Course 2 Health Coverage Basics

Module 1 - Health Coverage Basics

Course Introduction

Health Coverage Basics

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Welcome

Hello, my name is Neha. I am here to help you learn the answers to these questions and more as we review the basics of health coverage. Ready? Let’s go!

- What costs are associated with health coverage?
- What are the different ways that consumers can get coverage?
- What are Medicaid, the Children's Health Insurance Program (CHIP), and Medicare?

Course Goal

Some consumers you help may be new to health insurance and other types of health coverage. For example, they might be getting health insurance or Medicaid coverage for the first time. Each consumer will have different levels of understanding and comfort with health insurance, its terminology, and the types of coverage available.

As you get started, basic information about health insurance and other types of health coverage will help you develop your skills to support consumers using the Federally-facilitated Marketplaces (FFMs). Don’t worry if you need some more time before you feel comfortable using this information. You’ll learn to explain how all of these terms and costs work together in the Coverage to Care Assistance course.

Goal:

This course will help you understand basic health coverage information so you can help consumers find the coverage that best fits their needs.

Topics:

By the end of this course, you will understand:

- Common terms associated with health plans and health coverage;
- Purpose and types of health insurance in the private market, including managed care plans;
- Costs associated with health and prescription drug coverage;
- Information required in a Summary of Benefits and Coverage (SBC); and
- Public health coverage programs for eligible consumers including Medicaid, CHIP, and Medicare.

Module 2 - Overview of Health Insurance

Introduction

Many people have existing health insurance coverage and won't need to buy health insurance through the Marketplace. However, both insured and uninsured people may need your help understanding more about the Marketplace and the application process. Your job is to help them understand the coverage options available to them through the Marketplace and to help them decide which coverage option best fits their budgets and specific needs. By the end of this module, you should understand the following concepts and accomplish the tasks below them.

Key Definitions

Define "health coverage," "health insurance" and "health plan."

Importance of Health Coverage

Understand why health coverage is important.

How Health Insurance Works

Describe how health insurance works to provide health coverage for consumers.

Definitions

The terms **health coverage**, **health insurance**, and **health plan** have distinct meanings, even though they're often used interchangeably.

In this training**, health coverage** is defined as payment or reimbursement for health care costs that consumers are legally entitled to when enrolled in health insurance or a health plan. Health insurance and health plans are one way for consumers to get health coverage, but consumers can also get health coverage through government programs, such as Medicaid, Medicare, the Children's Health Insurance Program (CHIP), and the Veterans Affairs (VA) Health Benefits Program.

Health insurance is a contract that requires a health insurer or company to pay some or all of a consumer's health care costs in exchange for a premium.

A **health plan** is another form of health coverage in which an employer, rather than an insurance company, collects premiums and pays claims. A health plan may be administered by a health insurance company. When it is, the health insurance company pays claims and performs other functions on behalf of the health plan.

In this training, we primarily use the term "health insurance," as that is the type of coverage that consumers who enroll through the Marketplaces have.

Welcome

As an assister, it's important to be able to answer a wide range of questions or quickly find answers through available resources. It's likely you'll be asked questions including:

- What’s health insurance?
- Why is health insurance important?
- How does health insurance work?

Your job is to help consumers understand the coverage options available to them through the Marketplace and to help them decide which coverage option best fits their budget and specific needs.

Let's review some answers to these questions.

Health Insurance Overview

Health insurance can be confusing. Here’s one way that you can explain it to consumers.

In general, insurance is a contract that’s meant to protect you financially if an accident or covered event happens that’s expensive to fix or to recover from. Many people also get employer-sponsored coverage (ESC), which is health insurance, or a health plan offered by their employers. When you have insurance, you pay a fixed amount, called a premium, to an insurance company. If there’s an accident or some other covered event occurs, the insurance company will help cover some of the costs.

Health insurance and health coverage programs do even more. They pay for the big, unexpected events but also for some of the smaller, more routine things. For example, they help with the cost if you’re in the hospital and when you get a yearly check-up. Having health insurance or coverage lets you take care of small health problems as soon as you notice them rather than waiting until the problems get worse, and you become really sick.

Health insurance plans can be purchased through the Marketplace, private insurance companies, online insurance sellers, or agents and brokers. Many people also get employer-sponsored coverage (ESC), which is health insurance, or a health plan offered by their employers.

There are many kinds of private health coverage. They may offer very different benefits. Some types of coverage may limit which providers consumers can use.

Why is Health Coverage Important?

Here's why having health insurance or other health coverage is important:

- Health coverage often gives consumers access to preventive health care services to help them stay healthy. Most insurance plans and health coverage programs must cover many preventive services without cost sharing under the Affordable Care Act (ACA).
- Health coverage helps consumers pay for health care services if they become sick or injured.
- Without health coverage, costs for health services can be extremely high and may result in serious financial hardship.

The ACA prohibits private health coverage from refusing to cover consumers or charging consumers more because of pre-existing conditions, and from excluding coverage for a **pre-existing condition**.

Pre-existing Conditions

Pre-existing conditions are medical conditions (e.g., asthma, back pain, diabetes, or cancer) that consumers had before enrolling in health coverage.

How Does Health Insurance Work?

Health insurance companies often contract with certain providers to deliver medical services for an agreed-upon rate. These providers are known as a health insurance company's provider network. Health insurance companies create various provider networks to develop different health plan options for plan members to choose from.

Before they enroll, it's important for consumers to carefully review provider networks to make sure the providers they want to visit and the pharmacies they want to use participate in their desired health plans. It's strongly recommended that consumers contact their providers and pharmacies directly to confirm that they're participating in their preferred plan.

Knowledge Check

Why is health coverage important?

Answer: Health coverage often gives consumers access to preventive health care services to help them stay healthy, helps pay for health care services if they become sick or injured, and prevents financial hardship that can occur when consumers don't have health insurance and are required to pay higher costs for health services.

Key Points

- Consumers purchase health insurance or enroll in other health coverage to help pay for medical care and avoid serious financial hardship.
- Health insurance companies often contract with groups of health care providers —known as provider networks— to provide health care services for an agreed-upon rate.

Module 3 - Common Health Coverage Terms

Introduction

To help consumers make health coverage decisions, you should understand the following concepts and accomplish the tasks below them.

Provider networks

Describe health insurance provider networks.

Coverage costs

List the general types of costs associated with health coverage.

Formularies

Define prescription drug formularies (drug lists) and tiered formularies.

Provider Networks

Nearly all health insurance companies use provider networks to manage the costs of providing care to consumers. A **network** is a list of providers that consumers generally must use to get coverage or lower out-of-pocket costs.

- Some health plans, such as Health Maintenance Organizations (HMOs), will generally only pay for services performed by providers within their network (also known as in-network providers).
- Other plans, such as Preferred Provider Organizations (PPOs), may pay for services by any provider, even those who aren't in-network. It's often more expensive for consumers to go to providers who aren't in their health plans' networks (also known as out-of-network providers). *
- Some plans require consumers to choose an in-network primary care provider. A primary care provider is usually a doctor who directly provides or coordinates a range of health care services for a patient. Primary care providers may be responsible for coordinating care and making referrals to physician specialists. Costs charged for services provided by a primary care provider, including copayments, are usually lower than those for specialists regardless of whether the specialist is in-network or out-of-network.

*Note: You'll learn more about the different types of health insurance and other health coverage plans later in this course.

Costs Associated With Health Insurance

When consumers have health insurance, their cost of care is shared with the insurance company based on the plan they selected. Understanding terms related to health insurance helps consumers choose the coverage that best meets their needs and fits their budget. You can help them understand these terms.

Premium

A premium is the amount that must be paid to a health insurance company to maintain enrollment in a health insurance plan. Consumers and/or their employers usually pay it monthly.

Copayment (sometimes called a "copay")

A copayment is a fixed amount (e.g., $15) consumers pay health care providers for a covered health care service, usually at the time of service. Consumers pay the full cost of services until they meet their deductible, then they begin to pay the copayment or coinsurance amount. The amount can vary by the type of covered service — visiting a doctor, filling a prescription, or going to the emergency room. Copayments are generally lower for services delivered by primary care providers and higher for services delivered by specialists. Copayments for in-network providers are typically lower than copayments for out-of-network providers. Copayments are also typically lower for generic prescription drugs than for brand name prescription drugs.

Deductible

A deductible is the amount consumers pay out-of-pocket for certain covered health care services before their health insurance plan begins to pay. Many plans pay for certain services, like a checkup or disease management program, before a consumer has met their deductible.

