Federally-facilitated Marketplace Assister Curriculum

Serving Vulnerable and Underserved Populations

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
7501 Wisconsin Avenue
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August 29, 2014

Serving Vulnerable and Underserved Populations
Course 11
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Course Introduction

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Introduction

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Flash -- Alt Text:
Animation. Welcome to the Serving Vulnerable and Underserved Populations Course. The Department of Health & Human Services logo. Health Insurance Marketplace logo.

Flash -- Long Description:

Animation. Welcome to the Serving Vulnerable and Underserved Populations Course. The Department of Health & Human Services logo. Health Insurance Marketplace logo.

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Course Introduction

Overview

Welcome to the course on Serving Vulnerable and Underserved Populations! This course was designed to help you work effectively with consumers who may have difficulty getting health coverage and basic health care services.

The course includes information on:

- How to identify factors affecting access to health coverage for vulnerable and/or underserved populations, including how not having health coverage affects access to care
- How to work effectively with vulnerable and/or underserved populations, including American Indian and Alaska Native (AI/AN) consumers; consumers who may be eligible for Medicaid, the Children's Health Insurance Program (CHIP), and Medicare; older consumers; and families with mixed immigration status

In this lesson, "you" refers to the following types of Assisters: Navigators in the Federally-facilitated Marketplace and State Partnership Marketplaces, and non-Navigator assistance personnel in the Federally-facilitated Marketplace, State Partnership Marketplaces, and that are funded with Marketplace Establishment Grant funds.

This lesson isn't a required lesson for certified application counselors (CACs), and the regulatory standards and requirements in this lesson generally don't apply to CACs.

This course concludes with an exam.

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Course Introduction

How to Navigate this Training

Navigation

- Use the **BACK** and **NEXT** buttons at the bottom of the page to move forward and backward in a module.
- Use the **Menu** button at the bottom of the page to go to any module in the course.
- Use the **Help** button at the bottom of the page for a more detailed explanation of the navigation features in this course.
- Use the **Glossary** and **Resources** buttons at the bottom of the page for additional information.
- Use the **Exit** button at the top right corner to close this course. This course contains a bookmarking feature, which allows you to exit the training at any point and return to the place you left off at a later time.

About this Course

This course doesn't contain audio. You don't need speakers or a headset unless you're working with assistive technology. For assistance with accessibility options, please select the **Help** button located at the bottom of the page.

This course contains knowledge checks or practice exercises to help prepare you for the exam you're required to take at the end of the course.

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Introduction

Consumers who are considered vulnerable and/or underserved may face barriers that make it difficult to get health coverage and basic health care services.

When helping consumers enroll in health coverage through the Health Insurance Marketplace, you're likely to meet with vulnerable and/or underserved consumers. You should be familiar with who they are, why they experience barriers to getting health coverage, and what your responsibilities are to best help consumers that may be vulnerable and/or underserved.

This training will provide you with the skills to:

- Define vulnerable and underserved populations
- Identify factors affecting health coverage for vulnerable and/or underserved populations
- Help consumers with enrollment in health coverage through the Marketplace or through other federal and state assistance programs

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Graphic -- Alt Text:
A collage with four pictures of consumers representing vulnerable and/or underserved populations, including a pregnant woman, a gay couple, a minority family, and an elderly woman

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Definitions of Vulnerable and Underserved Populations

Vulnerable populations include consumers who share one or more of the following characteristics. They:

- Have a high risk for health problems and/or pre-existing conditions
- Have limited life options (e.g., financial, educational, housing)
- Display fear and distrust in accessing government programs or disclosing sensitive information of family members
- Have a limited ability to understand or give informed consent (e.g., consumers with limited English proficiency [LEP] or cognitive impairments)
- Face mobility impairments
- Have a lack of access to transportation services
- Have a lowered capacity to communicate effectively
- Face any type of discrimination

Underserved populations include consumers who share one or more of the following characteristics. They:

- Receive fewer health care services
- Encounter barriers to accessing primary health care services (e.g., economic, cultural, and/or linguistic)
- Have a lack of familiarity with the health care delivery system
- Face a scarcity of readily available providers

Consumers from vulnerable and underserved populations might have difficulty finding health coverage or health care that meets their needs.

Graphic -- Alt Text:
A picture of a person holding a sign that reads Homeless

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Vulnerable vs. Underserved

The term vulnerable is often used interchangeably with underserved. While underserved consumers have limited access to health care services, vulnerable consumers tend to experience additional issues with getting care. For example, a consumer with LEP is considered vulnerable but might not be underserved (e.g., because he or she might have access to high-quality care).

Keep in mind that there's considerable overlap among vulnerable and underserved populations, and many consumers you serve may fall into both categories.

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Graphic -- Alt Text:
The face of an older man

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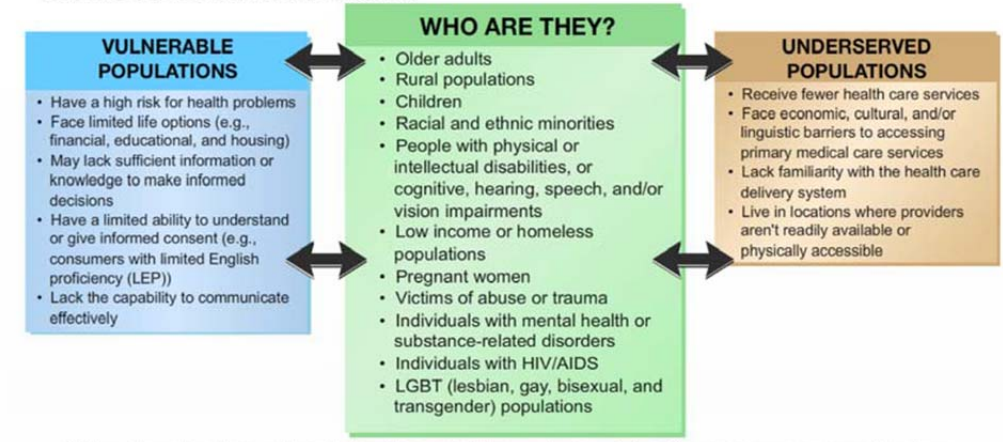
Examples of Vulnerable and/or Underserved Populations

This diagram shows the differences between vulnerable and underserved populations and illustrates that many of the consumers you'll serve fall into both categories.



Vulnerable and underserved populations have a right to equal access to health coverage programs and services.

Text Description of Image or Animation

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Flash -- Alt Text:
Diagram showing examples of consumers in vulnerable and underserved populations. See long description for more details.

Flash -- Long Description:

The diagram includes three boxes with two-way arrows linking the boxes. The first box on the left is labeled *Vulnerable Populations* and includes the following:

- Have high risk for health care problems
- Face limited life options (e.g., financial, educational, and housing)
- May lack sufficient information or knowledge to make informed decisions
- Have a limited ability to understand or give informed consent (e.g., consumers with limited English proficiency)
- Lack the capability to communicate effectively

The second box in the middle is labeled *Who Are They?* and includes consumers who may fall into the category of *both* vulnerable and underserved. It includes:

- 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 populations
- Pregnant women
- Victims of abuse or trauma
- Individuals with mental health or substance-related disorders
- Individuals with HIV/AIDS
- LGBT (lesbian, gay, bisexual, and transgender) populations

The third box on the right is labeled *Underserved Populations* and includes the following:

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

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Consumers with Pre-Existing Conditions

Health insurance companies can't refuse to sell a policy to consumers or charge them more just because they have a pre-existing condition, or charge a consumer more on this basis under any new policy. They also can't charge women more than men based on their gender under any new policy.

Certain existing plans, including grandfathered plans, may not offer these benefits. Consumers enrolled in such plans may choose to enroll in new plans that offer these benefits, either outside of the Marketplace, or through the Marketplace, if they are qualified.

- Consumers can enroll in a qualified health plan (QHP) during the Open Enrollment period. If they already have coverage, they should contact their current insurance company to learn more about terminating their current plan.
- Consumers can enroll in a QHP outside the Open Enrollment period if their grandfathered plan year ends outside of the Open Enrollment period, which gives them a special enrollment period to enroll in different coverage.

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Graphic -- Alt Text:
Doctor holding a clipboard and talking to female patient

Popup 1
Grandfathered Plans

Popup Text:
Health plans must notify consumers with these policies that they have a grandfathered plan. There are two types of grandfathered plans: job-based plans and individual plans (the kind consumers buy themselves, not through an employer). Grandfathered plans are those that were in existence on March 23, 2010. As long as these plans haven't been changed in ways that substantially cut benefits or increase costs for consumers, health insurance companies can continue to offer them to consumers.

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Married Same-Sex Couples

The Marketplace treats married same-sex couples the same as married opposite-sex couples. Insurance companies that offer health coverage to opposite-sex spouses must do the same for same-sex spouses. As long as a couple is legally married under the laws of the jurisdiction where the marriage was entered into, an insurance company can't discriminate against them when offering coverage. This means that same-sex spouses must be offered the same coverage that is offered to opposite-sex spouses. This holds true regardless of the state where:

- The couple, or either spouse, lives
- The insurance company is located
- The plan is offered, sold, issued, renewed, operated, or in effect

Federal regulations provide that health insurance companies offering non-grandfathered group or individual health insurance coverage can't employ marketing practices or benefit designs that discriminate on the basis of certain specified factors, including consumers' sexual orientations.

The Marketplace treats married same-sex couples the same as married opposite-sex couples when they apply for premium tax credits and cost-sharing reductions as well. Like married opposite-sex couples, married same-sex couples must file a joint federal tax return for the year that they're seeking help paying for coverage through the Marketplace to be eligible for help lowering their costs.

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Factors Affecting Access to Health Care

Vulnerable and/or underserved populations may face barriers to accessing health coverage and health care. Generally, access refers to the timely availability of health services to achieve the best health outcomes for a consumer.

Key barriers to accessing health care include:

- Lack of health coverage
- High health care costs
- Inconsistent sources of care
- Low health literacy
- Lack of reliable transportation or other difficulties physically accessing provider offices

Understanding these barriers will help you:

- Identify the most effective ways to communicate with vulnerable and/or underserved consumers
- Provide consumers with specific coverage information

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Graphic -- Alt Text:
An empty wheelchair at the bottom of a flight of stairs

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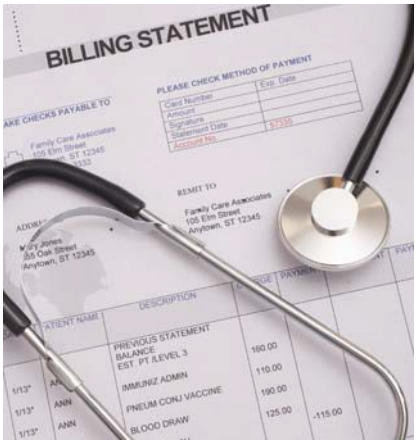
Factors Affecting Access to Health Care: Coverage Status

Health coverage is very important because it helps reduce the financial burden of seeking health care. Consumers who lack health coverage are less likely to get medical care and more likely to be in poor health. You should explain the dangers of lacking health coverage to the consumers you help.



Consumers who lack health coverage may:

- 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 might be better able to make informed decisions about obtaining coverage if they understand the physical and mental health-related disadvantages of lacking health coverage. They might also be better able to make informed decisions about getting coverage if they know about the individual shared responsibility payment, sometimes known as the individual mandate, which requires consumers to have minimal essential coverage (MEC) or pay a fee when they file their federal income taxes. Financial assistance may be available to lower the cost of a consumer's coverage.

Graphic -- Alt Text:
A billing statement and a stethoscope

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Factors Affecting Access to Health Care: Health Care Costs

Health coverage is intended to protect consumers from high health care costs. However, even with health coverage, the costs of health care can be limiting for consumers. For example, consumers who have health coverage may still experience expensive cost sharing, which can be a serious barrier to getting care.

If health coverage costs are too high, consumers may choose not to get health care or may decide that there is no reason to obtain health coverage. Consumers might benefit from learning that there are several options that may make health care coverage and costs more predictable and that will better fit their budget and specific needs. For example, the Affordable Care Act puts annual dollar limits on the out-of-pocket costs and provides other consumer benefits, such as free preventive services, both inside and outside the Marketplace. In addition, consumers who qualify for enrollment in a QHP through the Marketplace may also qualify for premium tax credits and cost-sharing reductions which help to reduce the cost of health coverage. Consumers who are not eligible for a QHP may qualify for Medicaid, a low cost public health program.

Graphic -- Alt Text:
A woman sitting on the floor in an empty room surrounded by stacks of receipts and bills

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Factors Affecting Access to Health Care: Inconsistent Sources of Care

Consumers without access to health coverage are likely to get treatment off and on from inconsistent sources of care. For example, a consumer who lacks health coverage may get care for an illness by going to a hospital, free clinic, and/or treatment center. This is reactive treatment to a health emergency, not care that would prevent such an emergency. Research has proven that consumers who regularly see the same doctor tend to have better health outcomes. If consumers have health coverage and visit the same doctor regularly, then their quality of care improves and they're more likely to get health care that prevents a health emergency from occurring.

