February Marketplace Update for Assisters

February 2018

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IRS Statement on Health Care Reporting Requirement

For the upcoming 2018 filing season, the IRS will not accept electronically filed tax returns where the taxpayer does not address the health coverage requirements of the Affordable Care Act. The IRS will not accept the electronic tax return until the taxpayer indicates whether they had coverage, had an exemption or will make a shared responsibility payment. In addition, returns filed on paper that do not address the health coverage requirements may be suspended pending the receipt of additional information and any refunds may be delayed.

To avoid refund and processing delays when filing 2017 tax returns in 2018, taxpayers should indicate whether they and everyone on their return had coverage, qualified for an exemption from the coverage

requirement or are making an individual shared responsibility payment. This process reflects the requirements of the ACA and the IRS's obligation to administer the health care law.

Taxpayers remain obligated to follow the law and pay what they may owe at the point of filing. The 2018 filing season will be the first time the IRS will not accept tax returns that omit this information. After a review of its process and discussions with the National Taxpayer Advocate, the IRS has determined identifying omissions and requiring taxpayers to provide health coverage information at the point of filing makes it easier for the taxpayer to successfully file a tax return and minimizes related refund delays.

Find more information about the individual shared responsibility provision.

https://www.irs.gov/tax-professionals/aca-information-center-for-tax-professionals

Getting Ready for Tax Season

Information on 1095-As

Like last year, assisters can help consumers who enrolled in coverage through the Health Insurance Marketplaces and received advance payments of the premium tax credit (APTC) understand the Form 1095-A that they receive from the Marketplace. Consumers must use the Form 1095-A to complete Form 8962 when they file their 2017 taxes. These forms allow consumers to reconcile the total APTC they received during 2017 with the amount of premium tax credit (PTC) for which they are eligible based on their final 2017 income and household information.

Forms should be received within the first few months of 2018. Consumers should receive a hard copy of this form in the mail, but can also access the form directly through their healthcare.gov account in the tax form section. If consumers do not have online accounts, they can create one to view their Form 1095-A. Depending on changes that may have occurred to consumers' coverage over the course of 2017, such as changing Marketplace plans during the year, **some consumers may receive more than one Form 1095-A**.

Please remember that as an assister, you are prohibited from helping consumers with filing their taxes, unless you are also a licensed tax professional.

Let consumers know that the monthly enrollment premium listed on their Form 1095-A (Part III, Column A) may be different from their plan's full monthly premium amount. This does not always mean there are errors that need to be corrected. The monthly premium on the Form 1095-A may be different from what is expected for several reasons that are addressed at https://www.healthcare.gov/tax-form-1095/. If consumers identify errors on their Form 1095-A, direct them to notify the Marketplace by calling the Marketplace Call Center at 1-800-318-2596. Below are some helpful resources to share with consumers as you help them understand how using APTCs for their Marketplace coverage affects their taxes. Click the hyperlink to access the resource:

- Complete guide to 2017 health coverage & your tax status
- Health Coverage Tax Tool
- How to Use Form 1095A

- How to Reconcile PTC

Information on Form 1095-B and Cs

This year, some consumers will receive Forms 1095-B or 1095-C. Like Form 1095-A, Forms 1095-B and C will provide consumers with information about their health coverage during the prior year. Consumers who have health coverage through the Marketplace and receive a Form 1095-A might also receive a Form 1095-B or Form 1095-C, if they or members of their household had coverage in 2017 through other programs or plans outside of the Marketplace, like Medicaid or private health insurance. Individuals who have questions about a Form 1095-B or 1095-C should contact the entity that provided them with the form.

Forms 1095-C will be provided to consumers by certain large employers. Forms 1095-B will be provided to consumers by health insurance providers, such as health insurance companies and government agencies including Medicare, Medicaid or CHIP. Insurance issuers and carriers aren't required to file Form 1095-B to report coverage in individual market qualified health plans that individuals enroll in through Health Insurance Marketplaces. This coverage generally is reported by Marketplaces on Form 1095-A. However, health insurance issuers will file Form 1095-B to report on coverage for employees obtained through the Small Business Health Options Program (SHOP).