Premiums don't count toward the deductible. For example, if a consumer's deductible is $1,000, the plan won't pay anything until the consumer has paid $1,000 for covered health care services. However, some health care services aren't subject to the deductible and may be covered by health insurance plans even if consumers haven't met the deductible. The deductible may not apply to all services.

Coinsurance

Coinsurance is a consumer's share of the cost of a covered health care service calculated as a percentage (e.g., 20 percent) of the amount allowed by the health plan for that service. Consumers pay the full cost of services until they meet their deductible, then they begin to pay the copayment or coinsurance amount. For example, if a health insurance plan's allowed amount for an office visit is $100, the coinsurance level for the service is 20 percent, and the consumer has met the deductible, the consumer pays 20 percent of $100, or $20. The health insurance plan pays the remaining 80 percent, or $80. Most plans may require a copayment and/or coinsurance for particular types of services.

Out-of-Pocket Costs

Out-of-pocket costs are consumers' expenses for medical care that aren't paid by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services. Consumers pay out-of-pocket costs in addition to their monthly premiums. Some consumers may be eligible for savings on out-of-pocket costs, called cost-sharing reductions (CSRs), based on their household incomes and sizes. CSRs will be reviewed later in the training.

The amount paid is limited by an out-of-pocket maximum. After the out-of-pocket maximum is reached in a plan year, the insurance company generally must pay for all covered benefits without imposing out-of-pocket costs. This limit includes deductibles, copayments, coinsurance, and any other amount that may be required to pay for benefits. This limit doesn't include premiums, extra amounts consumers pay for out-of-network cost sharing, or the cost of benefits that aren’t covered.

Out-of-Pocket Maximum

Monthly premiums do not count toward the out-of-pocket limit, nor does any amount consumers may spend for services that their health plan doesn't cover. Insurance companies also may exclude from the out-of-pocket limit any cost sharing for services outside of the network.

The maximum out-of-pocket limit any 2025 Marketplace plan can have is $9,200 for an individual and $18,400 for a family, but many plans will have lower out-of-pocket limits. Keep in mind that this doesn’t include monthly premium amounts.

Costs Associated With Health Insurance (Cont’d.)

Here are a few more terms about the costs of insurance that you can explain to consumers.

Claim

A claim is a request for payment that consumers or health care providers submit to a health insurance company for items or services they think are covered.

Allowed amount

An allowed amount is the maximum amount a health insurance company will pay for a covered health service. This may also be called an “eligible expense,” “payment allowance," or "negotiated rate." If providers charge more than the allowed amount, consumers may have to pay the difference (known as balance billing).

Balance billing

Balance billing happens when providers bill consumers for the difference between the provider's charge and the amount allowed by the health plan. For example, if a provider charges $100 and the allowed amount is $70, the provider may bill the consumer for the remaining $30. Some providers may not balance bill consumers for covered services. This typically happens when providers have a contract with consumers' health insurance companies to provide services at a discount, also known as a preferred provider or network agreement. It’s important for consumers to understand their plan's provider network and that they may have to pay more to visit certain providers if they’re outside of the plan’s provider network.

Note: As of January 1, 2022, the No Surprises Act prohibits out-of-network providers, facilities, or providers of air ambulance services from billing individuals more than the applicable cost-sharing amounts in three main scenarios:

- A person gets covered emergency services from an out-of-network provider or out-of-network emergency facility;
- A person gets covered non-emergency services from an out-of-network provider delivered with respect to a visit to an in-network health care facility; or
- A person gets covered air ambulance services provided by an out-of-network provider of air ambulance services.

Knowledge Check

Helen is a 46-year-old mother of three children. Her husband's health insurance plan has a $1,000 deductible for the family each plan year. Helen's 8-year-old son requires a medical procedure that will cost $1,500. The family already paid $750 toward the deductible this year.

Assuming that the service is covered by the health insurance plan, there are no copayments or coinsurance, and balance billing doesn't apply, what will Helen pay for her son's medical procedure?

Answer: Helen’s cost for her son’s medical procedure will be $250, the remaining balance of the $1,000 annual deductible.

Formulary or Drug List

Health plans use the term formulary, or drug list, to describe the list of prescription drugs that they cover. A drug formulary is a list of prescription drugs that a health insurance plan covers, including generic, brand-name, and specialty drugs. It typically includes details about the out-of-pocket costs consumers pay for each type of covered drug.

When helping consumers compare plans through the Marketplace, advise them to make sure that any drugs they're currently taking are listed on a plan's drug formulary before enrolling in that plan. Here are a few things to keep in mind when reviewing drug formularies with consumers.

- Formularies change regularly.
- They differ by the type of healthcare plan and also by how many categories and classes of medicines are covered. For example, a category of drugs may be blood glucose regulators. Insulins are the class for this drug.
- There are several different ways you can find drug coverage information, including:
    - The plan's SBC.
    - The "My plans & programs" page at HealthCare.gov.

Insurance companies often use an outside pharmacy benefits manager to provide coverage for prescription drugs. In this case, consumers may receive a separate insurance card for prescription drugs. Consumers may need to have this card with them when they pick up prescription drugs at a doctor's office or pharmacy.

Review Getting prescription medications | HealthCare.gov for more information.

Formulary Tiers

Tiers are groups of drugs with different cost sharing for each group. A drug in a lower tier will cost a consumer less than a drug in a higher tier. Each plan can divide its tiers in different ways. In general, a tiered formulary encourages consumers to select lower-cost drugs, like generic (non-brand-name) drugs.

Here's an example of a three-tiered formulary approach:

- The first tier includes generic drugs with the lowest cost to consumers (e.g., a $10 copayment).
- The second tier includes preferred brand-name drugs with a higher cost to consumers (e.g., a $25 copayment).
- The third tier includes non-preferred brand-name drugs with the highest cost to consumers (e.g., a $40 copayment).

If a plan uses tiers, its formulary will list which drugs are included in each tier.

Key Points

- Health insurance companies often contract with a network of health care providers to provide care to consumers. Plans may differ based on provider networks, how much consumers are responsible for paying, and the benefits they offer.
- Health insurance companies use deductibles, copayments, and coinsurance to share health care costs with consumers.
- A formulary, or drug list, describes the list of prescription drugs covered by a health insurance plan and includes details about the copayments or coinsurance required for each drug type.
- For Plan Year 2025, the maximum out-of-pocket limit any 2025 Marketplace plan can have is $9,200 for individual coverage and $18,400 for group coverage.

Module 4 - Summary of Benefits and Coverage (SBC)

Introduction

Under the Affordable Care Act (ACA), health insurance companies and health plans (i.e., health plans provided by employers, also known as employer-sponsored coverage, or ESC) offering group and individual coverage are required to give consumers an easy-to-understand summary of health plan benefits and coverage in a culturally and linguistically appropriate manner. This is called a Summary of Benefits and Coverage (SBC). By the end of this module, you should be able to understand the following concepts and accomplish the tasks below them.

SBC Purpose

State the purpose of an SBC

How to Obtain an SBC

Describe how to obtain an SBC

SBC Content

Describe the information provided in an SBC, including the Uniform Glossary of Terms

Purpose of the SBC

The SBC helps consumers understand their health care costs under a specific plan in plain language.

SBCs make it easier for consumers to compare different coverage options by summarizing key features of health plans, including:

- Covered benefits.
- Cost-sharing provisions.
- Coverage limitations and exceptions.

Most health insurance companies and health plans can't set dollar limits on what they will pay in a year for essential health benefits (EHB) while a consumer is enrolled in a particular health plan.

For more information on SBCs, refer to the

Understanding the Summary of Benefits and Coverage job aid and the

Summary of Benefits and Coverage webinar.

Information Provided on the SBC

All SBCs contain the following information:

Benefit Summary

A summary of plan information must be placed prominently at the beginning of the document.

Coverage Examples

The summary must include the estimated costs for three medical scenarios: having a baby, managing Type 2 diabetes, and emergency room treatment for a simple fracture. These estimates are based on national average costs and in-network benefit levels under each plan.

These coverage examples help consumers compare one plan's coverage to another.

Website and Phone Number

A prominently displayed website and phone number indicate where consumers can get additional information.

Minimum Essential Coverage/Minimum Value Standard

The summary must indicate whether a plan provides minimum essential coverage and meets the minimum value standard.

A sample SBC form can be found at Summary of Benefits and Coverage | HealthCare.gov.