Graphic -- Alt Text:
A young doctor taking an older woman's blood pressure

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Knowledge Check

You're advising a low-income 28-year-old man about his health coverage options through the Marketplace. He tells you that he hasn't been sick for the last three years, feels perfectly healthy, and doesn't think he needs health coverage. He also tells you that he has a family history of diabetes and has moved several times over the past five years. Everywhere he's lived, he's visited the local clinic and everything has "checked out." You would like to help him understand why health coverage might benefit him. Which statement below is FALSE?

Select **the correct answer** and then click **Check Your Answer**.

- ○ **A.** Although you may feel healthy, regular care is still very important. Doctors can help you find health problems you may not know are there and treat them before they get more serious.
- ○ **B.** If you got into an accident and didn't have health insurance, you'd have to pay out-of-pocket for your medical care. Emergency care can be extremely expensive.
- ○ **C.** People who don't have health coverage and don't see a doctor regularly tend to have poor health and shorter life spans.
- ○ **D.** If you continue to visit local clinics wherever you relocate, that will help you get the important preventive care you need and will also fit your budget and specific needs.

Check Your Answer | Reset

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Question:

You're advising a low-income 28-year-old man about his health coverage options through the Marketplace. He tells you that he hasn't been sick for the last three years, feels perfectly healthy, and doesn't think he needs health coverage. He also tells you that he has a family history of diabetes and has moved several times over the past five years. Everywhere he's lived, he's visited the local clinic and everything has "checked out." You would like to help him understand why health coverage might benefit him. Which statement below is FALSE?

Correct Answer:

D

Feedback for Correct Answer:

Correct! The consumer might benefit from learning about the importance of seeing a doctor to help treat health problems before they get more serious. Also, having health coverage can help consumers avoid expensive medical bills in case of an emergency. Moreover, consumers who have health coverage and a doctor they regularly see tend to have better health and live longer. Lastly, the quality of care and preventive services consumers get have been shown to improve when consumers see a regular doctor, as opposed to visiting a clinic in various locations.

Feedback for Incorrect Answer:

Incorrect. The correct answer is D. The consumer might benefit from learning about the importance of seeing a doctor to help treat health problems before they get more serious. Also, having health coverage can help consumers avoid expensive medical bills in case of an emergency. Moreover, consumers who have health coverage and a doctor they regularly see tend to have better health and live longer. Lastly, the quality of care and preventive services consumers get have been shown to improve when consumers see a regular doctor, as opposed to visiting a clinic in various locations.

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Key Points

You should be able to recognize when a consumer might be vulnerable and/or underserved and understand that vulnerable and/or underserved consumers might face barriers accessing health care programs and services.

You should be able to recognize how lacking health coverage creates barriers to accessing health care.

You should be able to help consumers understand the importance of seeing a doctor regularly and having health coverage, which can help reduce the costs of health care and allow consumers to get preventive care (often free of charge), get a timely diagnosis, and live longer, more healthy lives.

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How to Reach and Work Effectively with Vulnerable and Underserved Populations

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 health coverage. It's essential that you learn how to best reach and help consumers make important health coverage choices.

This training will provide you with the skills to:

- Recognize unique communication needs of vulnerable and underserved populations
- Identify tips for working effectively with vulnerable and underserved populations

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Graphic -- Alt Text:
A collage of people receiving medical care including an older woman talking with a child in a doctor's waiting room, a pregnant woman on an exam table, a little girl getting a vaccination, and a waiting room full of people

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How to Reach and Work Effectively with Vulnerable and Underserved Populations

Conducting a Needs Assessment for Consumers

Before beginning to help consumers, it's important to conduct an initial needs assessment. Once you've determined consumers' understanding of health insurance, the Affordable Care Act, and the Marketplace, you can begin to ask them questions about their current health coverage status and their needs and preferences for getting health coverage through the Marketplace.

This module will help you understand key considerations to remember when helping and conducting a needs assessment for consumers who may be vulnerable or underserved.

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Graphic -- Alt Text:
Woman filling out paperwork while an Assister watches her

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General Questions to Ask When Conducting a Needs Assessment

Here are some initial sample questions to ask consumers to find out important information about their general health coverage needs.

Needs Category	Sample Questions
Consumers seeking information	• What questions do you have about how the Affordable Care Act impacts your health coverage? • What questions do you have about the Marketplace application process? • What questions do you have about the eligibility requirements for enrolling in coverage through the Marketplace? • What information would you want to have before you choose your health coverage options through the Marketplace? • What questions do you have about paying for your health coverage? • What could I/we do to make this process easier for you?
Consumers seeking health coverage for themselves or their families	• What kind of health coverage have you and your family had in the past? • Who in your family needs health coverage? • What is most important to you in your health coverage (e.g., benefits and services, reduced cost, keeping a doctor)? • How does your employer help you and other employees with your health care costs?

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Importance of Identifying and Helping Vulnerable and Underserved Consumers

While conducting the initial needs assessment, it's important to remember that individuals who are members of vulnerable and/or underserved populations might have poorer health than the average consumer, and might get fewer or less adequate health care services.

You can best help these consumers by:

- Identifying those who may fit into one of these populations
- Considering their specific needs when informing them about how to access health coverage

Graphic -- Alt Text:
A smiling group of people of all ages and ethnicities

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Factors Contributing to Unique Communication Needs

To help vulnerable and underserved consumers, you must be able to communicate with them appropriately and effectively. Communication methods that work well with one community may not necessarily work well for another.

Factors to consider when communicating with vulnerable and/or underserved populations include:

- Cultural and linguistic differences
- Health literacy
- Accommodations for consumers with physical or intellectual disabilities
- Geographic location
- Demographic factors (i.e., age)

Graphic -- Alt Text:
Collage of an English as a second language (ESL) teacher holding a piece of chalk, an older woman reading a prescription bottle looking confused, someone in a wheel chair, and a family walking on a dirt path behind a herd of cattle

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Cultural and Linguistic Differences

The term cultural and linguistic competence is defined as a set of similar behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.

Remember that culture is defined as integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

Factors that influence culture include: age, country of origin, education level, gender identity, health practices, language spoken, occupation, physical ability and limitations, gender, sexual orientation, and socioeconomic status.

For you, cultural and linguistic competence means you should:

- Know that consumers may have cultural and linguistic differences; and
- Be able to respond appropriately to the needs associated with these differences.

Always remember that characteristics and behaviors of cultural groups can't be presented as a checklist. It's important not to group people together because doing so may prevent you from recognizing and serving the needs and preferences of individual consumers.

To avoid stereotyping, ask consumers how they perceive or identify themselves, their partners, and their family members. Then use the same terms as the consumers, and ask for clarification of the terms used if appropriate. Remember to treat each person as a unique individual.

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Tips and Examples: Treat Each Consumer as Unique and Avoid Assumptions

Keep the following tips and examples in mind as you work with consumers from different backgrounds and encounter people that look different from one another:

Tips	Examples
Respect the unique cultural needs of all consumers.	Some consumers may believe in culturally traditional medicine, like using herbs to treat illness, which is different from Western medicine. When helping consumers with these beliefs, it might be helpful to: 1. Acknowledge your respect for their beliefs (which is different than agreeing with them); 2. Explain the potential benefits of getting health coverage; and 3. Tell them you understand if they choose to decline health coverage (but explain that there may be a fee if they don't get health coverage).
Avoid making assumptions about a consumer's culture or identity based on the consumer's appearance, name, or other outward characteristics.	Consumers are all different in their own way. • A consumer who appears to you to be of a certain race or ethnicity may identify with something different, with characteristics not commonly associated with that race or ethnicity. For instance, a consumer with dreadlocks may appear to you to be African American but may be from a biracial family and may primarily identify with another race. • A consumer's gender identity may also be different from your perception. It's therefore recommended that you use gender-neutral pronouns.

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Tips and Examples: Acknowledging Different Linguistic Abilities and Cultures

The consumers you work with may have different English speaking and writing abilities and may also come from cultural backgrounds very different from your own. Here are some tips to consider to help you provide better service:

Tips	Examples
Acknowledge and accept that consumers will sometimes have mixed levels of linguistic abilities where speaking and writing skills differ. Be aware of and sensitive to this and know how to respond appropriately.	There may be times when you interact with consumers who will be able to understand and speak English well but may not be able to read and write in English. In this case, you'll need to identify materials in their preferred language. However, be sure that they can read in that language before giving them written information. Also, be sure to know how to get translation or interpretation services, including American Sign Language (ASL), to help them if translation or interpretation is required.
Know that culture includes the expression of religious beliefs that can influence health coverage decisions, and you must respect these beliefs.	You may encounter consumers who have a value system that doesn't allow them to use medicine to treat illness (e.g., Christian Scientists). It might be helpful to: 1. Help them understand how health coverage can benefit them; 2. Understand that they may reject health coverage, even after you explain how health coverage can benefit them; and 3. Know how to help them file for an exemption from the individual shared responsibility payment.

There's no expectation for you to know all of the cultural traits and linguistic needs of all consumers, but you should be aware that differences exist and know how to access resources that can help you provide quality assistance to all consumers.

Popup 1
Preferred Language

Popup Text:

Keep in mind that consumers might feel they speak and understand English well, when they actually don't. It's important to respect their opinion while acknowledging that they may have a preferred language other than English in which they feel more comfortable in communicating and receiving information.

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Effectively Communicating with Consumers with Limited English Proficiency

To communicate effectively with consumers with limited English proficiency (LEP), you can provide free translated written documents and oral interpretation services.

To communicate effectively with consumers who have hearing, speech, and/or vision impairments, you should provide information about the availability of audio and visual materials, Braille documents, and sign language interpreters in plain language. These services must be provided at no additional cost to consumers.

Graphic -- Alt Text:
Page of a book with the word communication highlighted

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Knowledge Check

Katarina and Felix aren't native English speakers. They both speak some English, but Felix speaks better English than Katarina. They don't have access to a car or enough money for public transportation. Based on this information, which of the following steps could you take to provide support to Katarina and Felix?

Select **all that apply** and then click **Check Your Answer**.

- ☐ **A.** Ask Katarina and Felix about their preferred spoken and written language.
- ☐ **B.** Without telling Katarina that professional interpreters are available or asking her what she prefers, inform Katarina and Felix that you aren't able to help them during this visit.
- ☐ **C.** Identify a location to meet close to Katarina and Felix's place of residence.
- ☐ **D.** Locate materials written in Katarina and Felix's native language or translate materials as necessary.

Check Your Answer | Reset

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Question:

Katarina and Felix aren't native English speakers. They both speak some English, but Felix speaks better English than Katarina. They don't have access to a car or enough money for public transportation. Based on this information, which of the following steps could you take to provide support to Katarina and Felix?

Correct Answers:

A ,C ,D

Feedback for Correct Answer:

Correct! It's a best practice to ask consumers about their preferred spoken and written language. You should locate materials written in Katarina and Felix's native language or translate materials as necessary. You're responsible for providing the written and oral language services that consumers need, or you might be able to refer consumers to other available resources. You should also tell Katarina that professional interpreters are available and ask what Katarina prefers. Use of a consumer's family or friends as oral interpreters can satisfy the requirement that you provide linguistically appropriate services only when requested by the consumer as the preferred alternative to an offer of other interpretive services. You should also do your best to accommodate Felix and Katarina's transportation limitations and identify a location to meet close to Katarina and Felix's place of residence.

Feedback for Incorrect Answer:

Incorrect! The correct answers are A, C, and D. It's a best practice to ask consumers about their preferred spoken and written language. You should locate materials written in Katarina and Felix's native language or translate materials as necessary. You're responsible for providing the written and oral language services that consumers need, or you might be able to refer consumers to other available resources. You should also tell Katarina that professional interpreters are available and ask what Katarina prefers. Use of a consumer's family or friends as oral interpreters can satisfy the requirement that you provide linguistically appropriate services only when requested by the consumer as the preferred alternative to an offer of other interpretive services. You should also do your best to accommodate Felix and Katarina's transportation limitations and identify a location to meet close to Katarina and Felix's place of residence.

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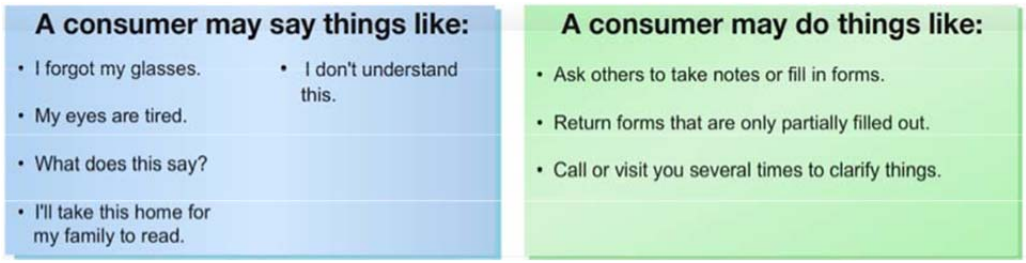
Consumers with Low Literacy

In general, literacy refers to an individual's ability to read and write. The ability to read, write, and speak English or another language, can affect how well consumers understand their health coverage options.

Consumers may be embarrassed or ashamed about their low literacy and try to hide the fact that they have difficulty reading or writing. However, a consumer who appears to have difficulty reading may have simply forgotten his or her glasses. Consider the factors at hand to alert you that there might be a literacy issue.