IRS Extends Deadline to Provide 1095-B and Cs

The IRS extended the 2018 due date for certain employers and health coverage providers to send 2017 health coverage information forms to individuals. The following organizations now have until March 2, 2018, to provide Forms 1095-B or 1095-C:

- Insurers
- Self-insuring employers
- Other coverage providers
- Applicable large employers

The March 2nd date is a 30-day extension from the original due date of January 31st.

This 30-day extension is automatic. Employers and providers do not have to request it. The due dates for filing 2017 information returns with the IRS are not extended. For 2018, the due dates to file information returns with the IRS are:

- Feb. 28 for paper filers
- April 2 for electronic filers

Because of these extensions, individuals may not receive their Forms 1095-B or 1095-C by the time they are ready to file their 2017 individual income tax return. While information on these forms may assist in preparing a return, taxpayers are not required to have these forms to file. Taxpayers can prepare and file

their returns using other information about their health coverage.

More information on the 1095-B and 1095-C extension can be found at https://www.irs.gov/pub/irs-drop/n-18-06.pdf.

CMS Announces Additional Special Enrollment Periods to help Individuals Impacted by Hurricanes in Puerto Rico and the U.S. Virgin Islands

*Agency provides extended special enrollment periods for 2018 Medicare and Exchange coverage.(*In Spanish*)*

The Centers for Medicare & Medicaid Services (CMS) announced additional opportunities for individuals affected by the 2017 hurricanes in Puerto Rico and the U.S. Virgin Islands to enroll in Medicare health and drug plans, as well as health insurance coverage through an Exchange that uses the federal eligibility and enrollment platform, for affected individuals who relocated to a state served by one of these Exchanges.. CMS is providing these special enrollment periods so that certain individuals and families who were impacted can access health coverage through the Exchange and have additional time to join, drop, or switch Medicare health and prescription drug plans. CMS announced initial special enrollment period opportunities in September, this extends these opportunities through March 31, 2018.

CMS established the following special enrollment periods to support individuals impacted by the 2017 hurricanes in Puerto Rico and the U.S. Virgin Islands:

- **Federal Health Insurance Exchange special enrollment period:** Individuals affected by the 2017 hurricanes in Puerto Rico and the U.S. Virgin Islands who relocated to a state served by an Exchange using the federal eligibility and enrollment platform, but were unable to enroll during the 2018 Annual Open Enrollment Period or any other special enrollment period, are eligible for an exceptional circumstance special enrollment period to enroll in 2018 Exchange coverage. Individuals in this situation may request this special enrollment period through March 31, 2018. These individuals should contact the Exchange Call Center at 1-800-318-2596 to request enrollment using this special enrollment period.

- **Medicare special enrollment period extension:** This special enrollment period will allow individuals affected by the 2017 hurricanes in Puerto Rico and the U.S. Virgin Islands to enroll, dis-enroll or switch Medicare health or prescription drug plans through March 31, 2018. This special enrollment period can be used even if the beneficiary made a choice during Medicare's fall open enrollment period. The special enrollment period can also be used for those who left Puerto Rico and would like to enroll in a local Medicare Advantage or Medicare prescription drug plan that would better meet their healthcare needs. Beneficiaries who change their permanent residence, rather than temporarily relocate, and no longer reside in their plan service area, are eligible to join a Medicare Advantage or prescription drug plan offered in the new area in which they reside through the existing residence change special enrollment period. Individuals who were displaced, used one of these two SEPs and then return to Puerto Rico or the U.S. Virgin Islands are also eligible to rejoin their prior Medicare health or drug plan or enroll in another

Medicare plan that meets their needs when returning to Puerto Rico or the U.S. Virgin Islands Individuals in these situations may contact 1-800-MEDICARE to request enrollment using this special enrollment opportunity.

For more information on special enrollment periods for the Federal Health Insurance Exchange, visit: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Territories-SEP-Guidance.pdf.

