as qualifying coverage, they will have to pay full price for their share of the Marketplace plan premium and covered services, without APTC or income-based CSRs, if otherwise eligible. Consumers who choose to remain in full-cost Marketplace coverage should notify their state Medicaid or CHIP agency of their Marketplace enrollment. If they choose to remain enrolled in full-cost Marketplace coverage, they may no longer be eligible for CHIP.

continue and eligibility for APTC/CSRs, if applicable, will be redetermined. ***Dually-enrolled consumers who do not want to pay full cost for their share of the Marketplace plan premium and covered services should end their Marketplace coverage immediately.*** The final notice includes instructions for next steps, such as ending Marketplace coverage, confirming whether or not someone is enrolled in Medicaid/CHIP, and appealing the Marketplace's decision; it also includes the date that the changes to financial assistance become effective. The Marketplace is also sending an updated Eligibility Determination Notice (EDN). All notices are mailed and/or posted to the household contact's Marketplace account.

Consumers who receive the Medicaid/CHIP PDM final notice may contact assisters for help understanding the notice and determining next steps. Here are some examples of the ways that assisters can help consumers who contact them:

- Help consumers understand the notice. Explain that the notice has been sent to them because the Marketplace has identified them as being enrolled in Marketplace coverage with APTC/CSRs and Medicaid or CHIP. This is important because consumers who are determined eligible for or are enrolled in Medicaid or CHIP that qualifies as MEC are not eligible for APTC and CSRs to help pay for the cost of their Marketplace plan premium and covered services. Because the consumer did not respond by the date listed in the initial warning notice, they will remain enrolled in a Marketplace plan but will no longer receive financial help for their coverage. Consumers who choose to remain in full-cost Marketplace coverage should notify their state Medicaid or CHIP agency of their Marketplace enrollment. If they choose to remain enrolled in full-cost Marketplace coverage, they may no longer be eligible for CHIP. For anyone else on the application who is still enrolled in a Marketplace plan, their coverage will continue and eligibility for APTC/CSRs, if applicable, will be redetermined. Dually-enrolled consumers who do not want to pay full cost for their share of the Marketplace plan premium and covered services will need to end their Marketplace coverage immediately. The final notice includes instructions for next steps, such as ending Marketplace coverage, confirming whether or not someone is enrolled in Medicaid/CHIP, and appealing the Marketplace's decision; it also includes the date that changes to financial assistance will become effective.
- Encourage consumers who have been determined eligible for or are enrolled in Medicaid or CHIP to take immediate action to end their Marketplace coverage if they do not want to pay full cost for their share of the Marketplace plan premium and covered services (see these instructions on HealthCare.gov: https://www.healthcare.gov/medicaid-chip/cancelling-marketplace-plan/). Explain the financial impact of not ending Marketplace coverage. Consumers who choose to remain in full-cost Marketplace coverage should notify their state Medicaid or CHIP agency of their Marketplace enrollment. If they choose to remain enrolled in full-cost Marketplace coverage, they may no longer be eligible for CHIP.

- Inform consumers who don't think they're enrolled in Medicaid or CHIP, who aren't sure if their Medicaid or CHIP benefits count as qualifying coverage, or who aren't sure if they've been determined eligible for or if they're enrolled in Medicaid or CHIP, that they may wish to contact their state Medicaid or CHIP agency to confirm their enrollment status (instructions are in the notice). If the state agency confirms that the consumer is not eligible for or enrolled in Medicaid or CHIP that counts as qualifying coverage, and/or if the consumer doesn't agree that their financial help should end, they can appeal the Marketplace's decision (more information is in the notice). However, if the state agency confirms that the consumer is eligible for or enrolled in Medicaid or CHIP that counts as qualifying coverage, the consumer will need to end their Marketplace coverage immediately if they don't want to remain enrolled in Marketplace coverage without financial assistance. Consumers who choose to remain in full-cost Marketplace coverage should notify their state Medicaid or CHIP agency of their Marketplace enrollment. If they choose to remain enrolled in full-cost Marketplace coverage, they may no longer be eligible for CHIP.
- Advise consumers who want more information about Medicaid or CHIP to contact their state Medicaid or CHIP agency.

Q&A: How to help consumers who receive the Medicaid/CHIP PDM final notice

Q1: When and how are these notices being sent to consumers?

A1: The Marketplace sent initial warning notices in February 2018 to the household contact for applications with one or more dually-enrolled consumers. This spring, the Marketplace is sending a final notice to the household contact for applications with dually-enrolled consumers who did not take action by the date in the initial warning notice. For these consumers, the Marketplace is also sending an updated EDN for all consumers in the household. All notices are mailed and/or posted to the household contact's Marketplace account, depending on what they selected as their communication preference.

Q2: How will consumers identify the Medicaid/CHIP PDM final notice, and what does the notice say?

A2: The subject of the final notice reads *"IMPORTANT: Members of your household are still enrolled in a Marketplace plan but will no longer get financial help."* The final notice:

- Lists the dually-enrolled consumers who did not take action by the date in the initial warning notice;
- Tells them the date that Marketplace coverage without financial assistance becomes effective;
- Alerts them that they should end Marketplace coverage immediately if they don't want to pay full cost for their share of the Marketplace plan premium and covered services;

- Provides instructions for consumers who want more information about Medicaid or CHIP, who aren't sure if their Medicaid or CHIP coverage counts as qualifying coverage, OR who aren't sure whether they're enrolled in or eligible for Medicaid or CHIP;
- Tells them what financial help consumers on the policy who are not dually-enrolled will get, if applicable;
- Directs consumers to the final EDN for more information on how to submit an appeal to the Marketplace if a consumer believes their financial assistance was ended incorrectly.

