Course 6 - Serving Select Population Groups and Communities

Module 1 – Training Overview

Welcome

Hi! Welcome to the Serving Select Population Groups and Communities course!

I'm Romain, and I'll be helping you learn the answers to these questions and more throughout the course. As an assister, you will work with many consumers who have difficulty getting health coverage and accessing basic health care services.

- What are examples of select population groups and communities?
- Do you know how to do a needs assessment?
- What are the specific Marketplace and Medicaid protections for American Indians/Alaska Natives (AI/ANs)?

Course Goal

When you help consumers apply for and enroll in coverage through the Marketplaces, you should be familiar with who they are, what coverage barriers they face, any special rules or provisions for helping them access coverage, and your responsibilities when you assist them.

Goal:

This course will introduce you to some select population groups and communities and help you work effectively to improve their access to health coverage, including:

- American Indians/Alaska Natives (AI/ANs)
- Consumers eligible for Medicaid, the Children's Health Insurance Program (CHIP), or Medicare
- Older consumers
- Households with mixed immigration status

Topics:

By the end of this course, you will understand:

- Characteristics of select groups and communities.
- Factors that impact obtaining health coverage.
- Marketplace application and enrollment.
- Unique communication needs.
- Approaches and techniques for working with select groups and communities.
- How to conduct a needs assessment.
- How to assist older consumers.
- The relationship between Medicare and the Marketplaces.
- How to work with older immigrant adults.
- Eligibility and documentation requirements for enrollment and to verify immigrant status.
- Immigration-related rules in the Marketplaces.

Module 2 – Select Population Groups and Communities

Introduction

Consumers belonging to select groups and communities may face barriers to getting health coverage and basic health care services. By the end of this module, you should understand the following concepts and accomplish the tasks below them.

Characteristics

Identify the characteristics shared by select population groups and communities.

Examples

List examples of select population groups and communities.

Access to Coverage

Identify factors affecting access to health coverage for select population groups and communities.

Underserved Communities

These underserved communities include:

- Black/African American populations.
- Latino populations.
- AI/AN and other Indigenous populations.
- Asian Americans and Pacific Islanders.
- Other persons of color.
- Members of religious minorities.
- Individuals with disabilities.
- People who live in rural areas.
- Populations impacted by persistent poverty or inequality.

The United States Census Bureau (Census) and the Office of Management and Budget (OMB) each classify certain areas as “rural.” The Census considers “rural” to include all people, housing, and territories not within an urban area.

The Census defines urban as:

- Urbanized Areas (UAs) of 50,000 or more people.
- Urban Clusters (UCs) of 2,500 — 49,999 people.

OMB decides which counties are metropolitan, micropolitan, or neither. Counties that are micropolitan or outside both metropolitan and micropolitan areas are considered rural. A metropolitan area is defined as having an urban core of 50,000 or more people, while a micropolitan area is defined as having an urban core of 10,000-49,999 people.

More information can be found on the HRSA website.

Characteristics of Select Population Groups and Communities

In your role as an assister, you may work with groups who have not been served.

Populations that have been economically/socially marginalized may include consumers who share one or more of the following characteristics:

- Have a high risk for multiple health problems or pre-existing conditions.
- Have limited options (e.g., financial, educational, housing).
- Display fear or distrust of government programs or disclosing sensitive information.
- Have a limited ability to understand or give informed consent without communication or language assistance services (e.g., individuals who are deaf or hard of hearing or have limited English proficiency (LEP) or cognitive impairments) that require the use of auxiliary aids and services.
- Have mobility impairments.
- Lack access to transportation.
- Have a lowered capacity to communicate.
- Face any type of discrimination.

Under-resourced populations include consumers who share one or more of the following characteristics:

- Receive fewer health care services.
- Face barriers to accessing health care (e.g., economic, cultural, and/or linguistic).
- Aren’t familiar with the health care system.
- Face a shortage of available providers.

Examples of Select Population Groups and Communities

You might work with consumers who belong to marginalized and/or under-resourced groups or communities. Some might belong to multiple groups.

Populations that have been economically/socially marginalized

- Have high risk for health care problems
- Face significant hardships (e.g., financial, educational, and housing)
- Have a limited ability to understand or give informed consent without the assistance of language services (e.g., consumers with LEP)
- Lack the skills to communicate effectively in English

Select Population Groups and Communities

- Older adults
- Rural populations
- Children
- Racial and ethnic minorities
- People with physical or intellectual disabilities or cognitive, hearing, speech, and/or vision impairments
- Low income or homeless individuals
- Pregnant individuals
- Victims of abuse or trauma
- Individuals with mental health or substance-related disorders
- Individuals with HIV/AIDS
- AI/Ans

Under-resourced Populations

- Receive fewer health care services
- Face economic, cultural, and/or linguistic barriers to accessing health care services
- Lack familiarity with health care delivery system
- Live in locations where providers aren't readily available or physically accessible

Protections for Consumers with Pre-existing Conditions

Consumers with pre-existing conditions can be part of an underserved or marginalized population. Health insurance companies that receive Federal financial assistance (FFA) from HHS generally can't refuse to sell a policy to these consumers or charge more just because someone has a pre-existing condition.

Certain existing plans, including individual grandfathered plans, may not offer the same coverage as other health insurance plans, including coverage of pre-existing conditions or preventive care. Consumers enrolled in such plans may enroll in new plans with these protections, either outside of or through the Marketplaces, if they qualify.

- Eligible consumers can enroll in a qualified health plan (QHP) during the Open Enrollment Period (OEP). If they already have coverage, they should contact their current insurance company about terminating their current plan.
- Eligible consumers can enroll in a QHP outside the OEP if they qualify for a Special Enrollment Period (SEP). Losing coverage is one example of a circumstance that could allow an SEP. Voluntarily terminating coverage is generally not considered a loss of coverage.

Grandfathered Plans

Grandfathered plans are plans in which an individual was enrolled on March 23, 2010 that have not made certain significant changes that reduce benefits or increase costs to consumers. Health plans must notify consumers if they have a grandfathered plan. There are two types of grandfathered plans: employer-sponsored plans and individual plans (the kind consumers buy themselves, not through an employer). If the plans haven't been changed in ways that substantially cut benefits or increase costs for consumers and the issuer has provided the required notice, insurance companies can continue to offer them to consumers. For more information, refer to the HealthCare.gov page about grandfathered plans.

Protections for Individuals in Health Coverage

Entities that provide health insurance or other health coverage that receive Federal financial assistance (FFA) (and others covered by Section 1557) are prohibited from discriminating against individuals on the basis of sex under the final Rule implementing Section 1557 of the Affordable Care Act. Discrimination on the basis of sex includes discrimination on the basis of sex characteristics; pregnancy or related conditions; and sex stereotypes. For example, providers of health coverage are not allowed to discriminate against a same-sex married couple.

The Centers for Medicare & Medicaid Services (CMS) regulations also provide that health insurance companies offering non-grandfathered group or individual health insurance coverage can't use marketing practices or benefit designs that discriminate on the basis of a consumer's sex, using the same definition of discrimination on the basis of sex as the final 1557 Rule.

Factors Affecting Access to Health Care

A few barriers often prevent consumers from accessing necessary health coverage and health care. Generally, “access” refers to the timely availability of health services to achieve the best possible health outcomes.

Key barriers to accessing care include:

- High health care costs
- Inconsistent sources of care
- Lack of coverage
- Lack of reliable transportation (private or public) or difficulty physically accessing provider offices
- Low health literacy
- Unavailability of providers (e.g., medically underserved areas)
- Understanding these barriers will help you:
- Give consumers specific coverage information
- Identify the most effective ways to communicate with consumers

High health care costs

If coverage costs are too high, consumers may choose not to use health care services they really need or may decide not to enroll in coverage. Consumers might benefit from learning there are several options that may make costs more predictable and better fit their budgets and specific needs.

For example, the Affordable Care Act (ACA) puts annual limits on cost sharing for essential health benefits (EHB) for enrollees in non-grandfathered covered plans. It also provides other protections for enrollees in such plans, like requiring non-grandfathered plans to cover certain preventive services without cost sharing, for coverage purchased both inside and outside the Marketplaces.

Inconsistent sources of care

Consumers without access to coverage are likely to get inconsistent treatment and care.

For example, a consumer who lacks coverage may get emergency care by going to a hospital, free clinic, and/or treatment center. This is reactive treatment, not care that would prevent emergencies.

Research has proven that consumers who routinely visit the same doctor tend to have better health outcomes. If consumers have coverage and visit the same doctor(s) regularly, their quality of care improves. They're more likely to get care that prevents health emergencies.

Lack of Coverage

Coverage is very important because it reduces the financial burden of seeking health care. Consumers without coverage are less likely to get care and more likely to have poor health.

Underserved populations are particularly at risk for insufficient health insurance coverage; and people with lower incomes are often uninsured.

As a best practice, you should explain the risks of insufficient coverage to consumers.

- Delay seeking care
- Get care that doesn’t fit their specific needs
- Get a late diagnosis of their disease
- Get less care
- Pay much higher costs for care and be in debt

Consumers can make more informed decisions if they understand the physical and mental health disadvantages of lacking coverage. Some consumers may not be aware that financial assistance may be available to lower the cost of coverage.

Addressing Needs Through the FFM Process

Certain parts of the application in individual market Federally-facilitated Marketplace (FFM) were designed to address some of the challenges.

1. Income Information: Face significant economic hardship

Individuals facing significant economic hardship can enter their household income information to determine their eligibility for insurance affordability programs like APTC and CSRs, and low-cost programs like Medicaid and CHIP.

2. If the consumer has health conditions that cause limitations to daily activities:

Individuals who have certain disabilities may be eligible for low- or no-cost health coverage due to disability. Please emphasize it will not affect their ability to buy insurance, nor will it result in higher premiums.

3. Enter your doctors and medical facilities to determine if they're covered by the plan: Shortage of available providers. Provider shortages can be a challenge, but you can help consumers find providers in their area that may be covered by a plan by using the doctor and drug coverage tool. You may also recommend the consumer call providers to ensure they are in the plan's network and taking new patients (if the consumer hasn't visited that doctor before).
4. Prefer alternate modes of communication: LEP and/or assistive technology.

Individuals with LEP can notify an FFM of their preferred language to ensure future communications are in that preferred language. Individuals with disabilities may notify an FFM if they need information in an alternate format.

5. Address Information: Are currently experiencing homelessness

Additional Information for Consumers Experiencing Housing Insecurity

Additional Information for Consumers Experiencing Housing Insecurity

An address is required to apply for health coverage in an FFM.

Consumers who are experiencing homelessness or housing insecurity can list the following addresses on an application:

- Shelter, friend, or relative within the state in which they're applying for coverage
- Post office box (P.O. box)

Many consumers experiencing homelessness may be eligible for Medicaid and other low-income services. If these consumers need additional help, you may direct them to the state Medicaid agency or other homeless service resources, like shelters and free community clinics. Be sure to follow all applicable CMS guidance when making referrals to organizations that aren't FFM assisters or HHS entities.