For more information on special enrollment period extension for Medicare, visit: https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Extension-SE-Period-PR-VI-CA-Wildfire.pdf.

Canceling vs. Terminating a Consumers Coverage

There are various reasons consumers may want to end their health care coverage; however, it is important for assisters and consumers to understand the difference between canceling and terminating coverage. A consumer would proceed with **terminating** coverage if the consumer has enrolled and paid at least one month's premium or her coverage has been effectuated. The Marketplace generally requires 14 days' notice before terminating coverage. However, if the consumer is terminating coverage for some but not all the household members on the application, in most cases the coverage will end immediately for the family member(s) being terminated. Consumers should report a life change to the Marketplace Call Center in order to remove someone from an application while keeping others covered. More information can be found at https://www.healthcare.gov/reporting-changes/how-to-report-changes/.

A consumer could end their coverage by cancelling if the consumer's start date has not passed or the consumer has not made their first month's premium. When coverage is cancelled, there is no advance notice required; but the cancellation must be done prior to the policy start date.

Important Reminders

- Visit https://www.healthcare.gov/how-to-cancel-a-marketplace-plan/ for more information.
- Call the Marketplace Call Center for help: 1-800-318-2596.
- Consumers can cancel their coverage by logging into their HealthCare.gov account and clicking "End (Terminate) All Coverage" prior to the policy effective date or by not paying their first month's premium.
- Terminating coverage generally requires a 14-day notice and cannot take place earlier than the policy start date. When ending coverage for some but not all family members or reporting changes to the consumer's household, the applicant will receive a new eligibility determination notice.
- Remind consumers to come back to report changes throughout the year.
- Note: The Marketplace Appeals Center does not review appeals for termination disputes that are not appealable (including, for example, a consumer who wants a retroactive termination). Retro

terminations due to Marketplace error or technical issue may be reviewed by caseworkers and evaluated, but if the retro termination is denied, there are no appeal rights.

It's important for consumers to have coverage in place before terminating or cancelling their coverage on the Marketplace. Once a consumer's Marketplace coverage has ended, they will not be able to re-enroll until next open enrollment period unless they qualify for a special enrollment period.

For more information, visit https://www.healthcare.gov/apply-and-enroll/change-after-enrolling/.

Consumer Action Needed - Initial warning notices have been sent to consumers who are receiving financial help with their Marketplace coverage and may also be enrolled in Medicaid or CHIP (also called Medicaid/CHIP Periodic Data Matching)

Key Takeaway: Consumers determined eligible for minimum essential coverage (MEC)[1]Medicaid or CHIP are not eligible for advance payments of the premium tax credit (APTC) or for income-based cost-sharing reductions (CSRs) to help pay for their Marketplace plan premium and covered services. The Marketplace has identified consumers who may be dually-enrolled in Marketplace coverage with APTC/CSRs and in MEC Medicaid/CHIP and has sent them notification of their dually-enrolled status. This spring, the Marketplace will end APTC/CSRs for dually-enrolled consumers who do not take action in response to the Medicaid/CHIP PDM initial warning notice; these consumers will remain enrolled in a Marketplace plan at full cost. Assisters can help affected consumers understand the notice(s) and complete the necessary next steps.

Overview

Consumers who are determined eligible for or are enrolled in MEC Medicaid or CHIP are ineligible for APTC and CSRs to help pay for the cost of their Federally-Facilitated Marketplace (Marketplace)[2] plan premium and covered services.[3][4]

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

[2] References to the "Marketplace" throughout refer to the Federally-Facilitated Marketplace and State-Based Marketplaces using the federal eligibility and enrollment platform.

[3] Generally, a 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.

Medicaid/CHIP Periodic Data Matching (PDM) is the process the Marketplace uses to identify, notify, and reduce the number of consumers who are enrolled in Marketplace coverage with APTC/CSRs and Medicaid or CHIP (i.e. "dually-enrolled" consumers).