If you believe that you've identified someone with low literacy, you should reference the resources provided in this training to better prepare you to help them, or seek guidance from a partner organization that has expertise with helping this type of consumer.



Text Description of Image or Animation

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Flash -- Alt Text:
Two boxes listing things a consumer may say or do to indicate lack of health literacy. See long description for more details.

Flash -- Long Description:

Two boxes listing things a consumer may say or do to indicate lack of health literacy:

A consumer may say things like:

- I forgot my glasses.
- My eyes are tired.
- What does this say?
- I'll take this home for my family to read.
- I don't understand this.

A consumer may do things like:

- Ask others to take notes or fill in forms.
- Return forms that are only partially filled out.
- Call or visit you several times to clarify things.

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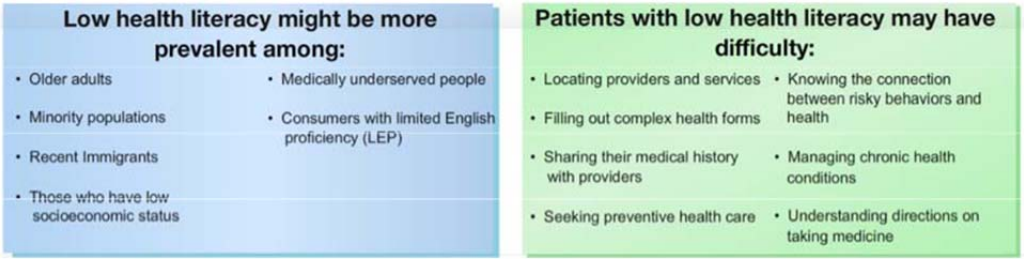
Consumers with Low Health Literacy

Generally, health literacy is the ability to get and understand basic information about health coverage and health care services, use the information about health coverage and health care services to make decisions, and follow instructions for treatment. Health-literate consumers understand health coverage and coverage options.

A combination of several of the following signs may indicate low health literacy in consumers.



Text Description of Image or Animation

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Flash -- Alt Text:
Two boxes listing characteristics of consumers and things a consumer may say or do to indicate lack of health literacy. See long description for more details.

Flash -- Long Description:

Two boxes listing characteristics of consumers and things a consumer may say or do to indicate lack of health literacy:
Low health literacy might be more prevalent among:

- Older adults
- Minority populations
- Recent Immigrants
- Those who have low socioeconomic status
- Medically underserved people
- Consumers with limited English proficiency (LEP)

Patients with low health literacy may have difficulty:

- Locating providers and services
- Filling out complex health forms
- Sharing their medical history with providers
- Seeking preventive health care
- Knowing the connection between risky behaviors and health
- Managing chronic health conditions
- Understanding directions on taking medicine

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How to Help Consumers with Low Literacy and Low Health Literacy

How can you help consumers, especially those with low literacy and low health literacy?

Tips for Working with Low Literacy Consumers	Tips for Working with Low Health Literacy Consumers
• Use commonly used words • Ask open-ended questions • Read written 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	• Avoid using acronyms • Avoid technical language when possible • Explain any necessary technical terms • Ask consumers to repeat back vital or key things that you say to them • Give information in small chunks • Understand that it may take additional time to help consumers

For more information on ways to work with consumers who have low literacy and low health literacy, refer to the "Resources" section.

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Plain Language and Consumers with Low Literacy and Low Health Literacy

To accommodate consumers, especially those with low literacy and low health literacy, you should:

- Use plain language and simple words, including when you describe difficult health coverage terms.
- Write information down and share it with the consumer, who can read it in greater detail 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 “The translator was obtained by me").

Plain language examples include:

- Instead of "qualified health plans," you can say "health plans that have been approved by the Marketplace."
- Instead of “premium tax credit,” you can say “a tax credit that can be used to lower your monthly health insurance payments.”

Graphic -- Alt Text:
A consumer Assister explaining a document to an older woman

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How to Reach and Work Effectively with Vulnerable and Underserved Populations

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Knowledge Check

Nina is one of your consumers who can't seem to make up her mind about health coverage. She frequently visits your office with questions and hasn't completed her eligibility application. You provide Nina with brochures and flyers about available health coverage options but in your conversations it becomes clear that she hasn't read the materials. You think Nina may have low literacy and/or low health literacy. Which one of the following actions would be the most appropriate way to help her?

Select **all that apply** and then click **Check Your Answer**.

- ☐ **A.** Schedule more time with Nina, and ask her open-ended questions about why she's not filling out an eligibility application.
- ☐ **B.** Encourage Nina to fill out her eligibility application at home by delaying your next meeting until the application is completed.
- ☐ **C.** Use visual aids to help Nina understand the information because written materials may not be helping her.
- ☐ **D.** Refer Nina to an insurance company of your choice, which may be better able to meet her needs.

Check Your Answer | Reset

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Question:

Nina is one of your consumers who can't seem to make up her mind about health coverage. She frequently visits your office with questions and hasn't completed her eligibility application. You provide Nina with brochures and flyers about available health coverage options but in your conversations it becomes clear that she hasn't read the materials. You think Nina may have low literacy and/or low health literacy. Which one of the following actions would be the most appropriate way to help her?

Correct Answers:

A ,C

Feedback for Correct Answer:

Correct! It's important for you to understand what keeps Nina from filling out an eligibility application. Nina shows signs of a consumer with low literacy and/or low health literacy and may not understand the written materials you have provided. Try alternatives, like pictures and audio recordings. While it's ultimately your responsibility to provide Nina with the assistance she needs, you're prohibited from providing biased information about her health coverage options.

Feedback for Incorrect Answer:

Incorrect. The correct answers are A and C. It's important for you to understand what keeps Nina from filling out an eligibility application. Nina shows signs of a consumer with low literacy and/or low health literacy and may not understand the written materials you have provided. Try alternatives, like pictures and audio recordings. While it's ultimately your responsibility to provide Nina with the assistance she needs, you're prohibited from providing biased information about her health coverage options.

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Consumers with Disabilities

Consumers with physical or intellectual disabilities may need special help to gain access to health coverage information.

The Americans with Disabilities Act (ADA), the Americans with Disabilities Act Amendments Act of 2008 (ADAAA), Section 504 of the Rehabilitation Act, and other disability laws might require you or the organization you work with to provide “reasonable modifications” and auxiliary aids and services for certain consumers with disabilities depending on whether you receive federal financial assistance.

Examples of reasonable modifications and auxiliary aids and services include:

- Modifying rules, policies or practices
- Removing architectural or communication barriers
- Providing aids, services, or assistive technology

You’ll learn more about this subject later in this training.

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Graphic -- Alt Text:
The universal symbols for physical, hearing, and sight impairments

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Accommodations for Consumers with Disabilities

What kind of reasonable modifications and auxiliary aids and services are you expected to provide for consumers with physical or intellectual disabilities?

Here are some examples:

- Materials that are Section 508 compliant, like electronic documents that consumers who are blind can read with screen readers or Braille text (Section 508 requires federal agencies to ensure that consumers with disabilities, both employees and members of the public, have equal access to and use of electronic information technology)
- Materials in large print for consumers who have low vision
- Sign language interpreters and closed-captioned video materials for consumers who are deaf
- Accessible equipment, like height-adjustable tables for consumers in wheelchairs
- Accessible buildings (e.g., buildings with ramps and offices, common spaces, and restrooms that can accommodate mobility devices) for in-person meetings for consumers with limited mobility
- Plain language materials for all consumers

It's not a best practice to assume consumers with disabilities always need your help. It's polite to offer help, but once you've offered it, wait for a response before acting. If the consumer accepts your offer of help, the consumer may provide you with directions on how you can assist.

Graphic -- Alt Text:
A wheelchair ramp leading into a building

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Consumers in Rural Communities

You may have trouble contacting some vulnerable and underserved consumers because of where they live. Consumers in rural areas may face barriers to accessing essential health services, which contributes to poorer health outcomes. They may also be underserved in terms of health coverage, which is why they need your help.

Rural consumers may have limited:

- **Access to transportation:** Rural residents may not be able to visit locations where they can get health coverage information (e.g., community centers). Note that urban residents may also have transportation issues (e.g., public transportation may not be located near their residence and/or they may not be able to afford it).
- **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 have the ability or resources to access health coverage information online; internet access may not be available in some very rural areas of the country.

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Reaching and Engaging Rural Consumers

What can you do to reach and work effectively with rural consumers?

- Partner with rural community-based organizations to help you reach consumers.
- Conduct outreach or other marketing events in locations where rural populations may work, live, or get community services. Consider conducting outreach in the locations below:
  - For rural consumers in general: consumer places of work, faith-based institutions, libraries, community clubs, Department of Agriculture (USDA) extension programs to reach farmers and schools
  - For rural consumers with low incomes: places where they apply for or get help (e.g., shelters, day centers, food banks, state's energy assistance program or other social service organizations)
  - For rural consumers with disabilities: buildings with ramps and that are otherwise accessible to consumers in wheelchairs or with limited mobility, and buildings with adequate signage

Graphic -- Alt Text:
A collage of photos, including a country church with a sign announcing a roast beef supper; a sign pointing to the post office, store, and community hall; volunteers at a food bank; and a rural schoolhouse

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How to Reach and Work Effectively with Vulnerable and Underserved Populations

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Knowledge Check

Jasmine is a 27-year-old consumer who lives in rural Arkansas. She is a lawfully present immigrant who identifies strongly with her Japanese culture. She works full-time as a hostess in a diner making $10 per hour. Jasmine is single and also has limited vision. You have scheduled a meeting with Jasmine for this week to discuss health coverage options. What do you need to do to prepare for your meeting?

Select **all that apply** and then click **Check Your Answer**.

- ☐ **A.** Learn about reasonable modifications and auxiliary aids and services under the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act, and be sure that you can meet vision-related needs that might come up for Jasmine.
- ☐ **B.** Find out how well Jasmine speaks English and if she prefers to use an interpreter. If so, you need to arrange for one in advance of your meeting with Jasmine.
- ☐ **C.** Reschedule Jasmine's appointment with a colleague in your office because you don't identify with her culture.
- ☐ **D.** Ask Jasmine to read health coverage information available online at HealthCare.gov in advance of your meeting so that she is well informed.

Check Your Answer | Reset

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Question:

Jasmine is a 27-year-old consumer who lives in rural Arkansas. She is a lawfully present immigrant who identifies strongly with her Japanese culture. She works full-time as a hostess in a diner making $10 per hour. Jasmine is single and also has limited vision. You have scheduled a meeting with Jasmine for this week to discuss health coverage options. What do you need to do to prepare for your meeting?

Correct Answers:

A ,B

Feedback for Correct Answer:

Correct! Jasmine has multiple needs because she is both vulnerable and underserved. Jasmine has a pre-existing condition, may not be familiar with the health care delivery system, and also may not have readily available providers in her geographic location. Jasmine may speak English well, but if she doesn't, you might be required to provide her with an interpreter or some other means of translation (e.g., telephonic) for your meeting with her, depending on Jasmine's preferences. Jasmine also has a visual impairment, so you might need to provide reasonable accommodations. Jasmine may need large-print materials and some written documents may have to be read out loud to her. Additionally, you should provide Jasmine with the same level of service that you provide to all of your consumers, so you should be able to respond appropriately to any needs associated with Jasmine's cultural and language differences.

Feedback for Incorrect Answer:

Incorrect. The correct answers are A and B. Jasmine has multiple needs because she is both vulnerable and underserved. Jasmine has a pre-existing condition, may not be familiar with the health care delivery system, and also may not have readily available providers in her geographic location. Jasmine may speak English well, but if she doesn't, you might be required to provide her with an interpreter or some other means of translation (e.g., telephonic) for your meeting with her. Jasmine also has a visual impairment, so you might need to provide reasonable accommodations. Jasmine may need large-print materials and some written documents may have to be read out loud to her. Additionally, you should provide Jasmine with the same level of service that you provide to all of your consumers, so you should be able to respond appropriately to any needs associated with Jasmine's cultural and language differences. Lastly, at this point you don't know if Jasmine has access to the Internet and it wouldn't be appropriate to require her to read online materials.

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How to Reach and Work Effectively with Vulnerable and Underserved Populations

Available Resources

Finding the right type of information to help you reach and work effectively with diverse vulnerable and underserved populations may be challenging.

The "Resources" section offers many helpful resources in the following areas:

- Working with consumers from different cultures
- Working with consumers with LEP
- Working with consumers with low health literacy
- Working with consumers with disabilities
- Working with consumers from rural communities

Graphic -- Alt Text:
Directional pole with arrows that say Help, Support, Advice, Guidance, and Assistance

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Key Points

You should be prepared to help consumers that are vulnerable (e.g., consumers with limited life options, pre-existing conditions, LEP, and/or mobility impairments) and underserved (e.g., consumers who experience barriers to accessing primary care and/or are unfamiliar with the health care delivery system). While underserved consumers have limited access to health care services, vulnerable consumers tend to experience additional issues with getting care, though many consumers may fall into both categories.

Key barriers to accessing health care for vulnerable and underserved populations include: lack of health coverage, high health care costs, inconsistent sources of care, low health literacy, lack of reliable transportation, and/or other difficulties physically accessing provider offices.