Knowledge Check

You're advising a low-income, 28-year-old man about his coverage options through an FFM. He tells you he hasn't been sick in three years, feels healthy, and doesn't think he needs coverage. He also tells you he has a family history of diabetes and has moved several times over the past five years. Any time he needs care, he visits a local clinic. You would like to help him understand why coverage might be beneficial. What might you tell him?

Answer: The consumer might benefit from learning that doctors can treat undiagnosed health problems before they get more serious. Also, coverage can help avoid expensive medical bills in an emergency. Consumers who have coverage and a doctor they regularly visit tend to have better health and live longer. Finally, quality of care and preventive services improve when consumers routinely visit the same doctor.

Key Points

- You should be able to recognize when a consumer might belong to a select population group or community and understand they may face barriers to accessing health care programs and services.
- You should be able to recognize how lacking coverage creates barriers to health care.
- You should be able to help consumers understand the importance of visiting a doctor regularly and that accessing lower-cost preventive care can help them live longer, healthier lives.

Module 3 - Communicating Effectively with Consumers

Introduction

An important part of your job is to help consumers get health coverage, possibly for the first time in their lives. Some consumers may know very little about the benefits of having health coverage. It's essential that you learn best practices for reaching these consumers and helping them make coverage choices. By the end of this module, you should understand the following concepts and accomplish the tasks below them.

Needs Assessment

Learn how to conduct a needs assessment.

Communication Needs

Understand a variety of unique communication needs.

Working Effectively

Identify strategies for effective communication with a variety of people.

Consumers from Rural Communities

Identify strategies for working effectively with consumers who live in rural communities.

Assessing Coverage Needs

Once you've determined consumers' understanding of health insurance, the Affordable Care Act (ACA), and the Marketplaces, you can begin to ask them questions about their current coverage status and their needs and preferences for getting coverage through an FFM.

This module highlights key points for assessing coverage needs and communicating effectively.

Conducting a Needs Assessment

Here are some sample questions to determine what consumers already know, what questions they have, and their coverage needs.

Consumers seeking information

- What questions do you have about how the ACA affects your coverage?
- What questions do you have about the Marketplace application process?
- What questions do you have about eligibility requirements for enrolling in coverage?
- What information do you need before choosing coverage options?
- What questions do you have about paying for coverage?
- What could I/we do to make this process easier?
- Are there any health care services you currently receive and want covered by your plan?

Consumers seeking coverage for themselves or their households

- What kind of coverage have you and your family had in the past?
- Who in your family needs coverage?
- What parts of coverage are most important to you (e.g., covered benefits and services, cost, keeping a doctor)?
- Does your employer help you with health care costs?

Factors Contributing to Unique Communication Needs

In addition to being able to ask questions to assess a consumer's individual needs, you should be able to communicate appropriately and effectively. Your goal is to build a trusting relationship with consumers (and any family members or caregivers they have asked to participate in the enrollment process). Communication methods that work well with one community or individual may not necessarily work well for others.

When you communicate, consider:

- Modifications for individuals with disabilities
- Cultural health beliefs and practices, and preferred language
- Demographic factors (like age)
- Geographic location
- Health literacy level
- Social risk factors (like financial instability, housing instability, food insecurity, lack of transportation)

Cultural and Linguistic Competence

“Cultural and linguistic competence” can be defined as behaviors, attitudes, and policies in a system, agency, or among professionals that are effective in cross-cultural situations. It implies having the capacity to function effectively as an individual or organization within the context of cultural beliefs, behaviors, and needs presented by consumers and their communities.

You're encouraged to review and follow the HHS Office of Minority Health (OMH) National Culturally and Linguistically Appropriate Services (CLAS) Standards, which give guidance on providing culturally and linguistically appropriate services to consumers. Federal rules for providing meaningful access and culturally and linguistically appropriate services (including the FFM Navigator and EAP CLAS Standards) will be outlined in depth in *Course 7 – Cultural Competence and Language Assistance*.

To be culturally and linguistically competent, you should be able to:

- Identify, understand, and respect differences in consumers' cultural beliefs, behaviors, and needs.
- Respond appropriately to consumers based on their cultural and language needs, which may include providing oral language assistance services—either in-person or via remote communication technology, translating documents, or visiting Think Cultural Health (hhs.gov) and LEP.gov for additional resources.
- Acknowledge, respect, and accept cultural differences.

Characteristics and behaviors of cultural groups can't be presented as a checklist. It's important not to group people together—this may prevent you from recognizing and serving the needs and preferences of individuals.

As a best practice, you should ask consumers how they perceive or identify themselves, their partners, and family members. Then, you should take care to use the same terms. You can politely ask consumers to help clarify these terms, if appropriate. You should treat each person as a unique individual.

Communication Tips: Illustrate Respect and Avoid Assumptions

Keep the following tips and examples in mind as you work with consumers:

Tip 1:

Respect the unique cultural needs of all consumers.

For example, some consumers prefer to seek out traditional healer services like using herbs or acupuncture to treat illness, which is different from seeking service providers who are trained in Western medicine.

When helping consumers with these beliefs, it might be helpful to:

- Acknowledge your respect for their beliefs (whether or not you agree with them).
- Explain the potential benefits of getting coverage.
- Tell them you understand if they choose to decline coverage.

Tip 2:

Avoid making assumptions about a consumer's culture or identity based on the consumer's appearance, name, or other outward characteristics.

All consumers are different.

- A consumer who appears to you to be of a certain race or ethnicity may identify with something different like characteristics not commonly associated with that race or ethnicity.

Acknowledge Various Linguistic Abilities and Cultures

Consumers may have different English speaking and writing abilities and may come from cultural or religious backgrounds that differ from your own. Here are some tips to provide better service:

Tip 1:

Acknowledge that consumers will have various speaking and writing skills. Be sensitive to this and know how to respond appropriately. Some consumers may understand and speak English but may not read or write in English.

- Identify materials in their preferred language(s)
- Know how to get translation or interpretation services, like American Sign Language (ASL), if needed.

Preferred Language(s)

Some consumers who speak English as a second language may prefer to use English in your interactions. Also, respect that others may have a preferred language that is not English.

Tip 2:

- Acknowledge that consumers will have varied cultural preferences that inform their health care decisions.
- Some consumers have religious beliefs or value systems that don't allow them to use medicine (e.g., Christian Scientists). Respect that some people may reject coverage because of their religious and/or cultural beliefs.
- Know how to assist consumers in filing a Religious Sect Exemption Application.

Knowledge Check

You have an appointment with Katarina and Felix. At the beginning, they share with you that English isn’t their primary language. They don't have access to a car or money for public transportation. Based on this information, how could you provide support to Katarina and Felix?

Answer: You are required to provide consumers with information and assistance in the consumer’s preferred language, at no cost, including oral interpretation of non-English languages and the translation of written documents, when necessary or when requested to ensure effective communication. Your organization is responsible for taking reasonable steps to provide meaningful access to each individual with limited English proficiency (including companions with limited English proficiency), including providing a qualified interpreter and translated documents without cost when it is a reasonable step to provide meaningful access. You should therefore ask Katarina and Felix whether they need an interpreter and translated materials, and let them know interpreters are provided free of charge. If they prefer to have an adult friend or family member interpret, they can do so (absent an emergency) only if they make this request in private with a qualified interpreter present, the friend or family member agrees to provide this assistance, the request and agreement are documented, and the reliance on that adult is reasonable under the circumstances. Relying on a minor child to interpret or facilitate is never allowed except as a temporary measure during an emergency. Although not required by law, it is a best practice to accommodate Felix and Katarina's transportation limitations and identify a meeting location close to Katarina and Felix's place of residence.

Consumers with Low Literacy

Literacy generally refers to an individual's ability to read and write. The ability to read, write, and speak English or another language affects how well consumers understand coverage options.

Consumers may be embarrassed or ashamed about low literacy and try to hide that they have difficulty reading or writing. Alternatively, consumers who have difficulty reading may have simply forgotten their glasses. Consider context to alert you if there might be a literacy issue.

Consumers may say or do things that indicate their literacy is low.

If you believe a consumer may have a low level of literacy, reference the resources in this training or seek guidance from an assister organization with expertise in low literacy.

Consumers with Low Health Literacy

Some consumers may not struggle with literacy as previously defined but have low health literacy. Health literacy is the ability to get and understand basic information about coverage and health care services, use the information to make decisions about care, and follow instructions for treatment. Generally, consumers with high health literacy understand how to use their coverage and navigate available coverage options. Other consumers may have high health literacy about some aspects of coverage, but low health literacy about other aspects. Your job is to assess how consumers are processing the information they're receiving and help them understand the information they need to make informed choices.

Consumers with Low Literacy and Low Health Literacy

How can you help consumers with low literacy and/or low health literacy?

Tips for working with consumers with low literacy:

- Ask open-ended questions
- Read instructions out loud and check that consumers understand you
- Speak slowly
- Draw or point to pictures, posters, and other visuals
- Confirm that consumers understand what you're saying
- Use plain language and simple words, especially when describing difficult coverage terms
- Write information down for the consumer to review at home
- Present complex information in small amounts to avoid potentially overwhelming the consumer
- Use active voice as much as possible (e.g., "I got a translator" and not "A translator was obtained by me")
- Provide or direct consumers to Coverage to Care materials

Tips for working with consumers with low health literacy:

- Avoid acronyms
- Limit technical language and explain necessary technical terms
- Ask consumers to repeat key information
- Give information in small chunks
- Understand it may take additional time to help consumers with low health literacy
- Instead of "qualified health plans," try, "Health plans approved by the Marketplace"
- Instead of "premium tax credit," try, "A tax credit to lower your monthly health insurance premiums"

Knowledge Check

You’re assisting Nina, and she can't decide if she wants to enroll in coverage. She’s come to your office with questions a few times and still hasn't completed her eligibility application. You’ve provided Nina with brochures and flyers about coverage options, but in your conversations, it seems she hasn't read the materials. You think Nina may have low literacy and/or low health literacy. How might you respectfully help Nina enroll?

Answer: It's important to understand what prevents Nina from filling out an eligibility application. Nina shows signs that she is a consumer with low literacy and/or low health literacy and may not understand written materials. In some instances, such as where low literacy is disability-related and an individual needs help filling out an application as a reasonable modification, that assistance is required by disability rights laws. It's an important part of your role to provide Nina with assistance.

Consumers in Rural Communities

Consumers in rural areas may face barriers to accessing essential health services, which contributes to poorer health outcomes. They're also likely to be underserved in terms of coverage, which is why they might need your help.

Access to Transportation

Rural residents may not be able to visit locations (like community centers) to get coverage information. Note that urban residents may also have transportation issues (e.g., public transportation may not be near their residence and/or affordable).

Access to Specialists

Specialists might be located in urban areas, making it more difficult for rural residents to visit them.

Access to Computers and Internet/broadband

Consumers may not be able to access coverage information online. Internet access may not be available in some rural areas, or consumers may not be able to afford it or access public internet sites or may have limited experience using the internet.