Copies of the notice are available in English and Spanish, with instructions on how to get language assistance services for consumers who need help in another language.

Q3: Can affected consumers who didn't respond to the initial warning notice retroactively terminate their Marketplace plan to avoid having to pay full cost for their share of Marketplace plan premiums and covered services?

A3: The Marketplace generally will not provide retroactive terminations for Marketplace coverage for dually-enrolled consumers. We urge consumers who are determined eligible for or enrolled in Medicaid or CHIP who do not want to remain enrolled in Marketplace coverage without financial assistance to end their Marketplace coverage immediately.

Q4: When will Marketplace coverage without financial assistance become effective for affected consumers?

A4: The Medicaid/CHIP PDM Stop APTC final notice will include the date on which changes to financial assistance will become effective for the household.

Q5: What should I tell consumers who think their financial help was terminated incorrectly to do?

A5: Tell consumers who believe their financial assistance was ended incorrectly that they can appeal the decision. The information on how to submit an appeal to the Marketplace is on their final notice. Help them understand the following information.

- Generally, they have 90 days from the date of this notice to request an appeal with the Marketplace.
- They can represent themelves or appoint a representative to help them with their appeal. This person can be a friend, relative, lawyer, or someone else.
- They can ask to keep their eligibility during your appeal. If they were previously eligible for Marketplace coverage or financial assistance and their eligibility is changed, they can appeal this change. In this case, they may be able to keep their previous eligibility during their appeal.
- The outcome of an appeal could change the eligibility of other members of their household even if they don't ask for an appeal.

To request an appeal, they can do one of these things:

- Visit HealthCare.gov/marketplace-appeals to get the Appeal Request form for their state; or
- Write a letter requesting an appeal. They need to include name, address, and the reason they're requesting the appeal. If they're requesting an appeal for someone else (like their child), also include their name.

Then, they fax the appeal request to a secure fax line: 1-877-369-0130 or mail it to:
Health Insurance Marketplace
ATTN: Appeals
465 Industrial Blvd.
London, KY 40750-0061

New Assister Resources

Assisters are encouraged to check out Marketplace.cms.gov for new resources that are helpful for assisters. New/Updated resources available on the site include a Refresher on Data Matching Issues (DMIs), How to Resolve DMIs, and How to Upload Required Documents

There's lots of helpful information to support your work as an assister as well as reference information to lean on regarding marketplace complex cases, policy and operations. This website is updated often so be sure to check back periodically for new content.

Standing Assister Resources: Helpful Links / Call Center Hours / Contact Us

Links to Helpful Resources

- Marketplace Assister Training Resources and Webinar
- Technical Assistance Resources
- CMS Marketplace Applications & Forms
- CMS Outreach and Education Resources
- Marketplace.CMS.gov Page
- CMSzONE Community Online Resource Library Pilot for Marketplace Assisters
- Find Local Help

Marketplace Call Center and Shop Center Hours

Health Insurance Marketplace Call Center: 1-800-318-2596 (TTY: 1-855-889-4325). For customer service support, to start or finish an application, compare plans, enroll or ask a question. Available 24 hours a day, 7 days a week. Closed Memorial Day, July 4th, and Labor Day. CACs and Navigators should call their dedicated phone lines so the Call Center can better

track the needs of assisters. The dedicated Assister Line can also help with password resets and can help with access to non-application SEPs. Contact your Navigator Project Officer (for Navigators) or your designated organization leadership (for CACs) for more information on the Assister Line.

Navigator Marketplace Call Center line: 1-855-868-4678

CAC Marketplace Call Center line: 1-855-879-2683

General consumer Call Center line: 1-800-318-2596 (TTY: 1-855-889-4325).

SHOP Call Center: For customer service support, including assisting employers and employees apply for and enroll in SHOP. 1-800-706-7893 (TTY: 711). Available M-F 9:00 am-7:00 pm EST. Closed New Year's Day, Martin Luther King Day, Memorial Day, July 3rd, Labor Day, Veterans Day, Thanksgiving and the day after, and Christmas.

Stay in Touch

To sign up for the CMS Weekly Assister Newsletter, please send a request to the Assister Listserv inbox (ASSISTERLISTSERV@cms.hhs.gov) write "Add to listserv" in the subject line, please include the email address that you would like to add in the body of your email. For requests to be removed from the listserv, please forward a copy of a webinar invite or newsletter received and write "Remove" in the subject line.

If you have specific questions or issues that you would like to see us highlight in our weekly webinar series or here in this newsletter please contact us.

- For **HHS Navigator grantees** - please get in touch with your Navigator Project Officer.
- For **CAC Designated Organizations in FFM states** - please send an email to CACQuestions@cms.hhs.gov.

Follow @HealthCaregov Twitter with the hashtag #ACAassisters for updates, reminders, and new publications for assisters.

We welcome questions, suggestions and comments, so please feel free to contact us!

Please note that the information presented in this Assister Newsletter is informal, technical assistance for assisters and is not intended as official CMS guidance. This document is only a summary of applicable requirements and does not itself create any legal rights or obligations.

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