This month, the Marketplace sent an initial warning notice to the household contact for dually-enrolled[5] consumers, stating that if they do not take action by the date in the notice, the Marketplace will end any APTC/CSRs being paid on behalf of affected consumers, and those consumers' Marketplace coverage will continue without financial help.[6]

The notice tells the household contact (and provides instructions) to do one of the following by a specified date:

- end affected consumers' Marketplace coverage with APTC/CSRs; or
- update their Marketplace application to tell the Marketplace that affected consumers are not enrolled in Medicaid/CHIP.

In Spring 2018, at least 30 days following the initial notice, the Marketplace will send a final notice to the household contact for applications with affected consumers who did not respond to the initial warning notice by the specified date. This notice will let consumers know that they are still enrolled in a Marketplace plan but will no longer receive financial help (APTC/CSRs). Consumers who choose to remain in full-cost Marketplace coverage should notify their state Medicaid/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, but could continue to receive CHIP coverage, if otherwise eligible, by ending their Marketplace enrollment.

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 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 will also send an updated Eligibility Determination Notice (EDN).

Q&A: How to help consumers who receive the notice(s)

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 Marketplace applications with one or more dually-enrolled consumers. In Spring 2018, the Marketplace

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[5] Due to technical limitations, dually-enrolled consumers in Ohio will not receive notices in this round of Medicaid/CHIP PDM. Consumers in this state 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 MEC Medicaid or CHIP, he or she will have to pay full price for his or her 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, but could continue to receive CHIP coverage, if otherwise eligible, by ending their Marketplace enrollment.

will send a final notice to the household contact for Marketplace applications with consumers who did not take action by the date in the initial warning notice. The Marketplace will also send an updated EDN for all consumers in the household. All notices are mailed to the household contact and/or posted to their Marketplace accounts, depending on what they selected as their communication preference.

Q2: How will consumers identify the Medicaid/CHIP PDM notices, and what do the notices say?

A2: The subject of the initial warning notice reads "Warning: Members of your household may lose financial help for their Marketplace coverage." The initial warning notice:

- Lists the dually-enrolled consumers;
- Provides instructions to either end their Marketplace coverage with APTC/CSRs, or update their Marketplace application to tell the Marketplace that they're not enrolled in Medicaid or CHIP;
- Gives them a date by which they must take action; and
- Provides instructions for consumers who want more information about Medicaid or CHIP, who aren't sure if their Medicaid or CHIP coverage qualifies as MEC, or who aren't sure whether they're enrolled in or have been determined eligible for Medicaid or CHIP.

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 for it." 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 to take immediate action to end their Marketplace coverage 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 qualifies as MEC, or who aren't sure whether they're enrolled in Medicaid or CHIP;
- Tells them what financial help consumers on the policy who are not dually enrolled will get; and
- Directs the consumer to the forthcoming EDN for more information on how to submit an appeal to the Marketplace if a consumer believes his or her financial assistance was ended incorrectly.

Copies of both notices will be available in English and Spanish, with instructions on how to get the help in other languages.

Q3: As an assister, why might consumers contact me?

A3: Consumers who receive either/both of the Medicaid/CHIP PDM notices may contact assisters:

- For help understanding the notice(s);
- For help ending Marketplace coverage with APTC/CSRs;
- For help updating their Marketplace application to tell the Marketplace they're not enrolled in Medicaid/CHIP;
- If they don't think they're enrolled in Medicaid or CHIP;
- If they aren't sure if they're enrolled in Medicaid or CHIP; or
- If they want more information about whether their Medicaid or CHIP coverage qualifies as MEC.

Q4: Where can I learn about what these consumers have to do?

A4: Find information in the Medicaid/CHIP PDM User Interface Guide at www.healthcare.gov/downloads/marketplace-medicaid-chip-guide.pdf. It explains the steps consumers should to take depending on their situation. You can share this guide with consumers as well.

Q5: How can I help these consumers?

A5: Help consumers understand the notice(s). Explain that the Marketplace has sent this notice to them because the Marketplace has identified members of their household as being enrolled in both a Marketplace plan with financial help **and** MEC Medicaid or CHIP. This is important because consumers who've been determined eligible for MEC Medicaid or CHIP are not eligible for a Marketplace plan with APTC/CSRs. Consumers who receive the notices should take immediate action.