Plan information

If important enhancements or reductions in benefits are made to a consumer's coverage during a coverage year, the consumer's health insurance company or plan must provide a notice describing any changes that aren't reflected in the most recent SBC for that coverage or plan. It must be provided to enrollees not later than 60 days before changes take effect. Changes made at annual renewal don't require a 60-day advance notice.

Uniform Glossary of Terms

Under the ACA, insurance companies and health plans are required to describe their coverage using a uniform glossary of commonly used terms, like **deductible** and **copayment** and make this glossary available to consumers. The Centers for Medicare & Medicaid Services (CMS) and the Department of Labor (DOL) also post the glossary at

Summary of Benefits and Coverage (SBC) and Uniform Glossary | CMS and

Summary of Benefits and Coverage and Uniform Glossary | U.S. Department of Labor (dol.gov).

Additional resources are available to help consumers understand and use an SBC, including:

- Regulations & Guidance
- Fact Sheets & FAQs
- Letters & News Releases
- Other Resources

Ways to Obtain an SBC

Health insurers and health plans must provide an SBC:

- When consumers enroll in coverage for the first time.
- At the beginning of each new plan year.
- Within seven business days after a consumer requests a copy.

Insurers may provide SBCs by mail or electronically as long as they make a paper copy available upon request.

If an SBC is posted on the internet, consumers must be notified about where the SBC is posted, and that the SBC is available in paper form free of charge upon request. The electronic version must be in a format that's readily accessible.

A health insurer that provides an SBC for individual health insurance coverage to the Department of Health and Human Services (HHS) for posting to HealthCare.gov has satisfied the requirement to provide a copy upon request.

Knowledge Check

Are the following statements about an SBC true or false?

An SBC contains a consumer's estimated costs for three medical scenarios: having a baby, managing Type 2 diabetes, and emergency room treatment for a simple fracture.

Health insurers and health plans must provide an SBC within seven business days after a consumer requests a copy.

An SBC summarizes key features of health plans, including covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

Answer: True. An SBC must summarize key features of a health plan, including covered benefits, cost-sharing provisions, and coverage limitations and exceptions. It must include a beneficiary's estimated costs for three medical scenarios: having a baby, managing Type 2 diabetes, and emergency room treatment for a simple fracture. A health insurer or health plan must provide an SBC within seven business days after a consumer requests a copy. Finally, insurers may provide SBCs in person, by mail, by email — if consumers consent to receive their SBCs electronically — or may also post SBCs online, provided applicable requirements are met.

Key Points

- Insurers and health plans must provide to consumers a SBC detailing simple and consistent information about their coverage and benefits.
- An SBC must contain examples of consumer costs for specific scenarios as well as cost-sharing limits and contact information.
- The Uniform Glossary of Terms provides definitions for key terms used in an SBC.

Module 5 - Types of Health Coverage

Introduction

Health coverage is available from a variety of sources. Some consumers purchase health insurance through the Marketplaces or directly from a health insurance company, while others get health coverage through their jobs or meet eligibility requirements to participate in government health coverage programs.

By the end of this module, you should be able to understand the following concepts and accomplish the tasks below them.

Available Coverage Options

Understand the types of private and public coverage options that might be available to consumers through the FFMs, including Marketplace plans, Medicaid, and the Children's Health Insurance Program (CHIP).

Managed Care Plans

Describe the types and features of managed care plans.

Other Coverage Options & Features

Describe the types and features of private health insurance plans and public programs.

Private Health Coverage Options

Health Insurance through the Marketplaces

Qualified consumers can enroll in individual coverage through the Marketplaces during the annual Open Enrollment Period (OEP) and applicable special enrollment periods (SEPs). The insurance plans offered in the Marketplaces are called qualified health plans (QHPs). The Marketplaces certify each QHP sold in a state. QHPs, among other things, must provide a comprehensive benefits package called essential health benefits (EHB) and follow limits on cost sharing.

Employer-sponsored coverage (ESC) can be made available by eligible small employers through the Small Business Health Options Program (SHOP) Marketplaces. If available, an employer will generally set the enrollment period for their employees, but SEPs may also be available depending upon employees' individual circumstances. The SHOP Marketplaces are covered in more detail in other courses.

Health Insurance Outside the Marketplaces

Consumers can also get individual market coverage directly through a health insurance company that sells insurance outside the Marketplaces. Health insurance companies are required to accept enrollments for coverage outside the Marketplaces during the individual market OEP and applicable SEPs. Coverage becomes effective along the same timelines that apply in the Marketplaces. However, if consumers purchase health insurance in the individual market outside the Marketplaces, they won't benefit from Marketplace programs to help lower their costs.

Note: Plans offered outside the Marketplaces might not be required to meet all of the same standards as QHPs.

Employer-sponsored Coverage (ESC)

Consumers who are currently employed may be able to purchase ESC through their employers.

If consumers lose or quit their jobs, they often may:

- Extend their ESC through a program called Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage.
- Be eligible for a special enrollment period (SEP) to purchase an individual market QHP through the Marketplaces or to purchase coverage outside the Marketplaces.
- Be eligible for Medicaid/CHIP.

Health Reimbursement Arrangements (HRAs)

A Health Reimbursement Arrangement (HRA) is available through an employer but isn’t traditional health coverage. An HRA is a group health plan funded solely by employer contributions that reimburses an employee’s medical care expenses, like premiums and cost sharing, up to a maximum dollar amount for a coverage period. There are two types of HRAs that you should be familiar with:

1. Individual Coverage Health Reimbursement Arrangement (ICHRA):
    - May be offered by employers of all sizes as long as they have one employee who isn’t a self-employed owner or the spouse of a self-employed owner and requires eligible employees and any covered dependents to have individual health insurance coverage (such as a Marketplace QHP) or Medicare Parts A and B or Part C for each month they are covered in order to receive reimbursements for medical care expenses, like premiums and cost sharing.
    - If an employee is offered an ICHRA that is affordable, they are not eligible for APTC if they enroll in Marketplace coverage. However, they can use their ICHRA to help pay premiums for their Marketplace QHP.
    - If an employee is offered an ICHRA that is not affordable, they may "opt out" of the ICHRA offer to be APTC-eligible, if they otherwise qualify for APTC.

2. Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)
    - May be offered by employers with fewer than 50 full-time employees who don't offer group health plan coverage to any of their employees and requires eligible employees and any covered dependents to have minimum essential coverage (such as a Marketplace QHP or Medicare) in order to receive reimbursements for a portion of medical care expenses. Minimum essential coverage is covered in more detail in Course 3 – Affordable Care Act Basics.
    - Employees who enroll in a Marketplace QHP and qualify for APTC should consider reducing their monthly APTC by their monthly QSEHRA amount so that they do not have to pay some or all of it back when they file their federal income tax return.

COBRA

Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage lets most consumers continue with their existing ESC for a limited period of time, typically at a higher cost than when they were employed, as employers aren't required to pay any portion of the premiums and can charge an additional 2 percent for administrative costs. Typically, consumers have 60 days from their last day of health coverage or when they received the election notice to enroll in COBRA continuation coverage.

Instead of choosing COBRA continuation coverage, qualified consumers who lose ESC generally may enroll in individual health insurance coverage, either through the Marketplace or outside the Marketplace, within a certain time period.

Coverage Under a Parent's Plan

In all states, young adults are eligible to enroll in or remain on health coverage under their parents' health plans until they turn 26 (or older in some states) if those plans cover dependent children.

- If a young adult is covered by a parent's job-based plan, their coverage usually ends when they turn 26 (or older, if permitted by the state). But they should check with the employer plan.
- If a young adult is on a parent's Marketplace plan, they can remain covered through December 31 of the year they turn 26 (or older, if permitted by the state).

Health Insurance in the Private Market

Consumers who enroll in private health insurance generally choose between a few common types of managed care plans. These plans give consumers different levels of access to providers.

Plans like indemnity plans provide alternatives to managed care.

HMO

An HMO (Health Maintenance Organization) is a health insurance plan that usually limits coverage to care from in-network providers who work for or contract with the HMO. HMO plans usually require consumers to get a referral from their primary care provider to visit a specialist, and they generally won't cover out-of-network care except in an emergency. In exchange for the limited access to providers, premiums are typically lower in an HMO than in other types of plans.

PPO

A PPO (Preferred Provider Organization) is a health plan that contracts with health care providers to create a network of participating providers. Consumers pay less if they use providers that belong to the plan's network (e.g., in-network providers). Consumers can visit providers outside of the network (e.g., out-of-network providers) at an additional cost. Referrals aren’t needed to visit specialists. In exchange for greater access to providers, premiums are generally higher in a PPO than in an HMO.