You should respect the needs of different consumers, understand how their needs affect your communication with them, and value how health coverage needs can be different based on the consumer's culture.

*Click **NEXT** to return to the main menu.*

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Working Effectively with American Indians and Alaska Natives (AI/ANs)

Introduction

In the United States (U.S.), there's a special government-to-government relationship between the federal government and federally recognized tribes, including regional and village corporations that were established under the Alaska Native Claims Settlement Act (ANCSA). There are more than 560 federally recognized tribes, including over 200 ANCSA regional and village corporations. The members of these tribes and shareholders of ANCSA corporations are referred to in this training as American Indians and Alaska Natives (AI/ANs). Special benefits and exemptions are available to AI/ANs under the Affordable Care Act, including:

- Year-round enrollment and the ability to switch plans monthly
- Cost-sharing reductions at zero cost sharing and limited cost sharing in any health plan category, depending upon income
- Eligibility for an exemption from the individual shared responsibility payment
- Ability to continue to get services from an Indian Health Service (IHS), tribal or urban Indian health care provider even after the AI/AN has enrolled in private insurance through the Marketplace

Assisters are encouraged to have ongoing education, outreach, and enrollment events with the AI/AN population and to continue these efforts past February 15, 2015, the date that the Open Enrollment period ends for 2015.

This training will provide you with the skills to:

- Identify the special relationship between the federal government and federally recognized tribes/ANCSA corporations
- Describe the structure of the Indian health system, the role of the IHS, and health challenges faced by the AI/AN population
- Recognize Marketplace benefits and exemptions for eligible AI/ANs and the application steps required to file for an exemption or enroll in health coverage through the Marketplace, Medicaid, and the Children's Health Insurance Program (CHIP)

*Click **NEXT** to continue.*

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Working Effectively with American Indians and Alaska Natives (AI/ANs)

Historical Background

Federally recognized tribes, ANCSA regional and village corporations, and the federal government have a historical government-to-government relationship based on U.S. treaties, laws, Supreme Court cases, Executive Orders, and the U.S. Constitution. The federal government has a legal duty, known as the Indian trust responsibility toward Indian tribes.

As part of this unique relationship, the federal government provides health care, social services, housing, education, and other services to AI/ANs, through federal agencies such as the Department of Health & Human Services (HHS) and the Bureau of Indian Affairs (BIA).

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Graphic -- Alt Text:
A collage of American Indian and Alaska Native individuals

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Working Effectively with American Indians and Alaska Natives (AI/ANs)

Definition of AI/AN

Who is an AI/AN?

The definition of AI/AN is different for purposes of the U.S. Census, eligibility for IHS services, special benefits under Medicaid and CHIP, and for the Marketplace. For purposes of the special protections in the Marketplace, an AI/AN is a member of a federally recognized tribe or a shareholder in an ANCSA corporation.

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Graphic -- Alt Text:
American Indian man standing holding a feather and an abalone shell with smoldering sage

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Working Effectively with American Indians and Alaska Natives (AI/ANs)

Health Care Services for AI/ANs

Over the years, many different U.S. government agencies have been responsible for providing health care to AI/ANs. In 1955, the federal government established the IHS under HHS to provide health care to people of Indian descent. The Affordable Care Act reauthorized and made permanent the Indian Health Care Improvement Act, which in addition to the Snyder Act, is the underlying authority for the IHS. 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 and are usually not charged for services provided in the facilities.

Currently, the Indian health care system includes 44 Indian hospitals and nearly 570 Indian health centers, clinics, and health stations. A large portion of these health facilities are managed by the tribes. When specialized services aren't available at these sites, health services are purchased from public and private providers through the Purchased/Referred Care Program, formerly known as the Contract Health Service (CHS) program. Thirty-four urban programs also offer services ranging from community health to comprehensive primary care in urban Indian communities.

Taken together and referred to as I/T/U, the IHS (I), tribes and tribal organizations (T), and urban Indian organizations (U) are the three components of the Indian health system. AI/ANs who enroll in the Marketplace can still get care at an I/T/U.

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Graphic -- Alt Text:
The Indian Health Service (IHS) logo--a caduceus (health symbol) and a feather in the center with the words Indian Health Service, PHS, and the year 1955 in the outer rim of the circle

Popup 1
Snyder Act

Popup Text:
The Indian Health Care Improvement Act of 1976 and the Snyder Act of 1921 comprise the basic legislative authority for the IHS.

The Snyder Act provides authority for the expenditure of funds, as Congress may appropriate, for the benefit, care and assistance to Indians throughout the United States.

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Working Effectively with American Indians and Alaska Natives (AI/ANs)

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Knowledge Check

You just scheduled your first meeting with Ann and Joe, a married American Indian/Alaska Native (AI/AN) couple. You'd like to do some research before the meeting so that you can better help them. Which of the following topics would be MOST relevant?

Select **all that apply** and then click **Check Your Answer**.

- ☐ **A.** The Indian Health Service (IHS) and the services it offers in Anna and Joe's community or areas nearby
- ☐ **B.** The history of the relationship between the federal government and federally recognized tribes so that you can challenge Anna and Joe on their knowledge and ability to prove they qualify for Marketplace benefits and exemptions for eligible AI/ANs
- ☐ **C.** Available Indian Health Service (I), tribes and tribal organizations (T), and urban Indian organizations (U) (I/T/U) service units in Anna and Joe's nearby community
- ☐ **D.** Affordable Care Act benefits for AI/ANs

Check Your Answer | Reset

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Question:

You just scheduled your first meeting with Ann and Joe, a married American Indian/Alaska Native (AI/AN) couple. You'd like to do some research before the meeting so that you can better help them. Which of the following topics would be MOST relevant?

Correct Answers:

A ,C ,D

Feedback for Correct Answer:

Correct! A large portion of AI/ANs access care through longstanding relationships with providers in the Indian health care system. You should learn more about the IHS, and I/T/U providers in general, to better help Ann and Joe. While it may be helpful to have basic knowledge of the historical government-to-government relationship between the federal government and federally recognized tribes, it would not be appropriate to quiz consumers on the history or to ask consumers for any additional information beyond the specified documentation required by the Marketplace for verifying status as an AI/AN.

Feedback for Incorrect Answer:

Incorrect. The correct answers are A, C, and D. A large portion of AI/ANs access care through longstanding relationships with providers in the Indian health care system. You should learn more about the IHS, and I/T/U providers in general, to better help Ann and Joe. While it may be helpful to have basic knowledge of the historical government-to-government relationship between the federal government and federally recognized tribes, it would not be appropriate to quiz consumers on the history or to ask consumers for any additional information beyond the specified documentation required by the Marketplace for verifying status as an AI/AN.

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Federally Recognized Tribes and AI/AN Population in the U.S.

What's considered a federally recognized tribe in the U.S.?

A federally recognized tribe is any Indian or Alaska Native tribe, band, nation, Pueblo, village, or community that the Department of the Interior (DOI) acknowledges as an Indian tribe, including ANCSA regional and village corporations. There are over 560 federally recognized tribes in the U.S. You may see the full list of federally recognized tribes and Alaska Native entities by visiting the Bureau of Indian Affairs (BIA) Tribal Directory and the list of ANCSA corporations available from the Alaska Department of Resources.

How many AI/AN people live in the U.S.?

According to the U.S. Census, there are 5.2 million people in the U.S. who identify themselves as AI/AN, either alone or in combination with one or more other races. Approximately, 2 million people receive services from I/T/Us.

Where do AI/AN people live in the U.S.?

While AI/AN consumers live in every state, the 10 states with the largest AI/AN populations are California, Oklahoma, Arizona, Texas, New York, New Mexico, Washington, North Carolina, Florida, and Michigan. Smaller AI/AN populations live in other states throughout the U.S.

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State of Health Care for AI/ANs

According to publicly available reports:

- One in three non-elderly AI/ANs under age 65 is either uninsured or depends solely on services provided through the IHS.
- More than half of AI/ANs are low-income.
- The number of low income AI/ANs under age 65 is higher than for any other racial or ethnic group and about twice as high as the poverty rate of all people in the U.S. under age 65.
- AI/ANs have the highest rate of many health conditions, with about one in five AI/ANs having two or more chronic conditions.

Because the IHS has limited appropriations, there is no guarantee that it'll meet all the health care needs of AI/ANs. For this reason, enrollment in the Marketplace is important. By enrolling in a Marketplace qualified health plan, AI/ANs benefit by having greater access to services that may not be provided by their local I/T/U, and the tribal communities benefit through increased resources to their I/T/Us.

Graphic -- Alt Text:
A young pregnant American Indian woman

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Working Effectively with American Indians and Alaska Natives (AI/ANs)

Eligibility for Marketplace Participation

Consumers must demonstrate that they meet certain eligibility criteria to show that they qualify as AI/ANs. They can do this by providing a copy of a document issued by a federally recognized tribe, the BIA, or ANCSA corporation showing membership, enrollment, or shareholder status (e.g., membership or enrollment card). This document should have a signature and/or seal on it.

To show their eligibility for Marketplace participation and premium assistance (advance payments of the premium tax credit and cost-sharing reductions), consumers must provide information about the size of their family and how much money they earn or receive, if they want to apply for help paying for coverage. In general, income from Indian trust land, natural resources, and items of cultural significance aren't counted for Marketplace, Medicaid, or CHIP eligibility, if the income isn't reported on a federal income tax return.

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Graphic -- Alt Text:
An American Indian man reviewing documents

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Working Effectively with American Indians and Alaska Natives (AI/ANs)

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Knowledge Check

When scheduling your meeting with Ann and Joe, you learn that they would like to know more about the benefits of health coverage. You plan to discuss health coverage available through the Marketplace, Medicaid, and the Children's Health Insurance Program (CHIP), but want to make sure they come prepared to your meeting. What information will Ann and Joe need to provide to show their American Indian/Alaska Native (AI/AN) status and take advantage of certain benefits and exceptions available only to AI/ANs, so that you can accurately advise them on their options in the Marketplace?

Select **all that apply** and then click **Check Your Answer**.

- ☐ **A.** The names of at least two ancestors for proof of tribal membership
- ☐ **B.** A copy of a document issued by a federally recognized tribe, Bureau of Indian Affairs (BIA), or Alaska Native Claims Settlement Act (ANCSA) corporation showing membership, enrollment or shareholder status (e.g., membership or enrollment card); the document should have a signature and/or seal on it
- ☐ **C.** Tax return documents or other materials that provide income information for their family
- ☐ **D.** The number of people in Ann and Joe's family

Check Your Answer | Reset

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Question:

When scheduling your meeting with Ann and Joe, you learn that they would like to know more about the benefits of health coverage. You plan to discuss health coverage available through the Marketplace, Medicaid, and the Children's Health Insurance Program (CHIP), but want to make sure they come prepared to your meeting. What information will Ann and Joe need to provide to show their American Indian/Alaska Native (AI/AN) status and take advantage of certain benefits and exceptions available only to AI/ANs, so that you can accurately advise them on their options in the Marketplace?

Correct Answers:

B ,C ,D

Feedback for Correct Answer:

Correct! To take advantage of certain benefits and exceptions available only to AI/ANs, Ann and Joe will need to provide a copy of a document issued by a federally recognized tribe, BIA, or ANCSA corporation showing membership, enrollment, or shareholder status (e.g., membership or enrollment card); the document should have a signature and/or seal on it. If they want to apply for help paying for coverage, they also need to provide tax return documents or other materials that provide income information for their family, and the number of people in their family. Names of ancestors aren't necessary for proof of tribal membership for enrollment in the Marketplace.

Feedback for Incorrect Answer:

Incorrect. The correct answers are B, C, and D. To take advantage of certain benefits and exceptions available only to AI/ANs, Ann and Joe will need to provide a copy of a document issued by a federally recognized tribe, BIA, or ANCSA corporation showing membership, enrollment, or shareholder status (e.g., membership or enrollment card); the document should have a signature and/or seal on it. If they want to apply for help paying for coverage, they also need to provide tax return documents or other materials that provide income information for their family, and the number of people in their family. Names of ancestors aren't necessary for proof of tribal membership for enrollment in the Marketplace.

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Overview of Affordable Care Act Provisions Relevant to AI/ANs

The Affordable Care Act provides AI/ANs with more health coverage choices. They can use an I/T/U if they're eligible, purchase affordable health coverage through the Marketplace, and/or access coverage through other sources, such as the Veteran's Health Administration program, Medicare, Medicaid, and CHIP, if they're eligible.

The benefit to health coverage through the Marketplace is that AI/ANs can access services they may not otherwise be able to get from I/T/U providers due to resource and staffing limitations. If AI/ANs choose to enroll in qualified health plans (QHPs) through the Marketplace, they'll still have access to I/T/U services and they may qualify for financial assistance.

AI/ANs enrolled in QHPs have:

- Year-round enrollment and the ability to switch plans monthly
- Cost-sharing reductions from zero cost sharing to limited cost sharing depending upon income
- Ability to apply for an exemption from the individual shared responsibility payment

You must be able to explain to AI/ANs how these provisions affect them.