Reaching and Engaging Rural Consumers

To reach, communicate, and work effectively with rural consumers, you should conduct outreach in locations where they may work, live, or access community services. Consider conducting outreach in the following:

- Consumers' places of work
- Faith-based organizations or places of worship
- Libraries
- Community clubs
- United States Department of Agriculture (USDA) extension offices to reach farmers and schools
- Community health centers
- Tribal government offices and Indian health care facilities
- Schools
- Big box stores
- Local newspapers
- Post Offices

Key Points

- You should respect the needs and preferences of consumers, understand how their needs affect your interactions, and value how preferences can differ based on consumers' cultures.
- You should be prepared to help consumers with different backgrounds and needs.

Module 4 - Working Effectively with AI/AN Individuals

Introduction

In the United States, there's a special government-to-government relationship between the Federal Government and federally recognized Indian Tribes and Alaska Native regional and village corporations. There are more than 570 federally recognized Indian Tribes, including Alaska Native regional and village corporations established under the Alaska Native Claims Settlement Act (ANCSA). In this training, members of federally recognized Indian Tribes and shareholders of ANCSA corporations are referred to as American Indians and Alaska Natives (AI/ANs).

If you have AI/AN consumers living in your service area, you are encouraged to have ongoing education, outreach, and enrollment events designed for these individuals. By the end of this module, you should understand the following concepts and accomplish the tasks below them.

American Indians and Alaska Natives (AI/ANs)

Describe how AI/ANs are defined for the purposes of health coverage and what is considered a federally recognized Indian Tribe.

AI/AN Health Care Systems and Services

Describe the structure of the health care system which serves AI/ANs.

Coverage under the Affordable Care Act (ACA)

Identify protections for eligible AI/ANs under the ACA.

Applying Through the Marketplaces

Explain eligibility requirements, issues, and process for AI/ANs applying for coverage through the Marketplaces.

Definition of AI/AN

Who is an AI/AN?

Because the United States has a government-to-government relationship with federally recognized tribes and Alaska Native regional and village corporations, there are certain protections in Medicaid, CHIP, and the Marketplaces. These protections apply to different categories of AI/ANs:

- For the Marketplaces, certain protections apply only to members of a federally recognized Indian Tribe or shareholders in an ANCSA corporation (ANCSA shareholders).
- For Medicaid, certain protections apply to members of a federally recognized Indian Tribe, ANCSA shareholders, or other individuals eligible to receive services from IHS.
- CHIP premium and cost-sharing protections apply to children who are qualifying members of a federally recognized Indian Tribe, an Eskimo or Aleut, or other Alaska Native enrolled by the Secretary of the Interior pursuant to the ANCSA, or who are considered by the Secretary of the Interior to be an Indian for any purpose.

For more specific information, please visit Information for American Indians and Alaska Natives Applying for Coverage.

Health Care Services for AI/Ans

I/T/U refers to three components of the Indian health system: (1) the IHS (I), (2) Tribes and Tribal organizations (T), and (3) urban Indian organizations (U). AI/ANs who enroll in qualified health plans (QHPs) through a Marketplace can still get care at an I/T/U.

I: The Indian Health Service

Over the years, many different U.S. government agencies have been responsible for providing health care to AI/ANs. The ACA made permanent the Indian Health Care Improvement Act. A large portion of AI/AN consumers access health care through providers in the Indian health care system, which may include tribal and urban Indian organizations. However, the IHS isn't an insurance program. AI/ANs don't pay premiums for ITU services because the IHS is prohibited by law from billing or charging AI/ANs for services, and AI/ANs are only charged under limited circumstances for services provided in Tribal or urban Indian facilities.

T: Tribes and Tribal Organizations

Tribes and Tribal Organizations Tribes may contract with IHS to operate their own health care facilities pursuant to agreements with IHS under the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law 93-638, also known as "638" agreements.

U: Urban Indian Organizations

Through contracts with the IHS, nonprofit Urban Indian programs also offer services ranging from community health to comprehensive primary care.

When certain services aren't available at IHS or Tribally operated facilities, AI/ANs might also be able to receive health care services through an IHS or Tribal Purchased/Referred Care (PRC) Program without cost sharing. Subject to specific eligibility requirements and the approval of funding, this program covers health care services that aren't reasonably accessible/available in IHS and Tribal health care facilities, like:

- Inpatient and outpatient care
- Medical support services:
- Laboratory
- Pharmacy
- Nutrition
- Diagnostic imaging
- Physical therapies
- Routine emergency ambulatory care
- Specialty care
- Transportation

Federally-recognized Indian Tribes and AI/AN Population

What's considered a federally recognized tribe?

For Marketplace purposes, an "American Indian" includes a member of a federally recognized Indian Tribe (i.e., listed on the Department of the Interior's Federally Recognized Indian Tribe List Act of 1994; this list is updated annually) and shareholders of ANCSA regional and village corporations.

As of January 2024, there are 574 federally recognized Indian Tribes.

Visit the BIA Tribal Directory for a current list of federally recognized Indian Tribes and Alaska Native Entities and the ANCSA Regional Association website for a list of ANCSA corporations.

How many AI/ANs live in the U.S.?

As of 2020, 9.7 million people in the U.S. identify as AI/AN, either alone or in combination with one or more other ethnicities. Approximately 2.6 million AI/ANs receive health services from I/T/Us. More information can be found in the Office of Minority Health's American Indian/Alaska Native Health website.

Where do AI/ANs live?

While AI/AN consumers live in every state, in 2019, the 10 states with the largest AI/AN populations were Alaska, Arizona, California, New Mexico, New York, North Carolina, Oklahoma, South Dakota, Texas, and Washington. More information can be found in the Office of Minority Health's American Indian/Alaska Native Health website.

AI/ANs Eligibility for Marketplace Coverage

Consumers must submit documentation to demonstrate they are a member of a federally recognized Indian Tribe or a shareholder of an ANCSA regional or village corporation, like a copy of a document issued by a federally recognized Indian Tribe, the BIA, or ANCSA corporation (e.g., membership or enrollment card). This document should have a signature or seal on it. While some Medicaid and CHIP agencies require documents to prove AI/AN status, many state agencies accept self-attestation. Visit the Health Coverage for American Indians and Alaska Natives page on HealthCare.gov for a list of some tribal documents an AI/AN consumer may need.

If consumers want to apply for financial assistance through a Marketplace, they should indicate it on their application and answer all applicable questions. AI/AN consumers may be asked about income from Indian trust land, natural resources, and items of cultural significance. While these types of income will be counted when determining eligibility for financial assistance through the Marketplace, generally won't impact Medicaid or CHIP eligibility. For instance, if an individual earns income from items of cultural significance (e.g., sale of Indian art, pottery, or jewelry), the income might be reported on a federal income tax return and be counted for financial assistance eligibility through the Marketplace, but may not count for Medicaid and CHIP eligibility.

Overview of Affordable Care Act Provisions Relevant to AI/ANs

AI/ANs have access to special protections under the ACA. These include:

- The ability to enroll year-round in QHPs and the ability to switch plans monthly.
- Cost-sharing reductions (CSRs) for QHP coverage regardless of Marketplace health plan category (Bronze, Silver, Gold, and Platinum), including zero cost sharing or limited cost sharing if they meet certain household income requirements.

Even if AI/AN consumers choose to enroll in private insurance through the Marketplaces with advance payments of the premium tax credit (APTC) or CSRs, they can continue to get services from an I/T/U.

Special Provision: Monthly Enrollment in QHPs

AI/ANs can enroll in coverage through the Marketplace any time during the year, not just during the yearly Open Enrollment Period (OEP). AI/ANs are also eligible to change health plans as often as once a month. Consumers who aren't members of federally recognized Indian Tribes or ANCSA shareholders must enroll during the yearly OEP (unless they otherwise qualify for an SEP or are applying on the same application as a tribal member who is eligible for the AI/AN SEP).

It is important to note that if AI/ANs change their plans, cost sharing requirements (like deductibles and out-of-pocket limits) will reset, if applicable.

Consumers should be mindful of potential coverage gaps due to the effective dates of new plan selections. Consumers can select a later effective date if they want coverage to begin in a later month.

Zero Cost Sharing vs. Limited Cost Sharing

There are special rules for AI/ANs to qualify for cost-sharing reductions (CSRs) that reduce cost sharing expenses like copays, coinsurance, deductibles, and other similar charges when enrolled in QHPs through the Marketplaces.

Zero Cost Sharing

AI/ANs with annual household incomes between 100 percent and 300 percent of the federal poverty level (FPL) can enroll in a zero cost sharing plan. Consumers do not have to pay any out-of-pocket costs such as copays, deductibles, or coinsurance when receiving care at an I/T/U or when receiving essential health benefits through a Marketplace plan's network providers. AI/ANs enrolled in zero cost sharing plans do not need referrals.

Zero cost sharing plans are available to eligible AI/ANs who enroll in a Marketplace plan under any metal level health plan category. (Note that a consumer who is not an AI/AN must be enrolled in a Silver level plan to receive CSRs.)

Limited Cost Sharing

AI/ANs with annual household incomes below 100 percent or above 300 percent of the FPL qualify for limited cost sharing. These consumers have no cost sharing when they get care from an Indian health care provider. With a referral from an Indian health care provider, AI/ANs in these income groups also can have zero cost sharing when receiving EHBs through a QHP.

Members of households with a mixed AI/AN status have special considerations when applying through the Marketplace.

A family that includes both members of federally recognized Tribes (or ANCSA shareholders), and persons who are not, might all enroll in the same Marketplace plan. However, if they do so, the family members who are not members of federally-recognized Tribes (or ANCSA shareholders) will not be able to use the special cost-sharing savings. Therefore, federally recognized Tribal members (or ANCSA shareholders) and non-Tribal family members with a household income under 300 percent of the FPL should consider enrolling in separate plans if they want to take advantage of all potential savings.

300 percent

For Plan Year (PY) 2025, 300 percent of the FPL is equal to:

- A single consumer household income of $45,180 or less (Alaska: $56,430. Hawaii: $51,930).
- A two-person family household income of $61,320 or less (Alaska: $76,620. Hawaii: $70,500).
- A three-person family household income of $77,460 or less (Alaska: $96,810. Hawaii: $89,070).

AI/AN Eligibility for Medicaid and CHIP

For Medicaid, certain protections apply to members of a federally recognized Indian Tribe, ANCSA shareholders, or other individuals eligible to receive services from the IHS.

AI/AN Medicaid beneficiaries have the following Medicaid protections:

- They do not have to pay Medicaid premiums or enrollment fees if they are eligible to receive or have received care from an ITU or through a PRC Program.
- They do not have to pay any cost sharing such as deductibles, coinsurance, or copayments for any Medicaid service from any Medicaid provider if they are currently receiving or have ever received care from an ITU or through a PRC Program.

AI/AN CHIP child beneficiaries cannot be charged any premium, enrollment fee, copayment, coinsurance, or deductible in CHIP.