POS

A POS (Point of Service) plan is a type of plan in which consumers pay less if they use health care providers that belong to the plan's network. With this type of plan, a consumer may go to out-of-network providers at a higher cost. Unlike PPO plans, POS plans generally require consumers to get a referral from their primary care doctor to visit a specialist.

EPO

An EPO (Exclusive Provider Organization) is a managed care plan where services are covered only if you use providers in the plan’s network (except in an emergency). Services received outside the network must generally be paid for entirely by the consumer.

Indemnity Plan

An indemnity plan lets consumers choose their own providers, and the health insurance company reimburses providers for a portion of the total cost of each service that consumers use.

HDHP

A HDHP (High Deductible Health Plan) is a type of health plan that features higher deductibles than traditional insurance plans in exchange for lower monthly premiums. HDHPs can be combined with a health savings account (HSA) or a flexible spending account (FSA). HSAs and FSAs let a consumer pay for qualified out-of-pocket medical expenses on a pretax basis. The money that's contributed to an HSA or an FSA isn't subject to federal income tax at the time of deposit but must be used to pay for qualified medical expenses. HSA distributions for purposes other than qualified medical expenses are subject to income taxes plus an additional 20 percent tax. A consumer generally uses the money in the HSA to help meet the deductible before the HDHP begins to pay for services. Funds contributed to an HSA roll over year to year if a consumer doesn't spend them, but most FSA funds don't carry over from year to year. In other words, any FSA funds that consumers don't spend by the end of the plan year generally can't be used for expenses in the next year. HDHPs may be more expensive for consumers with chronic or serious health conditions that require multiple specialist visits and procedures. It's important to remind consumers to consider these financial factors before deciding on a plan. However, you may not provide tax advice in your role as an assister.

Catastrophic Health Plan

Catastrophic plans are health plans that meet all of the requirements applicable to other Marketplace plans but don't cover any benefits (other than at least three primary care visits per year and certain preventive services) before the plan's deductible is met. The premium amount consumers pay each month for health care is generally lower than for other Marketplace plans, but the out-of-pocket costs for deductibles, copayments, and coinsurance are generally higher. Generally, people under 30 years of age before the beginning of the plan year or people age 30 and older with hardship exemptions or affordability exemptions may buy a Catastrophic health plan.

Knowledge Check

Juan, a 50-year-old construction supervisor, is very particular about the doctors he visits for his back problem. He asks you which plans will cover out-of-network care and pay for at least a portion of the health care costs.

What types of health insurance plans should you tell him would give him access to those features?

Answer: Both PPO and POS plans cover out-of-network care and pay for a portion of those health care costs for covered benefits. HMOs and EPOs generally don’t cover out-of-network care, and services received outside the network must generally be paid for entirely by the consumer.

Public Health Coverage Options

When consumers apply for coverage through the Marketplaces with financial assistance, their applications will be reviewed to determine if they're eligible for public health coverage through Medicaid and CHIP. It's important for you to understand how these government-operated health coverage programs work so you can help consumers identify the type of coverage that’s right for them. For the same reason, it's also important for you to have basic knowledge of other government-operated health programs that might be available to consumers.

Note: Like private health insurance, some public programs, such as Medicaid or CHIP, may have small premiums or copayments for consumers to pay to participate in the program. These cost-sharing amounts may be different depending on the state.

Medicaid

A state-administered health coverage program that provides free or low-cost health coverage to some low-income families and children, pregnant individuals, older adults, people with disabilities, and, in many states, other adults. The Federal Government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their programs, so Medicaid programs vary state by state and may have a different name in your state.

CHIP

CHIP is a program jointly funded by the federal and state governments that provides health coverage to uninsured low-income children and, in some states, pregnant individuals in families with income too high to qualify for Medicaid but who can't afford private health insurance.

Medicare

Medicare is the federal health coverage program for people who are 65 or older, certain younger people with disabilities, and people with end-stage renal disease (ESRD) (permanent kidney failure requiring dialysis or a transplant). Medicare beneficiaries pay a premium or qualify for benefits coverage based on payment of payroll taxes.

TRICARE

TRICARE is the Department of Defense’s health care program available to eligible members and their families of the eight U.S. uniformed services: the Army, Navy, Air Force, Marine Corps, Space Force, Coast Guard, Commissioned Corps of the Public Health Service, and the National Oceanic and Atmospheric Administration.

Veterans Affairs (VA) Health Benefits

The VA provides coverage for eligible veterans who served in the U.S military. The VA administers a variety of benefits and services that provide financial and other forms of assistance to service members, veterans, and their dependents and survivors.

Peace Corps

The Peace Corps provides volunteers with comprehensive health and dental insurance during their Peace Corps service.

Knowledge Check

Which coverage program would generally allow consumers to continue to purchase their existing employer-sponsored coverage if they lost or quit their job?

Answer: COBRA generally lets consumers continue to purchase their same employer-sponsored coverage if they lose or quit their jobs.

Key Points

- It's important for you to know about the different types of private and public coverage that might be available to consumers and to be able to explain the coverage options that might be available to consumers through the FFMs.
- Managed care is a way insurance companies manage cost, quality, and access to health care services.
- The most common types of health insurance plans consumers should know about include PPOs, POS plans, HMOs, HDHPs, and Catastrophic health plans.

Module 6 - Introduction to Medicaid

Introduction

It's important to know how Medicaid programs work with the Affordable Care Act (ACA) and the Marketplaces, in order to best help consumers who are or may be eligible for Medicaid. By the end of this module, you should be able to understand the following concepts and complete the tasks below them.

Benefits

List the mandatory Medicaid benefits

Types of Consumers

Identify the types of consumers eligible for Medicaid

Eligibility

Explain Medicaid eligibility and presumptive eligibility rules and requirements

Medicaid: What's New

Here's what's new in Medicaid policy:

Medicaid Coverage for Former Foster Care Youth who Turn 18 on or After January 1, 2023

As of January 1, 2023, a provision in the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act expanded coverage for former foster care youth that turn 18 on or after January 1, 2023, and move to a new state.

With this new policy, Section 1002 of the SUPPORT Act mandates that former foster care youth that are covered under Medicaid and turn 18 on or after January 1, 2023, are eligible to keep their Medicaid coverage across the country. Currently, the Marketplace considers eligibility for Medicaid for the former foster care category by asking specific questions about past participation in foster care for applicants aged 18-26 for this reason.

Option to Provide 12 months of Medicaid Coverage to Postpartum Individuals

As of April 1, 2022, states have an option to provide 12 months of continuous Medicaid coverage to postpartum individuals enrolled in Medicaid. If adopted for Medicaid, the state must also elect to apply the extended postpartum coverage to separate Children's Health Insurance Program (CHIP) coverage in the state for beneficiaries who are low-income pregnant children and low-income pregnant individuals, as applicable. Assisters should check with their state authorities to determine whether the state they operate in has exercised this option and the state timeline for implementation.

Continuous Eligibility for Children Enrolled in Medicaid/CHIP

Effective January 1, 2024, under the Consolidated Appropriations Act of 2023, states must maintain 12 months of continuous eligibility for most children enrolled in Medicaid and CHIP.

Medicaid Basics

Medicaid provides health coverage to millions of people in America, including:

- Low-income adults.
- Parents and children.
- Pregnant individuals.
- Older consumers.
- Individuals with disabilities.

In general, consumers must meet financial eligibility criteria and certain non-financial eligibility criteria to be eligible for Medicaid. Modified Adjusted Gross Income (MAGI) is the basis for determining Medicaid income eligibility for most children, pregnant individuals, parents, and adults. The MAGI-based methodology considers taxable income and tax filing relationships to determine financial eligibility for Medicaid. Additionally, to be eligible, consumers must be residents of the state in which they are receiving Medicaid. They must be either citizens of the United States or certain qualified noncitizens, such as lawful permanent residents (LPRs). In addition, some eligibility groups are limited by age, by pregnancy or parenting status.

Federal law requires states to cover certain groups of individuals, referred to as “mandatory eligibility groups.” Low-income families, qualified pregnant individuals and children, and individuals receiving Supplemental Security Income (SSI) are examples of mandatory eligibility groups.

States have a great deal of flexibility in designing and administering their programs. Each state operates its own Medicaid program within federal guidelines around:

- Setting eligibility standards.
- Determining the type, amount, and scope of services provided.
- Establishing payment rates for Medicaid services.