Graphic -- Alt Text:
Young American Indian man in a clinic with a lab technician about to take a blood sample

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Special Provision: Monthly Enrollment in Qualified Health Plans (QHPs)

AI/ANs have access to a monthly special enrollment period (SEP), which allows them to enroll in health coverage through the Marketplace monthly, rather than only during the yearly Open Enrollment period. This means they're eligible to change health plans once a month. Consumers who aren't members of federally recognized tribes or ANCSA shareholders must enroll during the yearly Open Enrollment period (unless they otherwise qualify for another SEP).

However, family members who are on a single Marketplace application are eligible for the SEP if one of the members on the application is a tribal member or ANCSA shareholder.

If one family member on the application is eligible for the SEP, all family members who apply on the same Marketplace application are eligible. This is true even if different family members are eligible for different Marketplace plans, based on differing eligibility for lower monthly premiums or out-of-pocket costs.

For consumers who change their plan or enroll in a new QHP between the first and 15th day of any month, the effective date of coverage will be the first day of the following month. If the consumer changes plans and enrolls in a new health plan between the 16th and the last day of any month, the coverage effective date will be the first day of the second following month. This means that there will be a period of time that the new QHP coverage won't be in effect.

Graphic -- Alt Text:
A calendar with a pencil lying across it

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Special Provision: No Cost Sharing

There are special rules for AI/ANs to qualify for cost sharing reductions, such as copays, coinsurance, deductibles, and other similar charges, when enrolled in QHPs offered through the Marketplace.

Members of federally recognized tribes and ANCSA shareholders with household incomes at or below 300% of the federal poverty level (FPL) have no cost sharing for essential health benefits (EHB). This is called a zero cost sharing plan and is available in any metal level Marketplace health plan, including Bronze level plans, which have the lowest premiums.

In 2014, 300% of the FPL is equal to:

- A single consumer household income of $35,010 or less (Alaska: $43,763)
- A two-person family household income of $47,190 or less (Alaska: $58,988)
- A three-person family household income of $59,370 (Alaska: $74,213)

A zero cost sharing plan for AI/ANs means that there's no cost sharing for AI/ANs when they get care from I/T/U providers, or when they get EHB when enrolled in a QHP through the Marketplace. AI/ANs don't need a referral under the Purchased/Referred Care Program (formerly known as a CHS referral) in order to qualify for zero cost sharing. Note that there may be cost sharing (determined by plan) for other services that aren't EHB.

AI/ANs whose income is over 300% of the FPL qualify for limited cost sharing when enrolled in a QHP. A limited cost sharing plan means that there's no cost sharing for services received at an I/T/U and no cost sharing for EHB that are referred under the Purchased/Referred Care Program and received through the QHP.

For households with both AI/ANs and non-Indians, the family members who aren't AI/ANs wouldn't qualify for a zero cost sharing or limited cost sharing plan and might opt to choose a separate QHP. If the family wants to stay in the same plan, then the family must decide if it wants to forgo the cost-sharing savings.

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Tribal Exemption

Members of federally recognized tribes, ANCSA shareholders, and people who are eligible to use an I/T/U are able to apply for an exemption from the individual shared responsibility payment. They can submit the exemption application at any time through the mail or when they file their next federal income tax return. The following individuals are eligible to apply for a tribal exemption and must file an application through the Marketplace:

- Members of an Indian tribe or ANCSA shareholder
- Members or descendants of federally recognized tribes, bands, or other organized group of Indians, including Alaska Native villages or groups, and those tribes, bands, or groups terminated since 1940
- Members of or descendants (in the first or second degree) of state recognized tribes who reside in urban centers designated by the Secretary of HHS
- California Indians
- Eskimo, Aleut, or other Alaska Natives
- Children under 19 who are the natural, adopted child, stepchild, foster child, legal ward, or orphan of an Indian
- Spouses of an Indian, if the tribe passed a tribal resolution that makes spouses eligible to get services from the Indian health system
- Non-Indian women who are pregnant with the child of an eligible Indian
- Those who are Indians (as well as their spouses and descendants) who are eligible for services through an Indian health care provider

Applicants are required to submit documentation of tribal membership or eligibility for services through the I/T/U. The document requirements are listed in Step 5 of the exemption application.

For more information on how to help consumers apply for a tribal exemption, refer to the following resources:

- Application for Exemption for AI/ANs and Other Individuals who are Eligible to Receive Services from an Indian Health Care Provider
- Instructions to Help You Complete an Exemption Application at the Health Insurance Marketplace

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Stand-Alone Dental Plan

AI/ANs are able to enroll in stand-alone dental plans offered through the Marketplace. The elimination of cost sharing for AI/ANs with incomes at or below 300% of the FPL doesn't apply to stand-alone dental plans. If an AI/AN consumer is enrolled in a stand-alone dental plan, they'll have to pay cost sharing, such as copays and deductibles. But if the AI/AN consumer is enrolled in a dental plan offered as part of a QHP, the cost-sharing limitations will apply. AI/ANs can still get dental services from I/T/U providers with no cost sharing.

Pediatric dental care is an EHB, but cost-sharing savings only apply to the dental services included in the QHP or from an I/T/U.

Graphic -- Alt Text:
A girl smiling and revealing her braces while a dentist stands in the background

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Working Effectively with American Indians and Alaska Natives (AI/ANs)

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Knowledge Check

You're finally meeting with Ann and Joe, who provide you with proof that they're members of a federally recognized tribe or shareholders in an Alaska Native Claims Settlement Act (ANCSA) corporation. You're discussing special Marketplace benefits and exemptions offered to American Indians and Alaska Natives (AI/ANs). Which one of the following is NOT an accurate statement for you to share with Ann and Joe?

Select **the correct answer** and then click **Check Your Answer**.

- ○ **A.** If AI/ANs choose to enroll in qualified health plans (QHPs), they may not have any cost sharing at an Indian Health Service (I), tribes and tribal organizations (T), and urban Indian organizations (U) (I/T/U) service unit regardless of income.
- ○ **B.** AI/ANs have monthly opportunities to enroll in a QHP. The yearly open enrollment period doesn't apply to AI/ANs.
- ○ **C.** AI/ANs can enroll in stand-alone dental plans with no cost sharing.
- ○ **D.** AI/ANs may enroll in a QHP to have access to a full range of health care coverage.

Check Your Answer | Reset

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Question:

You're finally meeting with Ann and Joe, who provide you with proof that they're members of a federally recognized tribe or shareholders in an Alaska Native Claims Settlement Act (ANCSA) corporation. You're discussing special Marketplace benefits and exemptions offered to American Indians and Alaska Natives (AI/ANs). Which one of the following is NOT an accurate statement for you to share with Ann and Joe?

Correct Answer:

C

Feedback for Correct Answer:

Correct! The statement on stand-alone dental plans isn't accurate. If AI/AN consumers enroll in stand-alone dental plans, they'll have to pay out-of-pocket costs such as copays and deductibles. All other statements are accurate.

Feedback for Incorrect Answer:

Incorrect. The correct answer is C. The statement on stand-alone dental plans isn't accurate. If AI/AN consumers enroll in stand-alone dental plans, they'll have to pay out-of-pocket costs such as copays and deductibles. All other statements are accurate.

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Working Effectively with American Indians and Alaska Natives (AI/ANs)

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Medicaid and CHIP

AI/ANs who currently get services or are eligible to get services from I/T/U providers, or through a referral under a Purchased/Referred Program and qualify for Medicaid or CHIP, are exempt from Medicaid premiums, enrollment fees, and cost sharing for copays, coinsurance, deductibles, and other similar charges.

Protected AI/AN income and resources such as property and rights related to hunting, fishing and natural resources, are exempt for Medicaid and CHIP eligibility. 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.

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Graphic -- Alt Text:
An Alaska Native mother and son touching noses

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Working Effectively with American Indians and Alaska Natives (AI/ANs)

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Marketplace Application Process and Specific Issues for AI/ANs

To apply for health coverage through the Marketplace, Medicaid, or CHIP, AI/AN consumers have the option to complete either the paper or online application or apply over the phone through the Marketplace Call Center.

The questions and processes are different for the paper and online application processes for AI/ANs. For both the paper and online application, AI/ANs can attest to their tribal membership but will need to submit proof of tribal membership/enrollment/ANCSA shareholder status within 90 days of application.

It's your responsibility to help AI/AN consumers understand what these requirements are, so that they're prepared for the application process. The following sections in this training will explain the paper and online applications in detail.

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Graphic -- Alt Text:
An American Indian woman looking at a computer monitor

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Paper Applications

There are two paper applications that AI/AN consumers can complete to apply for QHP coverage through the Marketplace:

- Application for Health Coverage (individuals or families)
- Application for Health Coverage & Help Paying Costs (individuals or families who wish to apply for programs to lower costs)

The Application for Health Coverage is intended for individuals who don't want to apply for help paying for health insurance costs. Step 3 of this application asks if a consumer or members of the consumer's household are AI/ANs. If the application is received outside of the annual Open Enrollment period, the Marketplace uses the responses to this question to determine whether the AI/AN consumer is eligible for an SEP.

The Application for Health Coverage & Help Paying Costs asks AI/ANs to complete Step 3 and Appendix B of the Application. The Marketplace uses the responses to the questions in Step 3 and Appendix B to determine whether the consumer is eligible for enrollment in a Marketplace QHP and for financial assistance, as well as whether the consumer is eligible for Medicaid or CHIP.

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Paper Application: Health Coverage & Help Paying Costs: Appendix B Questions 2-3

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

Question	Explanation of Question
2. Is this person a member of a federally recognized tribe? If yes, provide the tribe name.	Question 2 is used to determine whether the AI/AN consumers can qualify for an SEP and whether they're subject to cost-sharing reductions offered through the Marketplace. Please note: ANCSA shareholders are included in the definition of members of federally recognized tribes.
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	Question 3 is used to determine whether AI/AN consumers have to make copayments, or pay deductibles or other similar charges for Medicaid or CHIP.

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Paper Application: Appendix B Question 4

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

Question	Explanation of Question
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (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 • Payments 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 that have cultural significance	Question 4 is used to ensure that certain Indian income that might have been reported in the general income questions (Step 2 of the application) is 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 of the application. However, there might be instances where certain Indian income is taxable by the IRS but is excluded for purposes of 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.

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Working Effectively with American Indians and Alaska Natives (AI/ANs)

Online Application

The online application includes a question asking whether the applicant or household members are AI/ANs. Consumers who identify as AI/ANs will be directed to answer additional questions to find out if they're eligible for special benefits under Medicaid and CHIP.

These questions are covered on the following page.

Graphic -- Alt Text:
A young woman looking at her laptop and holding a cup of coffee

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Application Questions 1-2

The first two online application questions for AI/AN consumers are:

Question	Explanation of Question
1. Is this consumer eligible to get services from IHS, tribal health programs or urban Indian health programs, or through a referral from one of these programs?	Question 1 is used to determine eligibility for exemption from premium payments and enrollment fees when AI/AN consumers are enrolled in Medicaid or CHIP.
2. Has this consumer 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?	Question 2 is used to determine whether AI/AN consumers can be exempt from copayments, coinsurance, deductibles, and other similar charges for Medicaid or CHIP.

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Application Question 3

The third online application question for AI/AN consumers is:

Question	Explanation of Question
3. Certain money received may not be counted toward eligibility for Medicaid or CHIP. List any income (amount and how often) that the consumer reported on his or her application that comes from these sources: • Per capita (for each consumer) payments from a tribe that come from natural resources, usage rights, leases, or royalties. • Payments from natural resources, farming, ranching, fishing, leases, or profits from land said to be Indian trust land by the DOI (including reservations and former reservations). • Money from selling things that have AI/AN cultural significance, such as Indian jewelry or beadwork.	Question 3 is used to ensure that certain Indian income that might have been reported in the general income questions (Step 2 of the application) is excluded for determining eligibility for Medicaid and CHIP. As a general rule, Indian income that 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 IRS but is excluded for purposes of 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.

The applicant will be directed to answer the following additional question: Is the applicant or household member(s) a member of a federally recognized tribe?

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Popup 1
Federally Recognized Tribe

Popup Text:

If in response to this question, the consumer answers yes, the consumer will be directed to a drop down list of federally recognized tribes and ANCSA regional and village corporations, and will be asked to select the appropriate tribe from this list.

The consumer will be directed to upload or mail in proof of tribal membership/enrollment/shareholder status within 90 days of the date of application. If tribal documentation isn't received within 90 days, the applicant will no longer be eligible for the special monthly enrollment period and zero or limited cost sharing.

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Working Effectively with American Indians and Alaska Natives (AI/ANs)

Key Points

Federally recognized tribes and the federal government have a historical government-to-government relationship. Under U.S. treaties and laws, the federal government has a unique responsibility to provide members of federally recognized tribes with health care.

By enrolling in a Marketplace QHP, AI/ANs benefit by having greater access to services that may not be provided by their local I/T/U, and the tribal communities benefit through increased resources to their I/T/Us.

Eligible AI/ANs have certain benefits and exemptions under Medicaid, CHIP, and the Marketplace.

For Medicaid and CHIP, AI/ANs are exempt from cost sharing and certain Indian income is excluded in determining eligibility.

For the Marketplace, AI/ANs have special monthly enrollment periods, zero or limited cost sharing, and an ability to apply for an exemption from the individual shared responsibility payment.