Certain income is excluded when determining eligibility for Medicaid and CHIP. In general, the exemptions apply to income and property that are connected to the political relationship between the Tribes and the Federal Government and property with unique AI/AN significance.

NOTE: Per capita income from Indian gaming is not excluded when calculating income; tribal gaming per capita payments are taxable and should be reported on an application for coverage.

There might be instances where certain Indian income is taxable by the IRS but is excluded for the purposes of determining Medicaid and CHIP eligibility. For example, an individual might sell Indian jewelry and report that income to the IRS; however, if the jewelry has AI/AN cultural significance, it may not be counted for Medicaid and CHIP eligibility.

AI/ANs and Stand-alone Dental Plans

AI/ANs can enroll in stand-alone dental plans through the Marketplaces when they buy Marketplace health plans.

However, zero cost sharing doesn't apply to Marketplace stand-alone dental plans. If an AI/AN consumer is enrolled in a stand-alone dental plan, they will have to pay cost sharing like copayments and deductibles. But, if the consumer is enrolled in a dental plan offered as part of a QHP, the AI/AN cost sharing limitation will apply. AI/ANs can get dental services from I/T/U providers with no cost sharing.

Knowledge Check

You're meeting with Ann and Joe, who are members of a federally recognized Indian Tribe. You're discussing special Marketplace protections for AI/ANs. What is not true about the stand alone dental plan?

Answer: The statement on stand-alone dental plans is not accurate. If AI/AN consumers enroll in stand-alone dental plans, they'll have to pay copayments and deductibles. All the other statements are accurate.

FFM Application Process for AI/ANs

AI/AN consumers may complete eligibility applications for QHPs, Medicaid, and CHIP coverage through the FFMs by paper or online. They may also apply over the phone through the FFM Call Center.

For paper and online applications, AI/ANs will need to submit proof of tribal membership/enrollment/ANCSA shareholder status within 90 days of application. However, there are some differences between the application types.

It's your responsibility to help AI/AN consumers prepare for the application process they choose. This section explains the paper and online applications.

Paper Applications

Consumers can apply for Marketplace coverage using a paper application or online. There are two paper applications that AI/AN consumers can complete to apply for QHP coverage through the FFMs.

Application for Health Coverage (Individuals or Families)

The Application for Health Coverage is for individuals who do not want to apply for help paying their Marketplace coverage. Step 3 of this application asks if a consumer or members of their household are AI/ANs.

Application for Health Coverage & Help Paying Costs (Individuals or Families Who Wish to Apply for Programs to Lower Costs)

The Application for Health Coverage & Help Paying Costs is for individuals who want to apply for help paying for their Marketplace coverage. This application asks AI/ANs to complete Step 3 and Appendix B of the application. The Marketplaces use their responses to determine whether the consumer is eligible for enrollment in a Marketplace QHP and for financial assistance, and whether they're eligible for Medicaid or CHIP.

Paper Application: Health Coverage & Help Paying Costs

Appendix B of the paper application for Health Coverage & Help Paying Costs asks the following:

Note: Question 1 is not mentioned below as the purpose of this page is to focus on Questions 2-4 in the Appendix B: American Indian or Alaska Native (AI/AN) Household Member(s) form.

Question #2

Member of a federally recognized Indian Tribe?

This question determines whether consumers qualify for an SEP and whether they qualify for CSRs through the FFMs.

Note: ANCSA shareholders are considered members of federally recognized Indian Tribes.

Question #3

Has this person ever gotten a service from the IHS, a tribal health program, or urban Indian health program, or through a referral from one of these programs? If no, is this person eligible to get services from the IHS, tribal health programs, or urban Indian health programs, or through a referral from one of these programs?

This question helps determine whether consumers can be exempt from premiums, copayments, coinsurance, deductibles, or other similar charges for Medicaid or CHIP.

Question #4

Certain money received may not be counted for Medicaid or CHIP. List any income (amount and how often) reported on your application that includes money from these sources:

- Per capita payments from a Tribe that come from natural resources, usage rights, leases, or royalties
- Payment from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things (e.g., art, pottery, or jewelry) that have cultural significance

This question ensures certain Indian income that might have been reported in the general income questions (Step 2 of the FFM application) can be excluded for determining eligibility for Medicaid and CHIP. As a general rule, Indian income that the Internal Revenue Service (IRS) exempts from taxation shouldn't be included as income in Step 2. However, there might be instances where certain Indian income is taxable but is excluded for Medicaid and CHIP. For example, an individual might sell Indian jewelry and report that income to the IRS; however, if the jewelry has AI/AN cultural significance, it may not be counted for Medicaid and CHIP eligibility.

Online FFM Application

The online FFM application asks whether the applicant or household members are AI/ANs.

AI/AN-specific Application Questions

In the Household information section of the Marketplace application, consumers will be asked if they are American Indian or Alaska Native as well as who in the household are American Indian or Alaska Native. These questions determine whether any household members are AI/AN so that questions about whether they have received or are eligible to receive care from an I/T/U can be asked. Please note: ANCSA shareholders are considered members of a "federally recognized Indian Tribe".

AI/AN-specific Application Questions (Cont’d)

If any household member is AI/AN, they will be directed to choose their state from a drop-down list and select the Tribe or ANCSA entity.

The consumer will be directed to upload or mail in proof of tribal membership, enrollment, or shareholder status within 90 days of the date of application. The consumer can enroll in a plan without the proper documentation. However, if documentation isn't received within 90 days, the applicant won’t be eligible for the monthly SEP and zero or limited cost sharing. Consumers determined eligible for Medicaid or CHIP will receive additional information from the state if they need to upload or mail any documentation.

AI/AN-specific Questions

When filling out the household information portion of the application users, who identify as American Indian/ Alaska Native, will be asked to include how much of their monthly income comes from a type of tribal income. This question is used to make sure that certain Indian income that might have been reported in the general income questions (Step 2 of the FFM application) is excluded for determining eligibility for Medicaid and CHIP. As a general rule, Indian income that the IRS exempts from taxation shouldn't be included as income in Step 2 of the application. However, there might be instances where certain Indian income is taxable by the IRS but is excluded for the purposes of Medicaid and CHIP.

Knowledge Check

Thomas comes to you for help. He explains he is Sioux and wants to know if he needs health coverage through an FFM. He feels generally healthy and currently gets a yearly physical from an IHS physician. Based on this information, how might you respond to Thomas?

Answer: Based on his Tribal membership, Thomas can apply for health coverage through the Marketplace any time. The Marketplace may provide greater access to providers and services while allowing him to continue accessing services through the IHS.

Key Points

The United States has a government-to-government relationship with federally recognized Indian Tribes and Alaska Native regional and village corporations. The Federal Government provides members of federally recognized Indian Tribes with health care, consistent with its statutory authorities.

By enrolling in a QHP, AI/ANs have greater access to a wider range of providers and services that may not be provided by their local I/T/U.

Eligible AI/ANs have certain protections under Medicaid, CHIP, and in the Marketplaces.

Medicaid-eligible AI/ANs who are currently receiving or have ever received care from an I/T/U or through a PRC Program are exempt from cost sharing for any Medicaid-covered services.

Certain Indian income is excluded in determining eligibility for Medicaid and CHIP.

In the Marketplaces, AI/ANs have monthly SEPs and zero or limited cost sharing.

Both paper and online FFM applications have special questions to help AI/AN consumers.

NOTE: Whether an AI/AN enrolls in Medicaid, CHIP, a QHP through the Marketplaces, or employer-sponsored coverage, they can continue to get services from an I/T/U at no cost.

Module 5 - Assisting Consumers who are Immigrants

Introduction

You may assist people who come from other countries.

This module will prepare you to help consumers who need assistance verifying their immigration status or applying for health coverage programs and benefits. By the end of this module, you should understand the following concepts and accomplish the tasks below them.

Verification

Identify how to help consumers attest to and complete verification of their citizenship or immigration status.

Eligibility

Explain how immigration and citizenship status affect eligibility for coverage through the individual market Federally-facilitated Marketplaces (FFMs), insurance affordability programs, Medicaid, and the Children's Health Insurance Program (CHIP).

Key Terms

You may work with consumers who have various immigration statuses. Let's begin by reviewing some immigration status types:

U.S. Citizen

A U.S. citizen is someone born in the U.S. (including U.S. territories except for American Samoa) or born outside the U.S. if they:

- Were naturalized as a U.S. citizen
- Derived citizenship through naturalization of their parent(s)
- Derived citizenship through adoption by U.S. citizen parent(s)
- Acquired citizenship at birth because they were born to U.S. citizen parent(s)
- Are a U.S. citizen by operation of law

Lawfully Present

In order to be eligible to enroll in a Marketplace plan, a noncitizen must meet the Marketplace definition of "lawfully present."

Groups of noncitizens will be considered lawfully present for purposes of Marketplace coverage.

The following categories of noncitizens are considered "lawfully present" and therefore eligible to enroll in a Marketplace plan, if they're otherwise eligible:

A "qualified noncitizen";

- Individuals with a valid nonimmigrant status;
- Individuals paroled into the United States for less than 1 year, except for a noncitizen paroled for prosecution, for deferred inspection or pending removal proceedings;
- Individuals granted temporary resident status
- Individuals granted Temporary Protected Status (TPS)
- Individuals granted employment authorization
- Family Unity beneficiaries
- Individuals granted Deferred Enforced Departure (DED) in accordance with a decision made by the President;
- Individuals with a pending application for adjustment of status;
- Children under the age of 14 with a pending application for asylum, for withholding of removal or for protection under the regulations implementing the Convention Against Torture; and
- Individuals granted withholding of removal under the regulations implementing the Convention Against Torture; or
- Individuals with a pending or approved petition for Special Immigrant Juvenile classification

Eligibility for Medicaid and CHIP is typically based on whether a noncitizen has a "qualified noncitizen" immigration status, which is a narrower standard than being "lawfully present." In

some states, children and pregnant individuals can be eligible for Medicaid or CHIP even if they are not “qualified noncitizens,” as long as they are lawfully present. However, it is important to note that the Medicaid and CHIP definition of “lawfully present” is different from the definition used by the Marketplace. The Medicaid and CHIP definition of “lawfully present” can be found in the State Health Officials letters:
“Medicaid and CHIP Coverage of “Lawfully Residing” Children and Pregnant Women” letter.

Naturalized Citizen

Naturalized citizens are people who weren’t born in the U.S. but became citizens by fulfilling certain requirements. Naturalization is the conferring of U.S. citizenship after birth by any means whatsoever, including acquisition of citizenship.

Derived Citizen

Derived citizens are people who were naturalized by operation of law. Derived citizenship may be conveyed to children through naturalization after birth, but before the age of 18, through their U.S. citizen parents.

Qualified Noncitizen

The following list contains some categories of “qualified noncitizen.” Consumers generally must have a "qualified noncitizen" status in order to be eligible for Medicaid or CHIP. An asterisk indicates categories exempt from a five-year waiting period for Medicaid. Please note that for CHIP eligibility, LPR work quarters are not applicable.