Mandatory Medicaid Benefits and Cost Sharing

Medicaid provides a wide range of benefits to eligible consumers, and most Medicaid coverage is considered minimum essential coverage (MEC). While all state Medicaid agencies are generally required to provide certain benefits to certain beneficiaries, some states may choose to provide additional benefits. You should familiarize yourself with the benefits covered by your state's Medicaid program.

You can also review a comprehensive list of mandatory and optional benefits at the Medicaid.gov Mandatory & Optional Medicaid Benefits webpage.

Mandatory Medicaid benefits in all states include:

- Home health services.
- Physician services.
- Rural health clinic services.
- Federally qualified health center services.
- Laboratory and X-ray services.
- Family planning services.
- Early and periodic screening, diagnostic, and treatment services for eligible children (which includes health screenings for children and treatment if medical problems are identified).
- Inpatient hospital services.
- Outpatient hospital services.
- Nursing facility services.
- Nurse midwife services.
- Certified pediatric and family nurse practitioner services.
- Freestanding birth center services (when licensed or otherwise recognized by the state).
- Transportation to medical care.
- Tobacco cessation counseling for pregnant individuals.
- COVID-19 testing, treatment, and vaccinations (through September 30, 2024)
- Medication Assisted Treatment for opioid use disorder (MAT)
- Routine patient costs of items and services for beneficiaries enrolled in qualifying clinical trials.

States have the option to charge premiums and to establish out-of-pocket spending (cost sharing) requirements for Medicaid enrollees. Out-of-pocket costs may include copayments, coinsurance, deductibles, and other similar charges. Maximum out-of-pocket costs are limited, but states can impose higher charges for targeted groups of somewhat higher income people. Certain vulnerable groups, such as children and pregnant individuals, are exempt from most out-of-pocket costs and copayments and coinsurance cannot be charged for certain services.

COVID-19 Testing, Treatment, and Vaccinations

Medicaid coverage of COVID-19 testing, treatments and vaccinations currently varies by state. State Medicaid programs are currently required to cover COVID-19 vaccinations, testing, and treatments without cost sharing under the American Rescue Plan Act of 2021 (ARPA) but this coverage requirement will end on September 30, 2024.

Medicaid Eligibility Based on Categorical Requirements

You already learned that consumers must meet certain financial requirements to qualify for Medicaid. Nonfinancial requirements, such as state residence or U.S. citizenship or satisfactory immigration status, can also affect eligibility.

Under federal law, all states are required to cover certain groups of consumers called mandatory eligibility groups. These include:

- Pregnant individuals at or below a certain household income level.
- Children and parents/caretaker relatives in households at certain income levels.
- People with disabilities.
- Certain low-income older adults.

Some states choose to cover other groups of consumers called optional eligibility groups, which are those that federal law doesn't require states to cover under Medicaid. Common examples include:

- Medically needy consumers.
- Individuals with disabilities who are employed.

Medicaid coverage for optional groups varies from state to state.

It's important that you know which groups are covered by Medicaid and the household income requirements for each of them in your state.

In All States: Mandatory Eligibility Groups

Let's review each mandatory eligibility group in more detail.

Low-income Pregnant Individuals

All states must cover pregnant individuals whose household income is at or below at least 138 percent of the federal poverty level (FPL) and who meet all other eligibility criteria (e.g., state residency and immigration/citizenship requirements). Many states choose to set a higher household income level for pregnant individuals. Once Medicaid eligibility is established, pregnant individuals remain eligible during their pregnancy and postpartum period, which begins on the date the pregnancy ends through the last day of the month in which the 60-day period following the pregnancy ends.

States have the option to provide 12 months of extended postpartum coverage for individuals enrolled in Medicaid or CHIP while pregnant. Assisters should check with their state authorities to determine whether the state they operate in has exercised this option, as most states have elected 12-month postpartum extension.

States are also required to cover newborn children born to individuals who are enrolled in Medicaid or CHIP as a targeted low-income pregnant individual effective on the date of birth, including as a result of the birthing parent's retroactive eligibility in Medicaid. The newborn children are then continuously eligible for Medicaid or CHIP for the first year of life. If a newborn child can't be determined eligible for Medicaid based on the parent's enrollment, the parent(s) should be encouraged to submit an application for the child to the state Medicaid or CHIP agency as soon as possible. Individuals, including newborn children, can be found retroactively eligible for Medicaid for up to three months prior to application if they would have been eligible and received Medicaid covered services during that retroactive period.

Children in Low-income Households

In practice, all states must cover children whose family income is at or below 138 percent of the FPL and who meet all other eligibility criteria. All states have chosen to expand Medicaid coverage for children beyond the minimum eligibility threshold.

Additionally, states are required to cover:

- Children who are recipients of adoption assistance and foster care under Title IV-E of the Social Security Act.
- Former foster children and youth. The SUPPORT Act made changes to the Medicaid eligibility requirements for this eligibility group that apply exclusively to individuals who turn 18 on or after January 1, 2023, these individuals:
    - Are under the age 26;
    - Are not enrolled in any other Medicaid eligibility group;
    - Were in foster care under the responsibility of any state up to age 18 (or such higher age as the state has elected in its title IV-E plan); and
    - Were enrolled in Medicaid in any state while in such foster care in the state (or a higher age, up to 21, as elected by the state).

Low-income Parents or Caretaker Relatives

Low-income parents and other relatives (called "caretaker relatives") who care for dependent children are covered by Medicaid in every state if they meet their state's income requirements and all other eligibility criteria. The income thresholds for this group vary by state.

In states that have expanded Medicaid to the adult group and have a parent/caretaker eligibility level below 138 percent of the FPL, low-income parents and caretakers whose income is too high for the parent/caretaker group may be eligible in the adult group.

More information on Medicaid and CHIP eligibility is available at

Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels | Medicaid.

Elderly, Blind, or Disabled Individuals

Medicaid is also available to aged, blind, and/or disabled individuals who:

Receive Supplemental Security Income (SSI) payments or are considered to be receiving such payments;

Live in states that elect not to provide Medicaid to elderly, blind, or disabled individuals receiving SSI payments but who meet eligibility rules that are more restrictive than those for SSI;

Are eligible for Medicare and have limited household income and resources, also called "dual-eligible."

In Some States: Optional Eligibility Groups

There are many optional eligibility groups that federal law doesn't require states to cover under Medicaid. A few examples include:

- Children at higher income levels.
- "Medically needy" consumers: Medically needy consumers are those with significant health needs whose income is too high to otherwise qualify for Medicaid under other eligibility groups. Medically needy individuals can still become eligible by “spending down” the amount of income that is above a state's medically needy income standard. This process allows consumers to subtract or "spend down" their medical expenses from their income and other measurable financial resources to become eligible.
    - Consumers who are enrolled in a state Medicaid spend-down program or who have an application pending for spend down may be eligible for APTC or CSRs if they apply for those programs and enroll in a QHP through their state's Marketplace.
- Consumers living in medical institutions (e.g., nursing facilities) if their income is up to 300 percent of the SSI federal benefit rate. The SSI federal monthly benefit rate is $943 for an eligible individual, $1,415 for an eligible individual with an eligible spouse, and $472 for an essential person in 2024.
- Individuals with disabilities who are employed.

Knowledge Check

Which two groups of people are required by federal law to be covered by Medicaid?

Answer: Federal law requires all states to cover pregnant individuals at or below a certain household income level and children in low-income households. States have the option to cover those designated as "medically needy" and consumers living in medical institutions (if their income is up to 300 percent of the SSI federal benefit rate).

Presumptive Eligibility for Medicaid

Presumptive eligibility allows states to designate certain "qualified entities" to immediately enroll individuals who are likely eligible under a state’s Medicaid eligibility guidelines for a temporary period of time. States have the option to require qualified entities to assist individuals in submitting the full Medicaid application, but a full application cannot be required as a condition of receiving a presumptive eligibility determination.

The presumptive eligibility determination is based on an individual providing information about their income and household size and, at state option, information regarding citizenship, immigration status, and residency. If the individual appears to be eligible for Medicaid based on this self-attested information, the qualified entity shall determine that individual to be “presumptively eligible” for Medicaid.

You might encounter consumers who are receiving temporary Medicaid coverage through presumptive eligibility and who haven’t yet completed the Medicaid application process. Let these consumers know that they won't be able to keep their Medicaid coverage beyond a limited time if they don't complete and submit a Medicaid application prior to the end of their presumptive eligibility period.