Whether an AI/AN enrolls in Medicaid, CHIP or the Marketplace, or applies for an exemption, the AI/AN can continue to get services from an I/T/U at no cost to the individual.

The paper and online applications for health coverage have special details you should know about when helping AI/AN consumers.

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Considerations for Working with Older Consumers

Introduction

The Affordable Care Act establishes the Marketplace, which facilitates enrollment in health coverage through qualified health plans (QHPs), and permits states to expand their Medicaid programs.

For purposes of this training, the term “older consumers” means individuals who are:

- Already eligible for Medicare; or
- Will soon become eligible for Medicare.

Older consumers may need assistance to seamlessly transition between coverage offered through the Marketplace into Medicare.

Older consumers include those approaching age 65 and those older than age 65, regardless of whether they're currently eligible for Medicare. This training will explore topics essential to engaging, educating, and helping older consumers get health coverage through the Marketplace or referring them to other programs.

This training will provide you with the skills to:

- Identify the relationship between Medicare and the Marketplace
- Identify the Marketplace options for older consumers who are soon to be eligible for Medicare
- Identify the Marketplace options for older consumers who aren’t eligible for Medicare, including consumers who don’t meet citizenship and residency requirements for Medicare

Click ***NEXT*** to continue.

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Graphic -- Alt Text:
An older couple on bicycles

Popup 1
Medicare

Popup Text:
Medicare is the federal health care program for consumers age 65 and older, certain younger consumers with disabilities, and consumers with End-Stage Renal Disease (ESRD). While not everyone with Medicare is an older consumer, the information provided in this topic addresses those who are age 65 or older, which is the majority of consumers eligible for Medicare.

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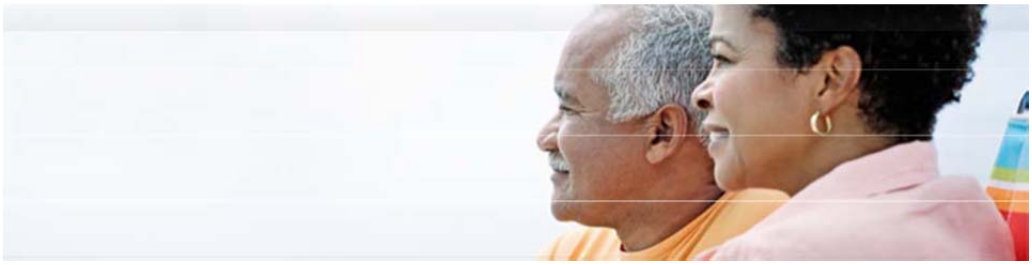
Considerations for Working with Older Consumers

How to Engage with Older Consumers

Remember that you should never stereotype and should always be respectful of each consumer you help. To best assist older consumers, you should be aware that they may face challenges in certain areas including:

- Disabilities
- Health Literacy
- Caregivers

Select each term to learn more.



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Graphic -- Alt Text:
Two older adults looking out over the ocean

Popup 1
Disabilities

Popup Text:
The need for reasonable accommodations increases with age. Reasonable accommodations may be necessary to ensure health coverage options are effectively communicated to older consumers with cognitive, hearing, speech, and/or vision impairments, as well as consumers with physical or intellectual disabilities. This includes providing reasonable accommodations to ensure compliance with the Americans with Disabilities Act (ADA), the Americans with Disabilities Act Amendments Act of 2008 (ADAAA), Section 504 of the Rehabilitation Act of 1973 (Section 504), and other relevant federal, state, or local laws. You'll learn more about this subject in another training.

Popup 2
Health Literacy

Popup Text:
Health literacy is the ability to receive and understand basic health care information and services, use the information and services to make decisions, and follow instructions for health-related treatment. Many health problems faced by older consumers may be complicated by low literacy and low health literacy. Recognizing and addressing this challenge will help you provide effective assistance to this population. For instance, you may need to spend time explaining health insurance terminology and how health insurance works before helping older consumers compare their health coverage options.

Popup 3
Caregivers

Popup Text:
The consumer seeking health care coverage should be the primary source of information and decision-making about health care coverage, even if the person is accompanied by a caregiver, authorized representative, guardian, or family member. When another person is authorized to represent the consumer, make sure that the consumer is the focus of the discussion and participates in the conversation to the greatest extent possible.

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Considerations for Working with Older Consumers

Working Effectively with Older Consumers

Older consumers may be eligible for several health coverage options, including coverage through the Marketplace, job-based coverage, and public programs like Medicare and Medicaid. Providing older consumers with accurate information about their health coverage options is an important part of your job.

You may work with any of the following:

- Older consumers who already have Medicare and are interested in getting health coverage through the Marketplace (this includes younger consumers with Medicare)
- Older consumers applying for health coverage through the Individual Marketplace or Small Business Health Options Program (SHOP) Marketplace and who'll soon be eligible for Medicare
- Older consumers applying for health coverage through the Marketplace who aren't eligible for Medicare
- Older consumers with Medicare who are offered insurance through the SHOP Marketplace by their employer
- Older consumers with health coverage offered by the federal government, such as through TRICARE, the Veterans Health Administration program, or the Federal Employees Health Benefits program
- Older consumers who have Medicare but are interested in enrolling in Medicaid

To effectively help older consumers and educate them about their options for health coverage through the Marketplace, Medicare, or Medicaid, you need to learn about the eligibility criteria and benefits for these programs.

Graphic -- Alt Text:
The Medicare and Medicaid logos above the words Health Care Reform

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Considerations for Working with Older Consumers

Introduction to Medicare

Medicare is the federal health care program for consumers age 65 and older, certain younger consumers with disabilities, and consumers with certain diseases.

Different parts of Medicare help cover specific services.

- **Medicare Part A (Hospital Insurance):** Part A covers inpatient hospital stays, care in skilled nursing facilities, hospice care, and some home health care. Some consumers may have Medicare Part A without a premium, but other consumers may have to pay a premium for Part A.
- **Medicare Part B (Medical Insurance):** Part B covers certain doctors' services, outpatient care, home health care, durable medical equipment and supplies, preventive services, and other services. There's generally a premium for Part B.
- **Medicare Part C (Medicare Advantage Plans):** Medicare Advantage Plans are a type of Medicare health plan offered by private health insurance companies that contract with Medicare to provide Part A and Part B benefits for their enrollees. Most Medicare Advantage Plans also offer prescription drug coverage (Part D).
- **Medicare Part D (Prescription Drug Coverage):** Part D covers prescription drugs. Health insurance companies approved by Medicare offer Part D coverage. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

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

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Graphic -- Alt Text:
Doctor's hand pointing at the word Medicare and showing the four components of Medicare: Hospital Insurance, Medical Insurance, Medicare Advantage Plans, and Prescription Drug Plans in four colored circles.

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Considerations for Working with Older Consumers

Premium-Free Part A Medicare

To be eligible for premium-free Part A Medicare, consumers must first be qualified based on their own work history and contributions to the Social Security program or those of a spouse, parent, or child. To be insured, consumers must have a specified number of quarters of coverage (QCs), which are earned through payment of payroll taxes under the Federal Insurance Contributions Act (FICA) during consumers' working years. The exact number of required QCs depends on whether consumers are filing for Part A on the basis of age, disability, or End-Stage Renal Disease (ESRD). Most people pay the full FICA tax, so the QCs they earn can be used to qualify them for both monthly Social Security benefits and premium-free Part A Medicare.

Consumers who have premium-free Part A Medicare generally can't enroll in QHPs through the Marketplace because it is against the law for a private insurer to sell an individual market Marketplace plan to someone who has Medicare coverage. However, by having premium-free Medicare, consumers will typically pay less for health coverage.

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Graphic -- Alt Text:
A paycheck stub showing various taxes including Social Security, Medicare, Federal, State, etc.

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Medicare Premium Part A

In general, consumers age 65 and older who don't have premium-free Part A Medicare (because they haven't earned enough QCs) but are eligible for and enrolled in Medicare Part B may elect to purchase Medicare premium Part A coverage by filing an application at the Social Security office. These consumers will need to pay monthly premiums, so this type of Medicare coverage is called Medicare premium Part A. In order to be eligible to enroll in Medicare premium Part A and/or Part B, consumers must be United States (U.S.) residents and either U.S. citizens or lawful permanent residents who have lived in the U.S. continuously for at least five years at the time their applications are filed and must not otherwise have Medicare Part A (e.g., because of disability or ESRD).

Older consumers desiring Medicare premium Part A can only file for coverage during a prescribed enrollment period and must also enroll or already be enrolled in Medicare Part B.

Assisters can find more information on Medicare benefits at Medicare.gov, and can search for their local State Health Insurance Assistance Program (SHIP) at Shiptalk.org.

Graphic -- Alt Text:
A Medicare Enrollment Form, a Social Security card, and a pen

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Older Consumers Enrolled in Medicare Who Are Interested in the Marketplace

Consumers who don't have premium-free Part A Medicare but who qualify to enroll through the Marketplace may choose to enroll in coverage through the Marketplace rather than purchase Medicare premium Part A and/or Part B coverage. These consumers may be interested in getting more information about the Marketplace. Consumers who submit an eligibility application through the Marketplace to find out if they qualify for Medicaid or the premium tax credit and cost-sharing reductions must include nontaxable household income, such as Social Security and Railroad Retirement benefits, in their reported income.

Coverage Facts	Messages to Consumers
• Consumers who have premium-free Part A Medicare may not be able to enroll in QHPs through the Individual Marketplace regardless of their income, because it's generally against the law for a private insurer to sell a Marketplace plan that's known to duplicate Medicare coverage to someone who has Medicare coverage. • Consumers who are eligible for Medicare premium Part A but aren't enrolled in it are eligible to enroll in QHPs through the Individual Marketplace and may be eligible for the premium tax credit and cost-sharing reductions. However, to enroll in QHPs through the Marketplace, older consumers must voluntarily end their Medicare premium Part A and Part B coverage, and avoid duplication of coverage. • Consumers who have Medicare or are considering enrolling in Medicare who meet the eligibility requirements can access programs available to help pay for Medicare costs, including Medicare Savings Programs (MSPs) and the Low-Income Subsidy or Extra Help for Medicare Part D costs. • Consumers who have only Medicare Part B could become able to enroll in QHPs through the Marketplace, and may be eligible to get the premium tax credit and cost-sharing reductions, only if they voluntarily end their Medicare Part B coverage.	• Premium-free Part A Medicare already covers most medically-necessary inpatient and hospital benefits. • Once you have premium-free Part A Medicare, you generally can't enroll in a QHP through the Marketplace because it's against the law for a private insurer to sell a Marketplace plan to someone with Medicare coverage (either Part A or Part B). • If you already have QHP coverage through the Marketplace, you'll stop getting Marketplace-based help with your costs once your Medicare Part A coverage begins. • If you'd like additional health coverage for things that Medicare doesn't pay for, you should consider purchasing a Medicare Supplement Insurance (Medigap) policy. In addition, Medicare Advantage plans (Medicare Part C) may offer additional services beyond what Medicare Part A and Part B cover in the original Medicare program.

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Considerations for Working with Older Consumers

Knowledge Check

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

Select **all that apply** and then click **Check Your Answer**.

- ☐ **A.** Tell him that he should contact his local State Health Insurance Program (SHIP) to find out if he qualifies for state-based financial assistance to lower his costs.
- ☐ **B.** Tell him that he can keep his current Medicare premium Part A and Medicare Part B and apply for programs through the Marketplace to help him with Medicare premium costs.
- ☐ **C.** Tell him that he can stay with his current Medicare premium Part A and Medicare Part B and apply for a Medicare Savings Program (MSP) to see if he's eligible to get help paying for his Medicare costs.
- ☐ **D.** Tell him that because he's enrolled in Medicare premium Part A and Medicare Part B, he isn't eligible to enroll in a qualified health plan (QHP) through the Marketplace. However, if he wants to find out how much his costs would be in a QHP, he could submit an eligibility application through the Marketplace. If the coverage and costs for the QHP are better for him, he could contact the Social Security office to learn about stopping his Medicare coverage in order to enroll in a QHP.

Check Your Answer | Reset

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Question:

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

Correct Answers:

C ,D

Feedback for Correct Answer:

Correct! You should tell Eduardo of the various programs that might help him lower his costs for Medicare. If he wants to compare his Medicare premium costs with the possible cost of enrolling in a QHP, you should help Eduardo fill out an eligibility application to see if he's eligible to enroll in a QHP through the Marketplace and/or qualifies for programs to lower his costs. When Eduardo gets his eligibility determination, you can review it with him to make sure he has the information he needs to decide whether he should keep his Medicare premium Part A coverage and apply for an MSP or opt out of Medicare premium Part A, and contact the Social Security office to end his Medicare coverage and enroll in a QHP through the Marketplace.

Feedback for Incorrect Answer:

Incorrect. The correct answers are C and D. You should tell Eduardo of the various programs that might help him lower his premiums costs for Medicare. If he wants to compare his Medicare premium costs with the possible cost of enrolling in a QHP, you should help Eduardo fill out an eligibility application to see if he's eligible to enroll in a QHP through the Marketplace and/or qualifies for programs to lower his costs. When Eduardo gets his eligibility determination, you can review it with him to make sure he has the information he needs to decide whether he should keep his Medicare premium Part A coverage and apply for an MSP or opt out of Medicare premium Part A, and contact the Social Security office to end his Medicare coverage and enroll in a QHP through the Marketplace.