- Lawful permanent residents (Green Card holders)
    - Lawful permanent residents with 40 work quarters or a military connection (e.g., active duty or veteran) are eligible for Medicaid regardless of the date they entered the U.S.
- Asylees *
- Refugees *
- Iraqi and Afghan special immigrants
- Amerasian immigrants
- Certain Afghan parolees
- Certain Ukrainian parolees
- Cuban/Haitian entrants*
- Paroled into the U.S. for at least one year
- Conditional entrant granted before 1980*
- Battered non-citizens, spouses, children, or parents
- Victims of trafficking and their spouses, children, siblings, or parents
- Applicants for victims of trafficking visas
- Granted withholding of deportation*
- Citizens of the Marshall Islands, Micronesia, and Palau who are living in one of the U.S. states or territories (referred to as Compact of Free Association, or COFA migrants)*

- Note: Under the Consolidated Appropriations Act, 2024 (CAA, 2024), effective March 9, 2024, COFA migrants are considered qualified noncitizens.

Note: The “qualified noncitizen” definition is used to determine eligibility for Medicaid and CHIP in all states, D.C., and the territories. Qualified noncitizens are also covered by Marketplaces under the “lawfully present” definition. However, it is important to understand the definition of “lawfully present” is different for QHP coverage.

Health Coverage Eligibility for Lawfully Present People

You should tell lawfully present consumers they might be eligible for:

- **Health coverage through an FFM**
- **Advance payments of the premium tax credit (APTC)**
- **Cost-sharing reductions (CSRs)** if their income is less than 250 percent of the FPL and they meet other eligibility criteria.
- **Medicaid/CHIP coverage** for children up to age 19 for CHIP and up to age 21 for Medicaid, and/or pregnant individuals in some states that have elected the CHIPRA 214 option. For children and pregnant individuals who are qualified noncitizens, the five-year waiting period, if otherwise applicable, does not apply.

Lawfully present people can be eligible for these benefits no matter how long they've been in the U.S.

To find FPL amounts, select the Resources tab in the menu.

Documentation Requirements for Enrollment

In addition to eligibility requirements, you should be able to describe the documents immigrant consumers need to complete a Marketplace application. These documents are necessary for consumers seeking QHP coverage, APTC, CSRs, and Medicaid/CHIP.

- Social Security Number (SSN) (individuals without SSNs are able to apply)
- Immigration documents
- Employer and income information for everyone in the household (like pay stubs, W-2 forms, or wage and tax statements)
- Information about any employer-sponsored coverage available to the household

Note that:

- The individual market FFM application requires only information from these documents — not the documents themselves – unless consumers' information can't be verified. Then, electronic or paper documents may be used.
- If consumers' information can't be verified and they encounter a citizenship/immigration data matching issue (DMI), they generally have 95 days to provide supporting documentation. They can upload documents to their online account or send copies to the FFMs by mail. During this time, applicants who are otherwise eligible are enrolled in the program they qualify for based on the information the application filer(s) provided.

Review your state's Marketplace application requirements and eligibility notice for any additional details or guidance.

Types of Immigration Documents

When completing Marketplace applications, consumers who are immigrants need to use their most current status and the supporting documents they have to verify that status.

Certificate of Naturalization (Form N-550 or N-570)

Enter the Certificate of Naturalization number and the alien number (also called the alien registration number or USCIS number).

Certificate of Citizenship (Form N-560 or N-561)

Enter the Certificate of Citizenship number and the alien number (also called the alien registration number or USCIS number).

Permanent Resident Card (I-551)

Enter the alien number (also called the alien registration or USCIS number), document expiration date, and card number (also called the receipt number). If a card number isn't available, consumers may select Other as the document type and provide an alien number and description of the document.

Temporary I-551 Stamp (on passport or I-94/I-94A)

Enter the alien number, passport number, country of issuance, and document expiration date.

Machine Readable Immigrant Visa (MRIV) (with temporary I-551 language)

Enter the alien number (also called the alien registration number or USCIS number), passport number, document expiration date, and country of issuance.

Machine Readable Immigrant Visa MRIV (with temporary I-551 language) may vary by jurisdiction or date issued. As long as the document contains the temporary I-551 notation and is not expired, the Marketplace should have enough information to verify the consumer's lawful presence status.

Employment Authorization Card (I-766)

Enter the alien number (also called the alien registration number or USCIS number), card number, category code, and the card expiration date.

Arrival/Departure Record (I-94/I-94A) or with a Foreign Passport

Enter the I-94 number, passport number, expiration date, and country of issuance.

Unexpired Foreign Passport

Enter the passport number, passport expiration date, and country of issuance.

Re-entry Permit (I-327)

Form I-327, also known as Permit to Re-Enter, is a travel document similar to a Certificate of Identity; it is issued by the USCIS to U.S. lawful permanent residents to allow them to travel abroad and return to the U.S. Consumers need to enter the alien number (also called the alien registration number or USCIS number) and the document expiration date.

Refugee Travel Document (I-571)

Form I-571 entitles refugees to return to the U.S. Consumers need to enter the alien number (also called the alien registration number or USCIS number) and document expiration date.

Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)

This document is issued by SEVP-certified schools (colleges, universities, and vocational schools) and provides supporting information on a student's F or M status. Consumers need to enter their Student & Exchange Visitor Information System (SEVIS) Identification (ID) from this document.

Certificate of Eligibility for Exchange Visitor (J-1) Status (DS-2019)

Form DS-2019 identifies an exchange visitor and their designated sponsor and provides a brief description of the exchange visitor's program. Consumers need to enter their SEVIS ID, passport number, country of issuance, I-94 number, and document expiration date.

Notice of Action (I-797)

Enter the alien registration number (also called the USCIS number) or the I-94 number.

Consumers may select from a list of additional documents and status types or select "other" or "none of these". If consumers select "other," they should provide a description of the document type and then enter the alien number (also called the alien registration number or USCIS number) or the I-94 number.

Best Practices for Entering Immigration Document Information

When you help consumers enter information from their immigration documents to verify their status, keep these best practices in mind.

Consumers should use the most current document available.

If consumers have more than one immigration document, they should select the most current document or the one that contains an alien number (also called alien registration or USCIS number), if possible.

How to recognize an alien number.

An alien number starts with an A and ends with seven to nine numbers.

Consumers seeking coverage should enter as much information as possible from their immigration documents.

If consumers have an alien number and an I-551 card number, they should enter both when prompted.

If consumers have an I-551 card number but don't enter it, it will take longer to verify their status.

Consumers can enter an I-551 number without entering a SSN if they don't have one. It is not necessary to enter an SSN to get Marketplace coverage if a consumer doesn't have one.

Consumers should enter as much information as possible from their immigration documents, even if the documents have expired or will expire soon.

Consumers should enter other documents or statuses, if applicable.

If any additional types of immigration status apply, consumers should:

- Attest to the relevant status or document type from the second list of documents or statuses.
- Enter the document name and any other information.

Consumers should provide this additional information even if they have selected one of the documents from the drop-down list.

Best Practices for Discussing Immigration Status

These best practices can help you discuss immigration status with consumers seeking health coverage for themselves or on behalf of someone else.

Provide information

Provide information about eligible immigration statuses and acceptable immigration documents. Consumers then have the information they need to determine who in their family may have an eligible immigration status to apply for health coverage.

Share information about other resources

Share information about other resources in the community that might be helpful.

Identify the applicant.

Be sure to correctly identify the consumer or consumers who are applying for health coverage by asking if the person is seeking coverage for themselves or on behalf of someone else. Ensure that consumers know that documentation of citizenship and immigration status is only necessary for those applying for coverage, not for other members of the household.

Avoid unnecessary questions

- Don't ask unnecessary questions, especially about the immigration status of people who aren't applying for health coverage and live in mixed status households. Asking unnecessary questions regarding the immigration status of non-applicant family or household members could violate Title VI of the Civil Rights Act of 1964 or Section 1557 of the Affordable Care Act.
- Avoid words like "undocumented," "unauthorized," or "illegal." Instead, show consumers a list of immigration status types and immigration document types at HealthCare.gov and ask them if they have any of the statuses or documents on those lists.

Allow each consumer to act on their own behalf

- Consumers should enter their own information in an online or paper application.
- If a consumer asks for help typing or using a computer to learn about, apply for, or enroll in coverage, you may only use the keyboard or mouse to follow their directions.

Answering Immigration Questions on a Marketplace Application

Let's consider the challenges consumers may face when they try to verify their immigration status in an FFM at HealthCare.gov.

When applying for coverage, all consumers will be asked if they are U.S. citizens or U.S. nationals. Consumers who are naturalized or derived citizens should select Yes when answering this question.

If a consumer attests to being a U.S. citizen or U.S. national, but the Social Security Administration can't verify their citizenship, the application asks whether the consumer is a naturalized or derived citizen. Naturalized and derived citizens should select Yes when answering this question as well.

Natural or Derived Citizenship Verification

Naturalized and derived citizens may optionally enter identifying information from their immigration documents:

- A naturalized citizen should have a Certificate of Naturalization (Form N-550 or N-570). They should enter the Naturalization Certificate number and alien number (also called the alien registration number or USCIS number).
- A derived citizen may have a Certificate of Citizenship (Form N-560 or N-561). They should enter the Certificate of Citizenship number and alien number.

If consumers don't have a Certificate of Naturalization or Certificate of Citizenship, the FFMs can't electronically verify their status as naturalized or derived citizens. However, consumers can still apply, get an eligibility determination, and provide copies of their citizenship documents later. Consumers may provide a combination of other documents to verify their status, like:

- U.S. passport
- State-issued driver's license or ID card
- Birth certificate

Non-U.S. Citizens and Non-U.S. Nationals

Non-U.S. Citizens and Non-U.S. Nationals must complete a more extensive process to verify immigration status in the FFMs. When the Marketplace application asks whether they are U.S. citizens or U.S. nationals, they must select No.

The following question will ask if the consumer has eligible immigration status. The consumer can select Learn more about eligible immigration status to view a list of eligible statuses. If they are eligible non-citizens, they should select Yes.

Non-citizen Immigration Documents

Consumers should select the most current immigration document that supports their status. However, if the only document the consumer possesses is expired, you can still enter the information from that document. You can help them understand and enter required information in the fields that appear for each document.

Remember, consumers who aren't applying for coverage for themselves won't be asked and don't need to provide information about their citizenship or immigration status.

If consumers have an immigration document that isn't on this list, they should select the Other document or status option.

If eligible non-citizens select Other document or status from the list, the application will provide a second list of documents or statuses. If any of these apply, they should select it and continue.

Non-citizen Immigration Documents (Cont'd)

Some consumers may need to select Other document or alien number/I-94 number from this list, enter a description of their document, and enter either their alien number or I-94 number beneath the description.

On some documents, an alien number may be called an alien registration number or USCIS number. Remember, it starts with an A and ends with seven, eight, or nine numbers. Some documents may have an 11-digit I-94 number instead of an alien number.