Qualified Entities

States can authorize entities like hospitals, health clinics, or schools to temporarily enroll consumers and their families in Medicaid coverage if they appear eligible.

Not all qualified entities are authorized by the state to make presumptive eligibility determinations for all individuals. For example, some may only be authorized to make presumptive eligibility determinations for children and pregnant individuals, but not low-income parents or caretaker relatives.

Not all hospitals are qualified to make presumptive eligibility decisions.

Nonfinancial Requirements for Medicaid

If consumers belong to a mandatory or optional eligibility group in their state and meet applicable financial requirements, they must also meet certain nonfinancial verification requirements to be eligible for Medicaid. For example, these consumers may need to provide proof of the following:

- State residency.
- Citizenship or satisfactory immigration status.
- Social Security Number (SSN).

Consumers with SSNs who apply for Medicaid coverage through a Marketplace must provide their SSN in the Marketplace application. If they don't, it will slow down the application process, and they will have to provide it later.

Medicaid and Immigration Status

You have learned the mandatory benefits available under Medicaid and the eligibility groups it covers. Some noncitizens may be eligible for limited Medicaid benefits. Let's review how immigration affects Medicaid eligibility.

Immigrants who are **qualified noncitizens** may be eligible for coverage through Medicaid and CHIP, if they otherwise meet their state's income and residency rules. In order to get Medicaid and CHIP coverage, most qualified non-citizens (such as many lawful permanent residents or green card holders) have a **five-year waiting period**. This means they must wait five years after receiving "qualified" immigration status before they can get Medicaid and CHIP coverage. There are exceptions to the five-year waiting period. Some noteworthy exceptions are:

- Refugees, asylees, or former refugees and asylees who have been granted lawful permanent resident status.
- At state option, lawfully present children up to age 19 for CHIP or up to age 21 for Medicaid and lawfully residing pregnant individuals if they otherwise meet all other eligibility requirements of their state. This is commonly known as the "CHIPRA 214 option."
- Citizens of the Marshall Islands, Micronesia, and Palau who are living in one of the U.S. states (referred to as Compact of Free Association or COFA migrants) if they otherwise meet all other eligibility requirements of their state.

All states are required to provide limited Medicaid coverage necessary for treatment of an emergency medical condition to consumers who would otherwise qualify for Medicaid but who aren't U.S. citizens or don't have satisfactory immigration status. Therefore, certain immigrants who aren't eligible for full Medicaid benefits may be able to get limited Medicaid coverage for treatment of an emergency medical condition even if they don't have a satisfactory immigration status.

Qualified Noncitizens

Qualified noncitizens include immigrants who have one or more of the following immigration status classifications:

- Lawful permanent residents (LPRs/Green Card holders).
- Asylees.
- Refugees.
- Cuban/Haitian entrants.
- Paroled into the U.S. for at least one year.
- Conditional entrants granted entry to the U.S. before 1980.
- Battered noncitizens, spouses, children, or parents.
- Victims of trafficking and their spouses, children, siblings, or parents, including individuals with a pending application for a Victim of Trafficking visa.
- Individuals who are granted Withholding of Deportation.
- Member of a Federally recognized Indian Tribe or American Indian born in Canada.
- COFA migrants.

Five-year Waiting Period

Many qualified noncitizens, including lawful permanent residents (LPRs), must wait five years after receiving “qualified” immigration status before they can get Medicaid or CHIP coverage. There are exceptions. For example, refugees or asylees don’t have to wait five years. The clock on the five-year waiting period begins on the date the individual first received qualified nonimmigrant status.

Emergency Medical Condition

An emergency medical condition is a condition that presents acute symptoms of sufficient severity, like severe pain, that, without immediate medical attention, could reasonably be expected to result in the following:

- Placing the consumer's health in serious jeopardy.
- Causing serious impairment to bodily functions.
- Causing serious dysfunction of any bodily organ or part.

Under emergency Medicaid, a heart attack and emergency labor and delivery are two examples of emergency medical conditions. States have some flexibility to define what conditions would be included under the definition of an emergency medical condition, in accordance with section 1903(v)(2) and (v)(3) of the Social Security Act.

Limited Medicaid Benefits

As an assister, you might help consumers who qualify for limited Medicaid benefit packages that aren’t considered minimum essential coverage (MEC). You can help these consumers submit a Marketplace application. Individuals and families may also be eligible for financial assistance with their Marketplace coverage, like premium tax credits and cost-sharing reductions (CSRs). More information about financial assistance with Marketplace coverage is available in a different training course.

- Limited Medicaid benefits packages that don't count as MEC generally include:
- Medicaid providing only family planning services.
- Medicaid providing only tuberculosis-related services.
- Medicaid providing only coverage limited to treatment of emergency medical conditions.
- Some types of medically needy coverage.
- Some coverage packages under states’ section 1115 Medicaid demonstration projects.

These programs currently aren't classified as meeting MEC standards. However, to the extent that certain programs within these categories provide comprehensive coverage, the Department of the Treasury and/or the Department of Health and Human Services (HHS) may recognize these programs as MEC.

Key Points

- Medicaid is a comprehensive health coverage program for low-income adults, parents and children, pregnant individuals, older consumers, and individuals with disabilities.
- All state Medicaid agencies are generally required to provide certain benefits to certain Medicaid beneficiaries while some states choose to provide additional benefits.
- You can help consumers who receive limited Medicaid benefits submit a Marketplace application. Individuals and families may also be eligible for financial assistance (i.e., APTC or CSRs) with Marketplace coverage.

Module 7 - Introduction to CHIP

Introduction

Many household members of consumers you assist will also qualify for the Children's Health Insurance Program (CHIP), another public health coverage program. You'll need to be familiar with CHIP and the eligibility requirements in your state. By the end of this module, you should be able to understand the following concepts and accomplish the tasks below them.

Who is Covered

Identify who is covered by the CHIP program.

Benefits

Describe the benefits of CHIP.

Eligibility

Explain CHIP eligibility and presumptive eligibility requirements.

CHIP Basics

As is the case for Medicaid, states must follow federal guidelines and have flexibility to develop some aspects of their own CHIP programs (e.g., when setting eligibility standards).

CHIP is a health coverage program for:

- Uninsured children up to age 19 whose family income is too high for them to qualify for Medicaid.
- Low-income pregnant individuals and/or newborns in some states who don't qualify for Medicaid.

CHIP Benefits and Cost Sharing

At this point, you might be wondering what types of benefits are covered for children enrolled in CHIP.

Most CHIP coverage is considered MEC. Since CHIP varies by state, the exact benefits a particular state covers may differ from other states. However, all states currently provide comprehensive coverage including:

- Routine checkups.
- Immunizations.
- Doctor visits.
- Prescriptions.
- Dental and vision care.
- Inpatient and outpatient hospital care.
- Laboratory and X-ray services.
- Emergency services.
- COVID-19 testing, treatment, and vaccinations (through September 30, 2024).

These benefits are similar to Medicaid services offered to consumers.

Some states charge small premiums and/or copayments for CHIP coverage. Families with children enrolled in CHIP aren't required to pay more than five percent of their yearly income for CHIP coverage — including out-of-pocket costs – but most programs charge premiums that are far lower. Cost sharing (e.g., deductibles, copayments, and coinsurance) isn't allowed for certain preventive services like well-baby or well-child visits.

COVID-19 Testing, Treatment, and Vaccinations

CHIP coverage of COVID-19 testing, treatments and vaccinations currently varies by state. State CHIP programs were previously required to cover COVID-19 vaccinations, testing, and treatments without cost sharing under the American Rescue Plan Act of 2021 (ARPA), but this coverage requirement ended on September 30, 2024.

CHIP Eligibility

CHIP provides low-cost health coverage to uninsured children up to age 19 in families whose income is too high for them to qualify for Medicaid.

Remember, MAGI is used to calculate consumers' financial eligibility for CHIP. Each state has its own rules about who qualifies for CHIP:

- Most states cover children in families with incomes up to at least 200 percent of the FPL.
- Nearly half of these states offer coverage to children whose household income is at or above 250 percent of the FPL.
- Other states allow children with higher income levels to pay higher premiums and buy into CHIP.

Remember, states also have the option to provide CHIP coverage to some low-income pregnant individuals. In some states, CHIP provides coverage to individuals for the duration of their pregnancy. As mentioned in Module 6, as of April 1, 2022, states have an option to provide 12 months of continuous Medicaid coverage to postpartum individuals enrolled in Medicaid. If adopted for Medicaid, the state must also elect to apply the extended postpartum coverage to separate CHIP coverage in the state for beneficiaries who are low-income pregnant individuals, as applicable. Assisters should check with their state authorities to determine whether the state they operate in has exercised this option and the state timeline for implementation.