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Considerations for Working with Older Consumers

Medicare and the SHOP Marketplace

Consumers who have Medicare can still get health coverage from an employer through the SHOP Marketplace, which is treated like a job-based group health plan. If a consumer is getting health coverage from an employer through the SHOP Marketplace based on the consumer's or their spouse's current employment and has Medicare coverage, Medicare Secondary Payer rules apply.

Consumers that have job-based coverage through the SHOP Marketplace should check with their employer to determine whether that coverage pays before Medicare. If it does, the consumer should sign up for Medicare Part A and consider delaying enrollment in Part B until the current employment or the job-based coverage ends, whichever occurs first.

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Graphic -- Alt Text:
Older couple going over papers in home with an Assister

Popup 1
Medicare Secondary Payer Rules

Popup Text:
Medicare Secondary Payer rules govern the coordination of benefits between Medicare and current employment-based group health plan coverage.

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Considerations for Older Consumers with Incomes Over 133% of the FPL

Older consumers who are ineligible for Medicaid (in most states, those who have incomes over 133% of the FPL or $20,920 for a family of two in 2014) may be interested in getting information about the Marketplace.

Coverage Facts	Messages to Consumers
• Older consumers first become Medicare-eligible at the start of the month of their 65th birthday. They may also qualify after they've received Social Security or Railroad Retirement Board disability benefits for 24 months. • Consumers newly eligible for Medicare have an Initial Enrollment Period (IEP) to sign up for Medicare (Part A and Part B). During the individual's IEP, they may also enroll in Medicare Advantage and Part D. For individuals who didn't enroll during the IEP or lost/ended coverage, there's also a General Enrollment Period from January 1st to March 31st each year for individuals to enroll in Part B (or Medicare premium Part A) with coverage beginning July 1 of that year. • If consumers don't sign up for Medicare during their IEP or aren't eligible to enroll during a special enrollment period, they may be assessed a late enrollment penalty and have a coverage gap. This financial penalty is a permanent premium increase for Medicare Part B. • In addition, there's an annual Open Enrollment period for enrolling into Medicare Advantage or Part D from October 15 – December 7 for coverage to begin January 1 of the following calendar year. This annual Open Enrollment period provides individuals with Medicare an opportunity to enhance their Medicare Part A and Part B coverage. • All Marketplace-based financial assistance for QHPs in the Marketplace will be terminated when an older consumer's Medicare Part A starts.	• Once you have Medicare, you generally can't enroll in QHPs through the Marketplace because it's against the law for a private insurer to sell a Marketplace plan to someone with Medicare coverage (either Part A or Part B). You also will stop getting Marketplace-based help with your costs through the Marketplace. • If you need help paying for Medicare prescription drug costs, you should call Social Security to apply for Extra Help.

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Older Consumers with Incomes Under 133% of the FPL

Older consumers who have incomes that qualify them for Medicaid (lower than 133% of the FPL, or $20,920 for a family of two in 2014) and who live in states that expanded their Medicaid programs may be interested in getting information about Medicare, Medicaid, and the Marketplace.

Coverage Facts	Messages to Consumers
• In states with an expanded Medicaid program, consumers under age 65 with incomes under 138% of the FPL who aren't eligible for Medicare may qualify for the new Medicaid adult eligibility group. • In states with an expanded Medicaid program, consumers who become Medicare-eligible will no longer be eligible for the new adult Medicaid eligibility category and will be automatically disenrolled. • States must screen consumers for all Medicaid programs, including MSPs. • If an older consumer isn't eligible for any Medicaid program, there are programs that may help pay for Medicare costs, including MSPs and/or Extra Help.	• If you become eligible for Medicare and are no longer eligible for Medicaid, you may qualify for programs that help you pay for your Medicare costs. • If you need help paying for Medicare prescription drug costs, you should call Social Security to apply for Extra Help. • If you need help paying for your Medicare Part B premiums, you should call your state Medical Assistance (Medicaid) office to apply for one of the MSPs. • 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 Marketplace.

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Knowledge Check

Sahand, who is 64 years old, contacts you for information regarding his health coverage options. With an annual income of $14,000 a year, Sahand thinks that it'll be difficult to afford premiums for health coverage. He hopes that he can get help through the Marketplace. What should you tell Sahand?

Select **the correct answer** and then click **Check Your Answer**.

- ○ **A.** Tell him that he may be eligible for Medicaid, and help him fill out an eligibility application through the Marketplace. The Marketplace will automatically assess or determine his Medicaid eligibility, depending on the state.
- ○ **B.** Tell him that he may be eligible for Medicaid, but the Marketplace can't determine his eligibility.
- ○ **C.** Tell him that because he'll be eligible for Medicare when he turns 65 next year, he's not eligible for Medicaid this year.
- ○ **D.** Tell him that he doesn't meet the income requirements to be eligible for Medicaid.

Check Your Answer | Reset

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Question:

Sahand, who is 64 years old, contacts you for information regarding his health coverage options. With an annual income of $14,000 a year, Sahand thinks that it'll be difficult to afford premiums for health coverage. He hopes that he can get help through the Marketplace. What should you tell Sahand?

Correct Answer:

A

Feedback for Correct Answer:

Correct! Sahand has an income under 133% of the federal poverty level (FPL) and may be eligible to enroll in Medicaid. The Marketplace will assess or determine his Medicaid eligibility, and the Marketplace or state Medicaid agency will be able to notify him of next steps.

Feedback for Incorrect Answer:

Incorrect. The correct answer is A. Sahand has an income under 133% of the federal poverty level (FPL) and may be eligible to enroll in Medicaid. The state where Sahand lives will determine his Medicaid eligibility, and the Marketplace or state Medicaid agency will be able to notify him of next steps.

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Considerations for Older Immigrant Adults

Older consumers who are lawfully present immigrants may be interested in getting more information about the Marketplace. However, non-U.S. citizens who have Medicare generally can't enroll in QHPs through the Marketplace because it's against the law for a private insurer to sell a Marketplace plan that is known to duplicate Medicare coverage to someone who has Medicare coverage.
There are special considerations for Medicare that apply to older consumers who are not U.S. citizens.

Coverage Facts	Messages to Consumers
• Lawfully present immigrants who have a sufficient number of QCs may get premium-free Part A Medicare. • To be eligible to enroll in Medicare premium Part A and/or Part B, a consumer needs to be age 65 or older, and be either a U.S. citizen or a lawful permanent resident having lived in the U.S. for five continuous years prior to the application for Medicare. • If a consumer isn't a U.S. citizen, but is lawfully present in the U.S. and doesn't have Medicare, the consumer may be eligible to purchase coverage through the Marketplace.	• If you have enough quarters of work history to qualify for Social Security, you may be eligible for Medicare if you meet the eligibility requirements. However, Medicare doesn't pay for your hospital or medical bills if you're not lawfully present in the U.S. • 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, but you'll have to pay monthly premiums for Medicare Part A and Part B coverage. • If you need help or have questions about Medicare, contact your local State Health Insurance Program (SHIP). • 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 for QHP health coverage, with or without financial assistance, through the Marketplace.

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Knowledge Check

Flora, who is 70 years old, is an immigrant. She came to the United States (U.S.) two years ago as a lawful permanent resident to live with her daughter. She doesn't have a job or health coverage. Unfortunately, she has health problems that require her to visit a doctor. Which of the following should you tell Flora?

Select **the correct answer** and then click **Check Your Answer**.

- ○ **A.** She's not eligible for insurance because she's an immigrant.
- ○ **B.** Because she's 70 years old, she has to apply for Medicare.
- ○ **C.** She may be eligible for coverage through the Marketplace, and you should help her with the application process.
- ○ **D.** Her only option is to enroll in Medicaid, and you should refer her to her state's Medicaid agency.

Check Your Answer | Reset

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Question:

Flora, who is 70 years old, is an immigrant. She came to the United States (U.S.) two years ago as a lawful permanent resident to live with her daughter. She doesn't have a job or health coverage. Unfortunately, she has health problems that require her to visit a doctor. Which of the following should you tell Flora?

Correct Answer:

C

Feedback for Correct Answer:

Correct! Flora doesn't meet the citizenship and residency requirement to enroll in Medicare. She may be eligible for coverage through the Marketplace.

Feedback for Incorrect Answer:

Incorrect. The correct answer is C. Flora doesn't meet the citizenship and residency requirement to enroll in Medicare. She may be eligible for coverage through the Marketplace.

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Transition to Medicare

Text Description of Image or Animation

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Flash -- Alt Text:
Interactive Table of 3 columns labeled from left to right: If consumers..., Then consumers..., And... See long description for more details.

Flash -- Long Description:

Interactive Table of 3 columns labeled from left to right: If consumers..., Then consumers..., And...

Prompt text to the left of the table: It's important that consumers close to age 65 who are applying for coverage through the Marketplace know about the benefits of enrolling in Medicare as soon as they become eligible.

Select the left column of the table to see what you should tell consumers for their particular circumstances.

First row of table:

If consumers...Are receiving Social Security Retirement or Social Security Disability benefits,

Then consumers...Will get information about Medicare a few months before they're automatically enrolled in Medicare Part A and Part B.

And...They should consider signing up for Medicare Part D at the beginning of their eligibility period, so that they'll have prescription drug coverage on their first day of eligibility.

Second row of table:

If consumers...Are newly eligible for Medicare and don't get Social Security benefits yet,

Then consumers...Will have an Initial Enrollment Period (IEP) to sign up for Medicare Part A and Part B and should apply for Part D at that time.

And...For someone turning 65 years old, the IEP includes the three months prior to, the month of, and the three months after a consumer turns 65. If consumers don't sign up for Medicare during their IEP, or if they don't have job-based coverage (including coverage through the SHOP Marketplace) based on current employment, they may:

- Become uninsured
- Have to pay a higher premium when they sign up for Medicare
- Have to make the individual shared responsibility payment for not having minimal essential coverage (MEC)

Third row of table:

If consumers...Have job-based coverage based on current employment, including coverage through the SHOP Marketplace,

Then consumers...Should sign up for Medicare Part A and consider delaying enrollment in Part B until the job-based coverage or the current employment ends, whichever occurs first.

Fourth row of table:

If consumers...Are close to age 65 and are in a Medicaid expansion program,

Then consumers...Should enroll in Medicare when their IEP begins and check with their State Medical Assistance (Medicaid) office to determine whether they qualify for Medicaid under another coverage group.

Fifth row of table:

If consumers...Are eligible for programs to lower their costs through the Marketplace,

Then consumers...Eligibility for these programs will end when their Medicare Part A coverage starts.

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Considerations for Working with Older Consumers

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Help with Medicare Premiums and Cost Sharing

Under the Affordable Care Act, consumers who have premium-free Part A Medicare aren't eligible for the premium tax credit and/or cost-sharing reductions. But they may be eligible for help with paying Medicare costs under other programs.

These programs include:

- Extra Help or Low-Income Subsidy (LIS) for help with Medicare Prescription Drug costs
- Medicare Savings Programs (MSPs) for help with Medicare Part A/B costs, which include:
  - Qualified Medicare Beneficiary (QMB) program
  - Specified Low-income Medicare Beneficiary (SLMB) program
  - Qualifying Individual (QI) program
- Dual eligibility for Medicare and Medicaid coverage

Consumers who enroll in a QHP before they enroll in Medicare may stay in the QHP, but they will lose any premium tax credits or cost-sharing reductions when their Medicare Part A coverage starts. More information on eligibility and coverage is available in the "Resources" section.

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Graphic -- Alt Text:
An older woman looking at a prescription bottle

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Considerations for Working with Older Consumers

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Knowledge Check

Which of the following is the best option for older consumers enrolled in qualified health plans (QHPs) and about to become eligible for Medicare?

Select **the correct answer** and then click **Check Your Answer**.

- ○ **A.** Apply for Medicare immediately, or as soon as their Initial Enrollment Period (IEP) begins
- ○ **B.** Stay enrolled in their current QHP
- ○ **C.** Wait until after they become eligible for Medicare to decide whether to apply for Medicare
- ○ **D.** Switch to another QHP with health coverage options similar to what Medicare provides

Check Your Answer | Reset

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Question:

Which of the following is the best option for older consumers enrolled in qualified health plans (QHPs) and about to become eligible for Medicare?

Correct Answer:
A

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

Feedback for Incorrect Answer:
Incorrect. The correct answer is A. If consumers are about to become eligible for Medicare, their best option is to enroll in Medicare immediately, or as soon as their IEP begins. They may experience increased costs, penalties, and gaps in coverage if they don't sign up when they first become eligible.

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Considerations for Working with Older Consumers

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Referrals for Older Consumers

Make sure to refer consumers to their State Health Insurance Assistance Program (SHIP) and other resources for in-depth information about Medicare and other services for older consumers that aren't within the scope of the Marketplace.