For consumers who **are** eligible for or enrolled in MEC Medicaid or CHIP:

- Encourage them to take immediate action to end their Marketplace coverage with APTC/CSRs or be prepared to pay all the costs of the Marketplace plan. Explain the potential 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, but could continue to receive CHIP coverage, if otherwise eligible, by ending their Marketplace enrollment.
- If they decide to end their Marketplace coverage, help them follow the instructions on HealthCare.gov for consumers who wish to end Marketplace with APTC/CSRs coverage when he or she has Medicaid or CHIP: https://www.healthcare.gov/help/end-marketplace-plan/.
- If they decide to keep their Marketplace plan without financial help in addition to their Medicaid or CHIP coverage, help them notify their Medicaid/CHIP agency.

For consumers who **are not** enrolled in Medicaid or CHIP:

- Help them to update their Marketplace application accordingly. They should report a "life change" on their Marketplace application and tell the Marketplace they're not enrolled in Medicaid or CHIP

that counts as qualifying coverage. The Medicaid/CHIP PDM User Interface Guide explains the steps to do this.

Q6: What should I do if the consumers think they're not enrolled in Medicaid or CHIP, aren't sure if they're enrolled in Medicaid or CHIP, or aren't sure if their Medicaid or CHIP benefits qualify as MEC?

A6: Inform these consumers that they should contact their state Medicaid or CHIP agency to confirm their enrollment status. (Instructions for doing so are in the notices).

- If the state agency confirms that the consumer is not eligible for or enrolled in MEC Medicaid or CHIP coverage, he or she should update his or her Marketplace application to tell the Marketplace that he or she is not enrolled in Medicaid or CHIP by reporting a life change. The Medicaid/CHIP PDM User Interface Guide explains the steps to do this.

- If the state agency confirms that the consumer is enrolled in MEC Medicaid or CHIP coverage, the consumer should immediately end his or her Marketplace coverage with APTC/CSRs.

Advise consumers who want more information about Medicaid or CHIP to contact their state Medicaid or CHIP agency:

- For Medicaid: Visit https://www.healthcare.gov/medicaid-chip/ and scroll down to "Apply for Medicaid and CHIP 2 Ways" and select your state from the drop-down menu under the second option to apply for coverage, "Through your state agency". Once the state is selected, there will be a link to the Medicaid agency website for further assistance.

- For CHIP: Visit https://www.insurekidsnow.gov/ or call 1-877-543-7669 for more information and assistance.

Q7: What if a consumer is enrolled in Medicaid or CHIP that counts as qualifying coverage and Marketplace coverage with APTC/CSRs, but believes they are actually eligible to remain enrolled in Marketplace coverage with APTC/CSRs?

A7: A consumer who's enrolled in Marketplace coverage with APTC/CSRs and Medicaid or CHIP that counts as qualifying coverage may believe they are eligible to remain enrolled in Marketplace coverage with APTC/CSRs if they experienced a change in household income or family size that makes them no longer eligible for Medicaid/CHIP that counts as qualifying coverage. The consumer should contact the state Medicaid/CHIP agency to inform them of these circumstances. If the state Medicaid or CHIP agency informs the consumer that they are no longer eligible for Medicaid or CHIP that counts as qualifying coverage, the consumer should update their Marketplace application to state that they are not enrolled in Medicaid or CHIP that counts as qualifying coverage; they can remain in their Marketplace coverage with APTC/CSRs, if otherwise eligible.

Q8: How soon after the final notice is sent will the Marketplace end APTC/CSRs on behalf of affected consumers?

A9: The Medicaid/CHIP PDM final notice will include the date on which changes to financial assistance

will become effective for the affected enrollees.

New Resources for Assisters

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:

- Sample Applications, forms and notices
- Fact Sheets and outreach materials
- Technical Assistance Resources like Webinar Presentations & Assister Newsletters

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 or SPM 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.

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