Advise consumers to enter as many fields from their immigration documents as possible, even though some fields may be labeled Optional. If consumers provide all available information, it will:

- Facilitate a smoother and faster application process,
- Ensure consumers' eligibility results are correct, and
- Prevent consumers from having to provide more information later.

Consumers should attest to all immigration statuses or document types that apply to them.

Other Immigration Application Questions

Consumers must answer a question to confirm whether the name that appears on their document(s) is the same as the name of the consumer applying for coverage.

For some consumers, the application may ask a series of optional questions that help the FFMs assess or determine eligibility for Medicaid or CHIP. These questions include:

- Whether they've lived in the U.S. since 1996.
- The date (month and year) they were granted their current immigration status.
- Whether they or their family members are veterans or on active duty in the U.S. Armed Forces.

Knowledge Check

You're helping Lena and her husband, Tomas, complete a Marketplace application. Lena tells you she has a Green Card and Tomas is a refugee from Cuba. Lena is concerned she and Tomas aren't eligible for health coverage. How might you appropriately response to address Lena's concerns?

Answer: Consumers who are "lawfully present" are eligible for coverage through the Marketplace. The term "lawfully present" includes immigrants who have "qualified non-citizen" immigration status (LPRs, or Green Card Holders) and refugees. Therefore, Lena and Tomas are both considered "lawfully present" and are eligible for Marketplace coverage.

The "qualified noncitizen" definition is used to determine eligibility for Medicaid and CHIP in all states, D.C., and the territories. Qualified noncitizens are also covered by Marketplaces under the "lawfully present" definition.

Consumers don't have to be U.S. citizens to qualify for Marketplace insurance, but they must be lawfully present. Immigrants don't automatically qualify for Medicaid. Avoid words like "undocumented," "unauthorized," or "illegal." Instead, show consumers a list of immigration statuses or immigration documents available at HealthCare.gov.

Scenario: Ronna

Ronna emigrated to the U.S. from Italy three years ago and doesn't currently have coverage. She arrives at your office for her appointment and asks whether she's eligible for coverage through the Marketplace.

Let's help Ronna complete some questions from her Marketplace application.

The Marketplace application asks consumers about their citizenship and immigration status. Remember, consumers must be U.S. citizens, U.S. nationals, or lawfully present immigrants to be eligible for Marketplace coverage.

After Ronna gives you consent to access her personally identifiable information (PII), you guide her through the application and come to a screen that asks whether she's a U.S. citizen or U.S. national.

Since Ronna has a Green Card, she is a permanent U.S. resident. Ronna should select No to indicate she is not a U.S. citizen or U.S. national.

Eligible

Immigrants without eligible immigration status aren't eligible to buy Marketplace health coverage or for premium tax credits and other savings on Marketplace plans.

Scenario: Ronna (Cont'd)

The following question will ask if Ronna has eligible immigration status, and she should select Yes, Ronna has eligible immigration status.

Ronna should select **I-551 (Permanent Resident Card, "Green Card")** from the **Document type** drop-down list and select **Save & continue**.

Scenario: Helping Ronna

You help Ronna find and enter her Alien number, which is listed under the heading A# or USCIS# on the card. Then you help Ronna enter her card number, which is listed as her “I-551 number.” The card number starts with three letters and ends with 10 numbers. The last number you help Ronna find and enter is her card expiration date, which is listed next to Card Expires.

Next, ask Ronna to confirm whether her name is spelled exactly as it appears on her Green Card. If it is, she’ll select Yes to answer the next question.

Ronna doesn’t have any additional document or status types listed, so she selects None of these.

Scenario: Helping Ronna (Cont'd)

On the next page, ask Ronna to confirm whether she has lived in the U.S. since 1996. This question helps the Marketplaces determine Ronna's eligibility for Medicaid or CHIP. Ronna selects No since she didn't move to the U.S. until 2011.

After Ronna selects Save & Continue, the Marketplace will attempt to verify her immigration status and eligibility.

Note: All questions about immigration status are optional, but the more information consumers enter, the less likely a DMI will occur.

Additional Information

If an FFM can't verify consumers' citizenship or immigration status on the first attempt using the Systematic Alien Verification for Entitlements (SAVE) Program, it will make a second attempt. This process can take three to five days. Consumers who encounter data matching issues while completing a Marketplace application must submit additional documents to the FFMs or they will lose coverage.

Immigration Status and Insurance Affordability Programs

Lawfully present immigrants may apply for APTC and CSRs to help lower their costs based on their household size, income, and other eligibility criteria.

For Plan Year (PY) 2025, if their estimated annual household income is—	**Lawfully present immigrants may be eligible for—**
Above 250 percent of the FPL in 2024: • $51,100 for a family of two. • $78,000 for a family of four. * Higher in Alaska and Hawaii	APTC that can be used immediately to reduce the cost of monthly premiums for health coverage through the Marketplaces, if they meet all other eligibility requirements.
Between 100 percent and 250 percent of the FPL in 2024: • $20,440 to $51,100 for a family of two. • $31,200 to $78,000 for a family of four. *Higher in Alaska and Hawaii	• APTC that can be used immediately to reduce the cost of monthly premiums, and • CSRs that lower out-of-pocket health coverage costs. *if they meet all other eligibility requirements
Below 100 percent of the FPL in 2024: • $20,440 for a family of two. • $31,200 for a family of four. *Higher in Alaska and Hawaii	• APTC, and • CSRs *if they meet all other eligibility requirements and aren't eligible for Medicaid based on immigration status.

Note: Most consumers must enroll in a Silver plan through an FFM to receive CSRs. Remember, this doesn't apply to American Indians and Alaska Natives.

Federal Poverty Level (FPL)

Federal poverty level amounts are higher in Alaska and Hawaii. The latest FPL guidelines can be found at the Department of Health and Human Services Assistant Secretary for Planning and Evaluation website.

Application Question About Eligibility for Medicaid and CHIP

Lawfully present immigrants with an annual household income below 100 percent of the FPL may be eligible for coverage through an FFM, as well as APTC and CSRs, if they are ineligible for Medicaid or CHIP because of immigration status.

The application may ask whether a consumer or any person in the consumer's household was found ineligible for Medicaid or CHIP coverage.

Consumers should only check the box next to an individual's name if both of the following apply:

- The individual was denied Medicaid or CHIP coverage by their state (not by an FFM), and
- The family's household income and household size have not changed since the denial.

Otherwise, consumers should select None of these people.

You can find additional information and instructions for responding to this question at HealthCare.gov.

Knowledge Check

While helping Maru complete an FFM application, she asks whether she qualifies for help paying monthly premiums if she enrolls in a QHP through a Marketplace. Maru is a lawfully present immigrant with a Green Card. However, she heard that immigrants aren’t eligible for help to lower costs. What do you tell Maru about the criteria for lowering costs through the FFM?

Answer: Maru may be eligible for help to lower costs based on her household income, household size, and other eligibility criteria, regardless of her immigration status. You should also explain the eligibility criteria so she can learn if she may qualify for programs to lower costs. Ordinarily, you wouldn't tell Maru to call the FFM Call Center because you should be able to help her compile and report the information required during the eligibility determination process.

Medicaid and CHIP Eligibility Requirements for Immigrants

Remember, the following consumers may be eligible for Medicaid and CHIP:

- Qualified non-citizens who entered the U.S. before August 1996.
- Qualified non-citizens who reach the end of the five-year waiting period (e.g., lawful permanent residents, Green Card holders).
- Qualified non-citizens exempt from the five-year waiting period (e.g., refugees, asylees, Cuban/Haitian entrants, trafficking victims, veteran families, COFA migrants).

Note: The full list of individuals who are considered "qualified noncitizens" for Medicaid and CHIP coverage is listed in 42 CFR 435.4. Federal funding doesn't cover noncitizens who don't have satisfactory immigration status except for the treatment of an emergency medical condition.

Other eligible consumers include:

- Consumers with conditional entrant status, granted U.S. entry because of a natural catastrophe, or because they're asylees.
- Certain victims of human trafficking:
- If non-citizens are age 18 or older, they must be certified by HHS as victims of trafficking. Children younger than age 18 need an HHS eligibility letter.
- T-visa holders' spouses and/or children.
- In states that have elected the CHIPRA 214 option in Medicaid and CHIP, lawfully present children under age 21 (under age 19 for CHIP) and/or pregnant individuals, even if they have not completed the five-year waiting period (please see your state's status here: Medicaid and CHIP Coverage of Lawfully Residing Children & Pregnant Individuals).

Scenario: The Tran Family

Medicare/Medicaid Key Tips

- Consumers who are eligible for Part B but do not enroll when they first become eligible for Part B may have to pay late enrollment penalties on their Part B premiums as well.
- Consumers can apply for Medicare Part B and for Medicare Premium Part A through the Social Security Administration.
- Consumers must enroll in Part B in order to add Premium Part A coverage.

Conversation between Hong, a consumer and Marketplace Coach.

Hong: Hello. My family would like to enroll in health coverage, but we need some help. None of us have coverage right now. We want to know how our immigration status affects our eligibility for coverage.

Coach: Thanks for coming in today. I'd be happy to help. Let's discuss the enrollment process and the eligibility requirements for Marketplace coverage, Medicaid, and CHIP.

The Tran Family: Verify Eligibility Status (Cont'd.)

After you get consent from the adult family members, you help them complete a Marketplace application.

As you review the family's immigration status and supporting documents, you learn that:

- Hong has been a lawful permanent resident for seven years.
- Her son, Hien, has been a lawful permanent resident for two years.
- Her father, Thu, has been a lawful permanent resident for seven years.

Hong: We also want to know if we can get lower costs based on our family's household income. I make $25,000 a year and claim my son and father as dependents on my federal income tax return. My dad has no income, and I'm not eligible for health coverage through work.

Tran Family: Eligibility Results

After the Tran family submits a Marketplace application, they receive the following eligibility determination based on their household income and each household member's immigration status.

Hien Tran

Hien has qualified non-citizen status for Medicaid but hasn't met the five-year waiting period, and the state he lives in doesn’t cover lawfully present children. Hien must have lawful permanent resident status (LPR) for five years before being eligible for Medicaid or CHIP. Hien is still eligible to enroll in a QHP through the Marketplace. He's also eligible for the premium tax credit even though his household’s annual income is below 100% of the FPL because he is not eligible for Medicaid based on his immigration status.

Hong Tran

Hong has qualified non-citizen status for Medicaid and has met the applicable five-year waiting period. Hong is eligible for Medicaid based on her household income because she lives in a state that expanded Medicaid for adults up to 138 percent of the FPL.

Thu Tran

Thu has qualified non-citizen status for Medicaid and he has met the five-year waiting period. The Marketplaces don’t determine Medicare eligibility; however, Thu might be eligible for Medicare since he is above age 65. Thu can apply for Medicare through the Social Security Administration. If he needs help or has questions about Medicare, he should contact his local State Health Insurance Assistance Program (SHIP) State Health Insurance Assistance Program (SHIP) office.