Infants born to pregnant individuals enrolled in Medicaid or CHIP are automatically eligible for Medicaid or CHIP up to one year of age. In addition, new birthing parents who lose access to healthcare services provided through unborn child CHIP coverage following the birth of their child may qualify for a Marketplace SEP for 60 days before or after their loss of coverage, if they’re otherwise eligible to enroll in a QHP through a Marketplace. The Affordable Care Act (ACA) also gives states the option to extend CHIP eligibility to the children of state employees who were previously excluded from CHIP coverage. As mentioned in Module 6, under the Consolidated Appropriations Act of 2023, effective January 1, 2024, states must maintain 12-months of continuous eligibility for children enrolled in Medicaid and CHIP.

In 2024, for states other than Alaska and Hawaii, 200 percent of the FPL is equal to a yearly income of $62,400 for a family of four and $40,880 for a family of two; 250 percent of the FPL is equal to a yearly income of $78,000 for a family of four and $51,100 for a family of two.

CHIP Eligibility and Presumptive Eligibility

Presumptive eligibility allows children to get access to CHIP services without having to wait for their application to be fully processed. Just like for Medicaid, states can authorize "qualified entities" – including health care providers, schools, Head Start programs, and other community-based organizations – to immediately enroll children who are likely eligible under a state's CHIP eligibility guidelines for a temporary period of time. States have the option to require qualified entities to assist individuals in submitting the full application, but a full application cannot be required as a condition of receiving a presumptive eligibility determination.

If individuals are enrolled temporarily under presumptive eligibility, they and their families must complete the application process prior to the end of the presumptive eligibility period to keep their coverage.

It's important to know if the state you're working in has presumptive eligibility. If so, resources may be available to help consumers complete the application process.

More information on which states provide presumptive eligibility.

CHIP Eligibility and Immigration Status

Medicaid and CHIP are also similar in terms of eligibility and immigration status.

Generally, noncitizens must be qualified noncitizens and, for those who are subject to the five-year waiting period, must have had that status for five years, if applicable, to be eligible for CHIP. However, some states have elected to cover lawfully present children and/or pregnant individuals. In these states, all lawfully present children under age 19 and/or pregnant individuals are eligible for CHIP without the five-year waiting period if they meet other eligibility requirements in the state.

Eligibility for CHIP is based on a child's immigration status and not on the citizenship or immigration status of the child's parents. Parents may also have the option to enroll their child(ren) in a separate child-only plan through a Marketplace if otherwise eligible.

Knowledge Check

CHIP coverage varies by state, so the exact benefits that a particular state covers in CHIP may also differ from other states. However, all states provide comprehensive coverage, including guarantee coverage for specific services.

What CHIP benefits are included in all states?

Answer: CHIP benefits for all states include immunizations, prescriptions, and laboratory and X-ray services.

Key Points

- CHIP covers uninsured children up to age 19 in low-income families with incomes too high for them to qualify for Medicaid.
- Although CHIP benefits vary by state, all states provide comprehensive coverage that includes immunizations, doctor visits, and prescription drugs.
- Eligibility for CHIP is based on a child's U.S. citizenship or satisfactory immigration status and state residency — not on the U.S. citizenship or immigration status of the child's parents.

Module 8 - Introduction to Medicare

Introduction

Let’s make sure you know how to help older consumers and those who have Medicare or will become eligible soon. By the end of this module, you should be able to understand the following concepts and accomplish the tasks below them.

Eligibility

Provide the eligibility requirements for Medicare.

Enrollment

Describe Medicare enrollment scenarios.

Benefits

Communicate the benefits available from Medicare.

Medicare & the Marketplaces

Describe the relationship between Medicare and the Marketplace.

Medicare Basics

Medicare is a health coverage program made up of different parts and benefits. Talk about it with consumers who:

- Are age 65 or over,
- Have End-Stage Renal Disease (ESRD), or
- Have a disability, regardless of age.

You should have a general idea of how both Medicare and Marketplace coverage work for these consumers so you can provide them with fair, accurate, and impartial information about their health coverage options.

Medicare isn't part of the Marketplace. But consumers who have Medicare Part A or Part C (also known as Medicare Advantage) have minimum essential coverage (MEC).

Medicare Eligibility

Medicare eligibility is complex. It’s advised to refer consumers who may be eligible for Medicare to their State Health Insurance Assistance Program (SHIP), a program in every state that offers one-on-one Medicare counseling and assistance to consumers and their families. More information on the SHIP program can be found at shiphelp.org.

Medicare Benefits: Different Parts

As an assister, it's a good idea for you to be familiar with the coverage options available to consumers who are eligible for Medicare. Let's review the different parts of Medicare and how they might affect consumers who come to you for more information about the Marketplace.

Note: In certain situations, consumers may have Medicare and also enroll in Marketplace coverage. You’ll learn about some of these situations in this module.

Medicare Part A (Hospital Insurance)

Part A covers inpatient hospital stays, care in skilled nursing facilities, hospice care, and some home health care. Most Medicare beneficiaries have Part A without a premium, but others may have to pay a premium for Part A.

Medicare Part B (Medical Insurance)

Part B covers certain doctors' services, outpatient care, home health care, durable medical equipment and supplies, preventive services, and more. Most beneficiaries pay a monthly premium for Part B.

Medicare Advantage Plans (Medicare Part C)

Medicare Advantage plans are a type of Medicare health plan offered by private health insurance companies that contract with Medicare to provide Part A and Part B benefits for their enrollees. Most Medicare Advantage plans also offer prescription drug coverage (Part D), and some offer additional benefits that Parts A, B, and D don't cover. Consumers with a Medicare Advantage plan pay a Part B premium and may also pay an additional monthly premium amount for other benefits that the plan covers.

Medicare Part D (Prescription Drug Coverage)

Part D covers prescription drugs. Health insurance companies approved by Medicare offer Part D coverage. Medicare Advantage plans may also offer prescription drug coverage that follows the same rules as Medicare prescription drug plans. There’s generally a premium for Part D.

Visit Medicare.gov for more information about Medicare benefits and enrollment processes.

Premium-Free Part A Medicare and Eligibility

Now that we've reviewed the different parts of Medicare, let's discuss eligibility for Part A. In general, consumers who paid Social Security and Medicare taxes for at least 10 years (or at least 40 quarters) are entitled to premium-free Medicare Part A. Those already getting Social Security benefits are automatically enrolled in premium-free Part A (when they become entitled), but others have to apply for premium-free Part A.

Consumers who have Medicare generally can't enroll in health plans through a Marketplace. Insurers can't sell an individual a QHP through the Marketplace if the insurer knows it will duplicate the individual's Medicare benefits. This is generally true even if a consumer has only Part A or only Part B coverage.

Additionally, if a consumer has been determined eligible for or is enrolled in Medicare that counts as minimum essential coverage (i.e., Part A or Part C), the consumer is not eligible for financial assistance — that is, premium tax credits (PTC) or cost-sharing reductions (CSRs) — to help pay for a Marketplace plan.

Premium Part A Medicare and Eligibility

In general, consumers aged 65 and older who aren't entitled to premium-free Medicare Part A (because they haven't paid Social Security and Medicare taxes for at least 10 years, or at least 40 quarters) may choose to purchase Part A coverage if they are eligible. Because these consumers will need to pay monthly premiums, this type of Medicare coverage is called **Medicare Premium Part A (Premium Part A)**.

Older consumers who want to get Premium Part A can apply for coverage only during a prescribed enrollment period and must also enroll in (or already be enrolled in) Medicare Part B. To purchase Premium Part A, consumers must also live in the U.S. **AND** be U.S. citizens or lawful permanent residents of the U.S. for at least five consecutive years. To apply for Premium Part A, consumers need to file an application at a Social Security office.

You can help consumers find more information about Medicare benefits at Medicare.gov. Remember, consumers can also search for their local SHIP for detailed information about Medicare at shiphelp.org.

Consumers who are eligible for but not enrolled in Premium Part A may choose to enroll in Marketplace coverage rather than purchase Part A and/or Part B coverage (as long as they're eligible for Marketplace coverage). Financial assistance for Marketplace coverage might not be available. There are consequences to not enrolling in Medicare when first eligible, however, including late enrollment penalties. For more information, visit Medicare.gov.