Medicare Premium Part A

U.S. citizens and qualified lawfully present immigrants age 65 and older who have at least 40 quarters of coverage (10 years for most people) may get Premium-free Part A. Some consumers may use the work history of a spouse to qualify.

Consumers aged 65 and over who don’t have sufficient quarters of coverage for Premium-free Part A may elect to enroll in Medicare Part B coverage (which also has a five-year residency requirement for immigrants) and then purchase Part A coverage by paying a premium. If consumers don’t purchase Premium Part A when they first become eligible, they may have to pay late enrollment penalties. In addition, consumers who are eligible for Part B but do not enroll when they first become eligible for Part B may have to pay late enrollment penalties on their Part B premiums as well.

Medicare Savings Program

Certain consumers can get help from their state with paying Medicare premiums. Consumers must be eligible for Medicare Part A and meet specific income and resource limits. In some cases, Medicare Savings Programs may also pay deductibles, coinsurance, and copayments if

consumers meet certain requirements. For more information, go to Minimum Federal Eligibility Requirements for Medicare Savings Programs in 2024

Extra Help (Part D)

Extra Help (Part D) is a program to help consumers with limited income and resources pay Medicare prescription drug program costs.

The Tran Family: Explain the Eligibility Determinations

Coach/consumer dialogue continues:

Coach: Hong, your Marketplace eligibility determination says you and your father, Thu, are eligible for Medicaid. Because you're both eligible for Medicaid, neither you nor your father are eligible for APTCs/CSRs if you enroll in a QHP through the Marketplace.

The Marketplace generally doesn't screen consumers for Medicare eligibility; however, your father may be eligible for Medicare based on his age. But since he qualifies for Medicaid and hasn't paid Medicare taxes long enough to qualify for premium-free Part A, he will have to pay a premium for both Part B and Part A if he enrolls in Medicare. Thu can apply for Medicare Part B and for Medicare Premium Part A through the Social Security Administration.

Your son, Hien, is not eligible for Medicaid or CHIP since he hasn't met the five-year waiting period required for lawful permanent residents. However, he is eligible to enroll in a QHP through the Marketplace. Based on your household income and household size, he's also eligible for APTC and CSRs to help lower his monthly costs. May I help you select a QHP for Hien?

Hong: Yes, thank you for explaining that to me. Let's enroll Hien in a QHP.

The Tran Family: Medicare Eligibility and Immigration Status

Remember to consider the Medicare eligibility requirements for immigrants who might qualify.

In this scenario, Thu Tran might also be eligible for Medicare Premium Part A and Part B because he meets the following criteria:

- His age (75)
- Was lawfully admitted for permanent residence and has resided in the United States continuously for the 5-year period immediately preceding the month in which he met all other requirements

If eligible, Thu must enroll in Part B in order to add Premium Part A coverage. He would have to pay monthly premiums for Medicare Part A in addition to his Part B premiums. In general, consumers who are eligible for or enrolled in Medicare aren’t eligible to receive a premium tax credit in the FFMs. However, consumers who are only eligible for Medicare Premium Part A may qualify for a premium tax credit.

Here's a key tip on helping immigrants age 65 and older who may be eligible for Medicare.

Considerations for QHPs, APTCs and CSRs related to Medicare Eligibility

- Consumers who are eligible for but not enrolled in Medicare Premium Part A may be eligible to enroll in QHPs through the FFMs.
- Depending on household income and other eligibility criteria, those consumers may be eligible for Marketplace programs to lower costs of health coverage (i.e., APTC and CSRs).
- Consumers who are not lawfully present aren’t eligible for coverage through the FFMs. To be eligible for Medicare Part B, consumers must be a resident of the US and either a citizen or lawfully admitted for permanent residence and have resided in the United States continuously during the 5 years immediately preceding the month in which they apply for enrollment. Medicare will not pay claims for individuals who are not lawfully present.

Key Tip

Remember that immigrants age 65 and older may not qualify for premium-free Medicare Part A if they haven't earned enough quarters of coverage based on payroll taxes or, in limited cases, the earnings of a spouse, parent, or child.

Helping the Tran Family

So far, the Tran family has:

- Completed the eligibility process
- Submitted an application for coverage

Next, we will review how to help them:

- Review their eligibility results and plan options
- Prepare to make plan selections

Knowledge Check

Suahila and Bilal entered the U.S. as refugees four years ago and became lawful permanent residents (LPRs) two years ago. They earn a combined household income of 95 percent of the FPL and live in a state that expanded Medicaid. Because they live in a state where the FFM can make the final eligibility determination for Medicaid, Suahila and Bilal want to know if they can apply for Medicaid through the FFM based on their household income and immigration status. Can Suahila and Bilal apply for Medicaid through the FFM based on their household income and immigration status?

Answer: Suahila and Bilal are exempt from the five-year waiting period for qualified non-citizens because of their previous refugee status. Residents of any state with an FFM can complete a Marketplace application to receive a determination or assessment for Medicaid, regardless of whether the state expanded Medicaid eligibility.

Immigrants Who Aren’t Lawfully in the United States

Consumers who aren't lawfully present don’t qualify for health coverage through a Marketplace. However, they can still complete an application for coverage for any family member(s) who are lawfully present.

Individuals applying for coverage for a family member who is lawfully present should not be asked to provide proof of their own citizenship or immigration status.

States also can’t deny benefits to an applicant because a family or household member who isn't applying hasn’t disclosed their immigration status.

Consumers who aren’t lawfully present aren’t eligible for:

- Health coverage through a Marketplace
- Programs to lower their costs through a Marketplace (e.g., APTC and CSRs)

Consumers who aren’t lawfully present may be eligible for:

- Emergency medical assistance (Emergency Medicaid) for treatment of an emergency medical condition under the Medicaid program
- Prenatal coverage for their unborn child through CHIP from conception to end-of-pregnancy (FCEP) child option (in some states)
- Public health programs, community health centers, and hospital care
- Private coverage offered outside the Marketplaces

Knowledge Check

Pierre and LaGrande aren't lawfully present, but their daughter Matou was born in the U.S. What is true about Pierre and LaGrande family's eligibility status?

Answer: Pierre and LaGrande, who aren't lawfully present but have a child who is a U.S citizen, can apply and enroll Matou in a QHP through a Marketplace. Pierre and LaGrande may be eligible for limited Medicaid to treat emergency medical conditions if eligible under the state's plan based on household income and other factors. Pierre and LaGrande aren't eligible to buy health coverage through a Marketplace. Because Matou is a U.S. citizen, she won't be subject to a five-year waiting period for Medicaid/CHIP.

Key Points

- Regardless of the parents' immigration status, if a child is born in the U.S., the child is a U.S. citizen.
- In order to avoid violating Section 1557 of the Affordable Care Act (ACA) or Title VI of the Civil Rights Act, you should not ask questions regarding the citizenship status, immigration status, or SSN of non-applicants.
- Consumers who aren't lawfully present can:
- Apply for health coverage for their family member(s) who are lawfully present without being asked about their own immigration status.
- Purchase coverage outside of the FFMs and be eligible for emergency medical assistance from Medicaid, if meeting all eligibility requirements in the state, except for U.S. citizenship or satisfactory immigration status.

Key Points (Cont'd)

- The immigration eligibility determination processes that apply in the individual market FFMs don't apply in a Federally-facilitated Small Business Health Options Program (FF-SHOP) Marketplace.
- The individual market FFM application asks consumers who aren't U.S. citizens or U.S. nationals to provide information to verify their immigration status. You should be familiar with the most common types of documents consumers may be asked to provide and where to find relevant information.
- Lawfully present immigrants who aren't eligible for Medicaid or CHIP may be eligible for APTC and CSRs based on their household income.
- Some consumers who fall under the definition of "qualified noncitizen" for Medicaid/CHIP coverage may not have to wait five years for Medicaid. These include, but are not limited to refugees, asylees, Cuban/Haitian Entrants, and Lawful Permanent Residents who adjusted from a status exempt from the 5-year bar. Other consumers under the definition of "qualified noncitizen" for Medicaid/CHIP coverage are only eligible for Medicaid after a five-year waiting period. Consumers who haven't yet met the five-year waiting period may still be eligible to enroll in QHPs through the Marketplaces. They may also qualify for APTC and CSRs.

Module 6 - Considerations for Working with Older Consumers

Introduction

Some older consumers enrolled in qualified health plans (QHPs) through the Marketplaces may need assistance to transition between coverage from QHPs to Medicare.

Older consumers include those approaching and older than age 65 that are soon to be or currently eligible for Medicare.

This module will explore engaging, educating, and helping older consumers get health coverage through the Marketplaces or referring them to other programs. By the end of this module, you should understand the following concepts and accomplish the tasks below them.

Working Effectively

Describe strategies for working effectively with older consumers.

Income Level

Describe financial considerations for older consumers.

Non-U.S. Citizens

Identify the issues and options for obtaining coverage for older consumers who aren’t U.S. citizens.

How to Engage with Older Consumers

Remember to always be respectful of everyone you help. Older consumers may face challenges with the following:

Disabilities

The need for reasonable modifications and auxiliary aids and services often increases with age. Auxiliary aids and services may be necessary for effective communication with consumers who have cognitive, hearing, speech, and/or vision impairments, as well as individuals with other types of disabilities. You'll learn more about this subject in the Working with Consumers with Disabilities course.

Caregivers

Consumers seeking coverage should be the primary decision makers about their health care coverage, even when they are accompanied by caregivers, guardians, or family members. Caregivers can participate in discussions about the consumer’s health care; however, you should strive to ensure the consumers are the focus of the discussion and participate to the greatest extent possible.

Health Literacy

As discussed previously in this course, some consumers may struggle with low literacy and/or low health literacy. Recognizing and addressing this challenge will help you provide effective assistance. You may need to spend time explaining health insurance terminology and how health insurance works before helping consumers compare their coverage options.

Working Effectively with Older Consumers

Older consumers may be eligible for several health coverage options, including coverage through the Marketplaces, employer-sponsored coverage, and Medicare or Medicaid. Providing older consumers with accurate information about coverage options is an important part of your job.

For example, you may work with:

- Older consumers applying for coverage through the Marketplaces for individuals and families or Small Business Health Options Program (SHOP) Marketplaces who'll soon be eligible for Medicare.
- Older consumers applying for health coverage through the Marketplaces who aren't yet eligible for Medicare.

To effectively help and educate older consumers about their options for coverage, you should learn about these programs. For more information, refer to the Affordable Care Act Basics course.

Considerations for Older Consumers with Income Over 138 Percent of the (FPL)

Older consumers who are not yet age 65 and are ineligible for Medicaid may ask for help applying for coverage through the Marketplaces.

If older consumers can't afford Marketplace coverage and are ineligible for Medicaid and Medicare, you can refer them to a local community health center. At a community health center, consumers can get services like vaccines, prescription drugs, and general primary and dental care. The amount consumers pay for these services depends on their household income. Other coverage options for uninsured consumers may be found in the CMS.gov Resources for the Uninsured webinar.

Ineligible for Medicaid

In states that expanded their Medicaid programs, adults under age 65 who have household income at or below a threshold (usually 138 percent of the FPL) may be eligible for coverage. As discussed later in this course, low-income individuals age 65 and older can also contact their state to find out if they qualify for Medicaid on a different basis.

Older Consumers with Income Under 138 Percent of the FPL

Older consumers may be interested in getting information about Medicare, Medicaid, and the Marketplaces.

Coverage Facts

In states that expanded Medicaid to low-income adults, consumers who become Medicare-eligible will no longer be eligible for Medicaid on that basis. State Medicaid agencies are required to screen consumers for all other forms of Medicaid eligibility, including Medicare Savings Programs (MSPs), before terminating a beneficiary's Medicaid coverage.

MSPs are Medicaid-administered programs for people on Medicare with limited income and resources. MSPs help individuals pay their Medicare premiums, copays, and deductibles. In addition, the Extra Help (Part D) program can help consumers pay Medicare prescription drug program costs, like premiums, deductibles, and coinsurance.

Messages to Consumers

If you become eligible for Medicare and are no longer eligible for full Medicaid benefits, you may qualify for Medicaid programs to help pay Medicare costs.

If you need help paying for Medicare prescription drug costs, you should call Social Security to apply for Extra Help (Part D). Extra Help (Part D) is a program to help consumers pay prescription drug program costs, like premiums, deductibles, and coinsurance.

If you need help paying for your Medicare Part B premiums or other Medicare cost sharing, you should contact your state’s Medicaid office to apply for a Medicare Savings Program (MSP).

If you aren't eligible for Medicaid or don't have Medicare, you may still be eligible for financial assistance or health coverage through the Marketplaces.

Knowledge Check

Sahand, who is 64 years old, contacts you for information regarding his coverage options. He is the only source of income for the household, and his annual income is $50,000 a year, which is below 133 percent of the FPL for his family of six. Sahand thinks it will be difficult to afford health coverage premiums. He hopes to get help through his state's Marketplace. What should you tell Sahand?

Answer: Sahand's income is under 133 percent of the FPL, so he may be eligible to enroll in Medicaid. The Marketplace will assess or determine his Medicaid eligibility, and the Marketplace or state Medicaid agency will notify him of next steps.

Considerations for Older Immigrant Adults

Let’s review some special considerations for Medicare that apply to older consumers who aren’t U.S. citizens.

Coverage Facts

In general, to be eligible for Part B when a consumer isn’t entitled to premium-free Part A, a consumer must:

- Live in the U.S.;
- Be a U.S. citizen or a lawful permanent resident having lived in the U.S. for at least five continuous years; and
- Be age 65 or older.

Part B coverage has a premium. If the consumer fails to enroll in Part B when first eligible, the individual may have a late enrollment penalty.

Messages to Consumers

If you have enough quarters of work history to qualify for Social Security, you qualify for premium-free Part A if you meet the eligibility requirements, but you aren’t eligible to have claims paid by Medicare if you're not lawfully present in the U.S. on the date the service is provided. If you’re entitled to premium-free Part A, you can enroll in Part B (which requires you to pay a premium), but you aren’t eligible to have claims paid by Medicare Part B if you're not lawfully present in the U.S. on the date the service is provided.

If you don't have enough quarters of coverage to qualify for Social Security but are a U.S. citizen or a lawful permanent resident who has lived in the U.S. for five continuous years, you may still be able to enroll in Medicare if you meet the eligibility requirements. You'll have to pay monthly premiums for Part A and Part B coverage.

If you need help or have questions about Medicare, contact your local State Health Insurance Assistance Program (SHIP) office.

If you have questions about how to get help with your premiums, you should call your state Medical Assistance (Medicaid) office and ask about MSPs.

- If you aren't eligible for Medicaid or don't have Medicare, you may still be eligible to enroll in a QHP – with or without financial assistance – through the Marketplaces.

Knowledge Check

Flora, who is 70 years old, is an immigrant. She came to the U.S. two years ago as a lawful permanent resident. She doesn't have a job or health coverage. Based on Flora’s information, what should she know about her healthcare options?

Answer: Flora isn’t eligible for Medicare because she doesn't meet the citizenship and length of residency requirement to enroll in Medicare Part B and doesn’t appear to have the necessary quarters of coverage for premium-free Part A. She may be eligible for coverage through a Marketplace.

Key Points

- Be mindful that older consumers may face challenges that require reasonable modifications and auxiliary aids and services when assisting them.
- Older consumers may be eligible for different resources and coverage options available in their communities and states.
- Older consumers who aren't U.S. citizens must be lawfully admitted for permanent residence and have resided in the U.S. continuously during the five years immediately preceding the month in which they apply for enrollment to be eligible for Medicare.

Conclusion

Great job! In this course, you learned about factors that affect access to health care for a variety of population groups and communities.

You've finished the learning portion of this course. If you choose to take the exam, the code to access this exam is: 420167.

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 2 – Select Population Groups and Communities

Serving Groups that have been Marginalized and/or Under-resourced Populations Resources: Specific Populations: Learn about the unique mental health and substance use issues faced by different U.S. population groups and how Substance Abuse and Mental Health Services Administration (SAMHSA) addresses them.
SAMHSA.gov/programs

Health Literacy and Communication: The Department of Health and Human Services' Office of Disease Prevention and Health Promotion (ODPHP) has pulled together key tools, research and reports, and resources for public health and health communication professionals.
Health.gov/our-work/national-health-initiatives/health-literacy

The CMS: Frameworks for Healthy Communities and Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities Plans for advancing health equity. The goals of the plans include increasing understanding and awareness of disparities, creating and sharing solutions, and accelerating implementation of effective actions.
CMS Framework for Healthy Communities | CMS

CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities

Special Populations Help: Assister resources on serving select population groups and communities.
CMS.gov/marketplace/in-person-assisters/technical-resources/help-special-populations

Office for Civil Rights (OCR) website: Official website of HHS OCR, which contains information about federal laws on discrimination, privacy, and conscience and religious freedom.
HHS.gov/ocr/index.html

Office for Civil Rights (OCR): How to File a Civil Rights Complaint: Consumers who believe they have been discriminated against on the basis of race, color, national origin, sex, age, disability, or religion may file a complaint with OCR.
HHS.gov/civil-rights/filing-a-complaint/complaint-process/index.html

Assister Tip Sheet: Dos and don'ts for providing non-discriminatory, CLAS, and services accessible for consumers with disabilities in Federally-facilitated and State partnership marketplaces. CMS.gov/marketplace/technical-assistance-resources/dos-and-donts-clas.pdf

Module 3 – Communicating Effectively with Consumers

Application for Health Coverage: A paper Marketplace application.
CMS.gov/marketplace/applications-and-forms/marketplace-application-without-financial-assistance.pdf

Application for Health Coverage & Help Paying Costs: A paper Marketplace application for coverage and affordability programs.
CMS.gov/marketplace/applications-and-forms/marketplace-application-for-family.pdf

Coverage to Care: The Centers for Medicare & Medicaid Services (CMS) Office of Minority Health (OMH) has created resources in English and Spanish to explain what health coverage is and how to get primary care and preventive services to help consumers and their families live long, healthy lives.
CMS.gov/priorities/health-equity/c2c

Getting Help in a Language Other than English: A CMS document that provides instructions for accessing the FFM Call Center written in a variety of languages.
CMS.gov/marketplace/outreach-and-education/getting-help-in-a-language-other-than-english.pdf

Module 4 – Working Effectively with AI/AN Individuals

Bureau of Indian Affairs (BIA) Tribal Leaders Directory: Official website of the BIA, providing a directory of Federally-recognized Indian Tribes and a variety of resources on tribal government services.
BIA.gov/service/tribal-leaders-directory

CMS Division of Tribal Affairs: The CMS Division of Tribal Affairs works closely with American Indian and Alaska Native communities and leaders to enable access to culturally competent health care to eligible Medicare and Medicaid recipients. The Division is responsible for creating and disseminating informational materials to AI/AN beneficiaries, providers, and relevant health professionals.
CMS.gov/training-education/partner-outreach-resources/american-indian-alaska-native/outreach-education-resources

Information and Tips for Assisters Working with AI/AN: A CMS document that provides background information about existing and new options for AI/AN related to affordable health coverage. The tip sheet highlights protections, how assisters can help AI/AN submit documentation to support individual market FFM applications, and other resources.
CMS.gov/marketplace/technical-assistance-resources/working-with-aian.pdfInformation for AIANs applying for coverage (cms.gov)

Health Coverage Options for AI/AN: Fact sheet for Assisters in order to assist AI/AN understand health coverage options through the Marketplace, Medicaid, and CHIP.
CMS.gov/marketplace/technical-assistance-resources/AIAN-health-coverage-options.pdf

Assisting AI/AN Consumers: Helping AI/AN understand and evaluate marketplace health coverage options webinar.
CMS.gov/marketplace/technical-assistance-resources/assisting-american-indian-alaska-native-consumers.pdf

Module 5 – Assisting Consumers who are Immigrants

Social Security Administration: Official website of the Social Security Administration. Information on Medicare, applications, and procedures.
SSA.gov/

State Health Insurance Assistance Programs (SHIP): Official website for SHIP.
SHIPhelp.org/

A Quick Guide to Immigrant Eligibility for ACA and Key Federal Means-tested Programs: This resource provides information about eligibility and rules governing immigrants' access to federal and state public benefits programs.
NILC.org/wp-content/uploads/2015/11/imm-eligibility-quickguide-2015-09-21.pdf

Federal Poverty Level Guidelines: Official Department of Health and Human Services (HHS) guidance on FPL levels.
ASPE.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

Refugee Medical Assistance: A description of refugee medical assistance programs.
ACF.hhs.gov/orr/programs/refugees/cma

Health Coverage Options for COFA Migrants: Fact sheet that provides Assisters with information to help COFA migrants understand their health coverage options.
CMS.gov/marketplace/technical-assistance-resources/health-coverage-options-cofa-migrants.pdf

Immigrant Eligibility for Marketplace and Medicaid and CHIP Coverage webinar:
CMS.gov/marketplace/technical-assistance-resources/immigrant-eligibility-marketplace-medicaid-chip.pdf

Module 6 – Considerations for Working with Older Consumers

Medicare: Official Medicare website offering resources about the Medicare program.
Medicare.gov/

Administration for Community Living: Area Agencies on Aging (AAA): A locator tool that identifies Area Agencies on Aging.
Eldercare.acl.gov/Public/About/Aging_Network/AAA.aspx

No Wrong Door: Aging and Disability Resource Centers (ADRCs): A locator tool that identifies ADRCs by geographic location. Eldercare.acl.gov/Public/Index.aspx

Independent Living Research Utilization (ILRU): Resources and information on independent living for people with disabilities as well as a locator tool for Centers for Independent Living.
ILRU.org/

National Council on Aging: Benefits Check-up: A resource that helps consumers identify and locate federal, state, and private benefits programs.
Benefitscheckup.org/

National Council on Aging: A resource for older consumers that provides information on health, health care, and economic stability programs.
NCOA.org/