Help With Medicare Costs

What can you tell consumers who have or are entitled to Medicare Part A since they aren't eligible for premium tax credits (PTCs) and/or cost-sharing reductions (CSRs) through a Marketplace?

Consumers with Medicare Part A might also be eligible for help with paying Medicare costs under these other programs:

- Extra Help with Medicare prescription drug costs (low-income subsidy).
- Medicare Savings Programs (MSPs) for help with Medicare Part A and Part B costs, which include:
    - Qualified Medicare Beneficiary (QMB) program, which helps pay for Part A premiums, Part B premiums, and deductibles, coinsurance, and copayments for services and items that Medicare covers.
    - Specified Low-income Medicare Beneficiary (SLMB) program, which helps pay for Part B premiums only.
    - Qualifying Individual (QI) program, which helps pay for Part B premiums only.
    - Qualified Disabled and Working Individuals (QDWI) program, which helps pay for Part A premiums.

More information on eligibility and coverage is available in the Resources tab in the menu.

Knowledge Check

Eduardo, who is 71 years old, comes to your office for more information about his health coverage options. He's currently enrolled in premium-free Medicare Part A and Medicare Part B. He wants to know more about other options that might be available to help lower his costs. What would be appropriate to discuss with Eduardo?

Answer: You should tell Eduardo about Medicare Savings Programs, which will help him lower his Medicare costs if he is eligible. Since Eduardo is currently enrolled in Medicare, he can’t enroll in a QHP through the Marketplace because insurers can’t sell Medicare enrollees a QHP if they know it will duplicate Medicare coverage. Additionally, since premium-free Medicare Part A is considered MEC, being eligible for it makes him ineligible for APTC and CSRs. Lastly, he can’t drop his Medicare without also dropping his Social Security or Railroad Retirement Board benefits, and he’ll also have to pay back all retirement benefits he’s received plus all costs paid by Medicare for his health care claims. Therefore, it’s advisable to remain enrolled in Medicare premium-free Part A rather than drop it to enroll in Marketplace coverage.

Medicare Eligibility and Immigration Status

Generally, consumers must be age 65 or older, reside in the US and be either (i) U.S. citizens or (ii) lawful permanent residents and live in the U.S. continuously for the past five years preceding the month in which they submit an application for Medicare Part B. Medicare claims under Part A or Part B won't be paid for consumers who aren't lawfully present in the U.S., even if they earned enough quarters of coverage to qualify.

You can learn more about Medicare eligibility for immigrants in the "Serving Select Population Groups and Communities" course in this training.

Consumers who aren't U.S. citizens can contact the Social Security Administration for more information about Medicare eligibility requirements.

Knowledge Check

What is usually the best option for older consumers enrolled in a health plan through a Marketplace for individuals and families if they're about to become entitled to premium-free Medicare Part A?

Answer: If consumers are about to become eligible for Medicare, their best option is usually to enroll in Medicare as soon as their IEP begins. They may experience increased costs, fees, and gaps in coverage if they don't sign up for Medicare when they first become eligible.

Key Points

- Consumers who already have Medicare Part A and/or Part B generally can't enroll in health plans through a Marketplace because it's against the law for a private insurer to sell a Marketplace plan to someone who has Medicare coverage when the insurer knows the plan will provide duplicate benefits.
- If consumers are enrolled in a health plan and get financial assistance through a Marketplace, they'll lose their eligibility for Marketplace-based financial assistance when their Medicare Part A coverage begins or when they become eligible for premium-free Part A due to age, disability, ESRD or ALS diagnoses. However, consumers with premium-free Part A typically pay less for health coverage than they would for Marketplace coverage.
- Consumers who don't have Medicare coverage and who aren't eligible for premium-free Part A may be able to enroll in a health plan through a Marketplace and may be eligible for financial assistance, if otherwise eligible.
- Consumers who have Part B only or Premium Part A and Part B may be eligible to enroll in a health plan through a Marketplace, but an insurer that knows its plan will duplicate a consumer's Medicare coverage can only sell them a health plan after they voluntarily end all their Medicare coverage.
- Additional programs for lowering consumers' costs may be available through Medicare.

Conclusion

Congratulations! You learned about the purpose of health coverage and how health coverage works. You can now describe various types of private and public health coverage options that might be available to consumers, including Marketplace plans, Medicaid, CHIP, and Medicare.

You've finished the learning portion of this course. Select Exit Course to leave the course and take the Health Coverage Basics exam or to close the course and return to the exam later.

If you choose to take the exam, the code to access this exam is: 649820.

Resources

Note: There are some references and links to nongovernmental third-party websites in this section. CMS offers these links for informational purposes only, and inclusion of these websites shouldn't be construed as an endorsement of any third-party organization's programs or activities.

Module 3 — Common Health Coverage Terms

Using Your Health Insurance Coverage: Getting prescription medications.

Healthcare.gov/using-marketplace-coverage/prescription-medications/

Summary of Benefits and Coverage: An example of an SBC and a Uniform Glossary of Terms.

Cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/IndexSummaryBenefitsCoverage

HealthCare.gov Glossary: An index to reference key terms about health coverage.

Healthcare.gov/glossary/

No Surprises Act: Consumer webpage to learn more about the protections that apply to the consumer.

CMS.gov/medical-bill-rights

Module 4 ——Summary of Benefits and Coverage (SBC)

SBC webinar: What is the SBC?

CMS.gov/marketplace/technical-assistance-resources/summary-of-benefits-and-coverage-overview.pdf

Understanding the Summary of Benefits and Coverage (SBC): Information and guide for Assisters in order to interpret the SBC for health plans and assist consumers with using the SMC to compare health plan benefits.

CMS.gov/marketplace/technical-assistance-resources/summary-of-benefits-fast-facts.pdf

Health insurance Rights and Protections: Summary of Benefits and Coverage.

Healthcare.gov/health-care-law-protections/summary-of-benefits-and-coverage/

CMS.gov: Summary of Benefits and Coverage (SBC) and Uniform Glossary.

CMS.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/IndexSummaryBenefitsCoverage

DOL.gov: Summary of Benefits and Coverage and Uniform Glossary.

DOL.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/summary-of-benefits

Regulations and Guidance: Summary of Benefits and Coverage and Uniform Glossary.

CMS.gov/marketplace/resources/regulations-guidance?redirect=/home/regsguidance.asp#Summary_of_Benefits_and_Coverage_and_Uniform_Glossary

Fact Sheets & Frequently Asked Questions (FAQs):

CMS.gov/marketplace/resources/fact-sheets-faqs#Summary_of_Benefits_and_Coverage_and_Uniform_Glossary;

Letters and News Releases:

https://www.cms.gov/marketplace/resources/letters#Summary_of_Benefits_and_Coverage_and_Uniform_Glossary

Module 5 — Types of Health Coverage

More About COBRA: Additional information for consumers who have coverage through COBRA. Healthcare.gov/unemployed/cobra-coverage/

TRICARE and the ACA: A summary of how consumers with TRICARE coverage are affected by the ACA and associated regulations.

Tricare.mil/About/MEC.aspx

The VA and the ACA: A summary of how VA coverage is regarded under the ACA regulations.

VA.gov/health-care/about-affordable-care-act/

Health Reimbursement Arrangements (HRAs): Three important things to know in regard to HRAs.

Healthcare.gov/job-based-help/

State Health Insurance Assistance Program: Help with navigating Medicare.

SHIPhelp.org/

Module 6 — Introduction to Medicaid

Existing Medicare coverage: Information regarding consumers who already have Medicare coverage and how this affects their eligibility for Marketplace coverage.

Healthcare.gov/medicare/

Federal Poverty Guidelines: Official HHS guidance on FPL levels.

ASPE.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

Module 7 — Introduction to CHIP

State Medicaid & CHIP Profiles: Resources that highlight the key characteristics of states' Medicaid and CHIP programs.

Medicaid.gov/state-overviews/index.html

Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels:

Medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels/index.html

Presumptive Eligibility: Information on which states provide presumptive eligibility.

Medicaid.gov/medicaid/enrollment-strategies/presumptive-eligibility/index.html

Module 8 — Introduction to Medicare

Medicare.gov: More information about Medicare benefits and enrollment process.

Medicare.gov/

SHIP: Consumers can also search for their local SHIP for detailed information about Medicare.

Shiphelp.org/

Social Security Office Locator: Consumers who aren't U.S. citizens can contact the SSA for more information about Medicare eligibility requirements.

Secure.ssa.gov/ICON/main.jsp