Learn more about additional resources available for older consumers by selecting these options:

- State Health Insurance Assistance Program (SHIP)
- Area Agencies on Aging (AAA)
- Aging and Disability Resource Centers (ADRCs)
- Centers for Independent Living (CILs)
- Benefits Checkup
- Benefits 101 (National Council on Aging)

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Graphic -- Alt Text:
An Assister showing an older woman printed materials and online resources to help her learn more about Medicare and other services

Popup 1
State Health Insurance Assistance Program (SHIP)

Popup Text:
A program in every state that offers one-on-one Medicare counseling and assistance to consumers and their families. Consumers with questions about Medicare should be referred to their local SHIP.

Search for a SHIP.

Popup 2
Aging and Disability Resource Centers (ADRCs)

Popup Text:
ADRCs are programs where consumers of all ages, incomes, and disabilities go to get information and one-on-one counseling on the full range of long-term services and support options. ADRCs offer the following services: information and assistance, long-term care options counseling, benefits counseling, emergency response, prevention and early intervention, and access to publicly funded long-term care programs. Nearly every state and territory has an ADRC. Search for an ADRC.

Popup 3
Centers for Independent Living (CILs)

Popup Text:
CILs are community-based, cross-disability, non-profit organizations that are designed and operated mainly by consumers with disabilities. Their core services include peer support, information and referral services, individual and systems change advocacy, and independent living skills training. CILs often offer additional services, including transition from institutional to community settings. Search for a CIL.

Popup 4
Benefits 101 (National Council on Aging)

Popup Text:
This is a webinar training series offering an introduction to public benefits relevant to older consumers and younger consumers with disabilities. View the webinar training series here.

Popup 5
Benefits Checkup

Popup Text:

The National Council on Aging (NCOA) developed a free Internet service that helps consumers age 55 and older (and their caregivers) identify federal, state, and private benefits programs that can save them money and cover the costs of everyday expenses. Consumers can apply for many of the programs online or print an application form. View Benefits Checkup.

Popup 6
Area Agencies on Aging

Popup Text:

The AAA determines the needs of older consumers and works to address those needs through advocacy and the funding of local services. Locate a state and/or area AAA.

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Key Points

Older consumers who have Medicare Part A and/or Part B generally can't enroll in QHPs through the Marketplace because it's against the law for a private insurer to sell a Marketplace plan that is known to duplicate Medicare coverage to someone who has Medicare coverage.

If consumers are enrolled in QHPs and getting financial assistance through the Marketplace, they'll lose their eligibility for Marketplace-based financial assistance when their Medicare Part A coverage begins. However, consumers with premium-free Part A Medicare typically pay less for health coverage.

Older consumers who don't have Medicare may be able to enroll in QHPs through the Marketplace and may be eligible for the premium tax credit and cost-sharing reductions.

Older consumers who have Medicare Part B only or Medicare premium Part A and Part B can only enroll in QHPs in the Marketplace, if they voluntarily end all their Medicare coverage.

Additional programs for lowering consumers' costs may be available through Medicare.

Also, make sure you know how to help consumers in accessing information available through their local SHIP and other resources like ADRCs, CILs, and NCOA materials.

*Click **NEXT** to return to the main menu.*

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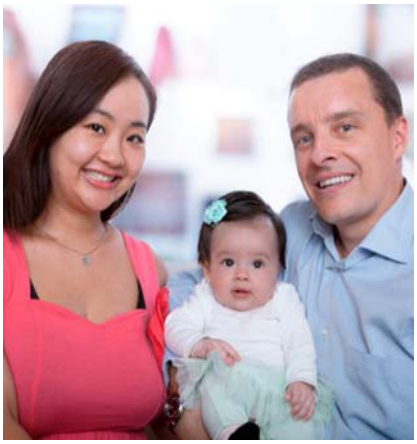
Mixed Immigration Status Families

Introduction

When helping consumers, you're likely to work with families who come from other countries. Sometimes, one or more members of the same family will be lawfully present or citizens of the United States (U.S.), while other members won't. A family like this is considered a mixed immigration status family.



This training will provide you with the skills to:

- Identify how health coverage eligibility may be different for each consumer in a mixed immigration status family and how to best help these families
- Recognize eligibility and documentation requirements for specific types of health coverage: Marketplace qualified health plan (QHP), Medicaid, Children's Health Insurance Program (CHIP), pediatric dental benefits, and child-only plans
- Identify how immigration-related rules apply in the Small Business Health Options Program (SHOP) Marketplace

Click ***NEXT*** to continue.

Graphic -- Alt Text:
Two parents with their baby

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Definition of Lawfully Present

To qualify for health coverage through the Marketplace, a consumer must be lawfully present in the U.S. Lawful presence describes an immigrant or other non-citizen who either:

- Has been admitted into the U.S. legally and is still present within the legally-approved period, or
- Has permission from the U.S. Citizenship and Immigration Services (USCIS) to stay or live in the U.S.

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Graphic -- Alt Text:
A group of new U.S. citizens taking the Oath of Allegiance at a citizenship ceremony

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Mixed Immigration Status Families

Background on Mixed Immigration Status Families

Pierre and LaGrande aren't lawfully present in the U.S. They have a daughter, Matou, who was born in the U.S. and is a U.S. citizen. Matou qualifies for health coverage through the Marketplace, but her parents don't. This is an example of a mixed immigration status family seeking health coverage through the Marketplace.

Keep in mind that those who aren't lawfully present can still apply for health coverage for their family member(s) who are in the U.S. legally without being asked to give a Social Security number (SSN) or other proof of being lawfully present. Parents like Pierre and LaGrande who aren't lawfully present, but have a child who's a U.S citizen, can apply for health coverage for that child without any penalties from the Department of Homeland Security (DHS).

You can reference additional information about mixed immigration status families, including “A Quick Guide to Immigrant Eligibility for Affordable Care Act and Key Federal Means-tested Programs,” in the "Resources" section. Also, review your state's guidance on lawfully present immigrants. In addition, there might be health care services in your state offered to individuals who aren't lawfully present in the U.S. It’s helpful to explore other health care service options in your state.

Graphic -- Alt Text:
A mother and father with a young daughter on her father's shoulders

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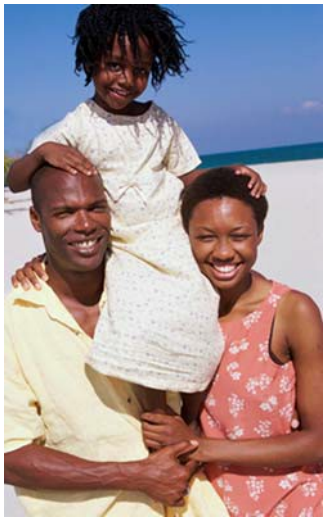
Correctly Identifying Applicants in Mixed Immigration Status Families

A consumer's immigration status may be a sensitive topic. You should be mindful of this during your conversations with consumers. In working with immigrant families, be sure to correctly identify the applicant by asking consumers whether they're seeking health coverage for themselves or on behalf of someone else.

Correctly identifying the applicant matters, because asking unnecessary questions regarding the immigration status of non-applicant family or household members could violate Title VI of the Civil Rights Act or its implementing regulations.

Returning to Pierre, LaGrande, and Matou, all questions that you ask Pierre and LaGrande when filling out the application for Matou should be in reference to Matou. For example, if a question on the application states, “Are you a U.S. citizen?” the question is referring to Matou's citizenship and not that of her parents. The eligibility determination Matou's parents receive from the Marketplace will only provide information about Matou's coverage options, since she is the applicant.



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Graphic -- Alt Text:
A mother and father with their young daughter on their shoulders

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Mixed Immigration Status Families

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Sensitivity When Working with Mixed Immigration Status Families

Some consumers who are immigrants may:

- Not know their immigration status or have incorrect information about their status
- Not know if they're eligible for coverage and/or have incorrect information about their eligibility
- Not have an SSN or a Green Card, even when they're lawfully present

To effectively help mixed immigration status families, you should:

- Avoid asking questions that could cause consumers who are immigrants to say they, or another family member, aren't lawfully present in the U.S.
- Avoid words like "undocumented," "unauthorized," or "illegal," and use words like "eligibility status."
- Ask consumers who are immigrants applying for help paying for coverage about their income status before asking about their immigration status.
- Tell consumers who are immigrants that in the Marketplace, the DHS only reviews their status to determine eligibility and not for any other purpose.
- Avoid providing information that could discourage eligible applicants from applying. If you inform a non-applicant who is filing an application for an eligible child that all persons unlawfully in the U.S. will be reported to U.S. Immigration and Customs Enforcement (ICE), you could be in violation under Title VI of the Civil Rights Act because the statement could deter, delay, or deny eligible consumers from getting health coverage.

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Tips to Effectively Serve Mixed Immigration Status Families

To effectively help mixed immigration status families, you should also:

- Avoid asking an applicant or a non-applicant for the non-applicant's citizenship status or immigration status.
- Avoid asking for the SSN of a non-applicant, unless a premium tax credit would be provided to a non-applicant tax filer to help pay premiums for the applicant or if they are applying for other insurance affordability programs.
- Help all consumers, even if an applicant or a non-applicant representative hasn't disclosed his or her citizenship status, immigration status, or SSN.
- Keep fact sheets and other resource materials on eligible immigration status handy, and ensure that the materials are in a language consumers can understand.
- Give consumers who are immigrants reassuring messages about privacy and confidentiality, especially about citizenship status, immigration status, and SSNs.
- Provide free interpretation services and translated documents to consumers who don't speak English.

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Graphic -- Alt Text:
Portrait of a young couple with two young children.

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Mixed Immigration Status Families and Privacy

To provide effective assistance to immigrants, you need to know what personal information can be collected, how it can be shared, and potential harmful outcomes for consumers if information isn't kept secure.

Keep in mind these key points:

- Personally identifiable information (PII), which can include a consumer's name, address, income, or SSN, may be collected, used, and disclosed only if necessary to determine Marketplace, Medicaid, or CHIP eligibility or in a manner consistent with the scope of the consumer's specific consent.
- PII can only be disclosed to and used by those persons who are authorized to get or view the information. You should never retain any PII without proper consent.
- Marketplace applications or supplemental forms may not request the SSN of non-applicants, unless a premium tax credit would be provided to a non-applicant tax filer to help pay premiums for the applicant.

Always keep privacy issues in mind when working with all consumers.

Graphic -- Alt Text:
Silhouette of woman touching privacy button with fingerprint

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Mixed Immigration Status Families

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Knowledge Check

Aakash and Nita aren't lawfully present in the United States (U.S.). They have a son, Bhaskar, who was born in the U.S. Which of the following statements are true about this family?

Select **all that apply** and then click **Check Your Answer**.

- ☐ **A.** Bhaskar isn't a U.S. citizen because his parents aren't U.S. citizens.
- ☐ **B.** Aakash, Nita, and Bhaskar are an example of a mixed immigration status family.
- ☐ **C.** Aakash and Nita should provide you with the information about their immigration status so that you can help them apply for health coverage for Bhaskar.
- ☐ **D.** Aakash and Nita can apply for health coverage for Bhaskar without worrying about immigration-related legal issues.

Check Your Answer | Reset

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Question:

Aakash and Nita aren't lawfully present in the United States (U.S.). They have a son, Bhaskar, who was born in the U.S. Which of the following statements are true about this family?

Correct Answers:

B ,D

Feedback for Correct Answer:

Correct! Bhaskar is a U.S. citizen, and this is an example of a mixed immigration status family. Aakash and Nita can apply for health coverage for Bhaskar without worrying about immigration-related legal issues. However, you shouldn't ask Aakash or Nita questions about their citizenship or immigration status because that information is irrelevant to the eligibility determination for Bhaskar.

Feedback for Incorrect Answer:

Incorrect! The correct answers are B and D. Bhaskar is a U.S. citizen, and this is an example of a mixed immigration status family. Aakash and Nita can apply for health coverage for Bhaskar without worrying about immigration-related legal issues. However, you shouldn't ask Aakash or Nita questions about their citizenship or immigration status because that information is irrelevant to the eligibility determination for Bhaskar.

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Mixed Immigration Status Families

Health Coverage Eligibility for Lawfully Present Immigrants

When you meet with consumers who are lawfully present immigrants, you should tell them that they're required to have health coverage or they may have to pay a fee.

You should also tell lawfully present consumers that they're eligible for the following:

- Health coverage through the Marketplace, if they reside in the U.S. and aren't incarcerated (other than pending the disposition of charges)
- A premium tax credit to help lower costs if their income is less than 400% of the federal poverty level (FPL), which is $79,160 for a family of three in 2014, and they meet other eligibility criteria (like not having access to affordable, job-based minimum essential coverage)
- Cost-sharing reductions if their income is less than 250% of the FPL, which is $49,475 for a family of three in 2014

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

To find out other FPL amounts, visit the "Resources" section.

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Graphic -- Alt Text:
Mother and daughter speaking with the receptionist in a doctor's office

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Documentation Requirements for Enrollment

In addition to eligibility requirements, you should be able to describe to consumers who are immigrants the type of documents they'll need to have in order to apply for enrollment in a QHP through the Marketplace, the premium tax credit, cost-sharing reductions, Medicaid, and CHIP.

Consumers may need to have:

- SSN (or document numbers for any lawfully present immigrants who need insurance); note that:
  - SSN isn't required for consumers seeking emergency Medicaid.
  - Electronic documentation, not just authentic paper documents, may be used.
  - Two documents are required to establish the immigration status.
  - If verification of citizenship or immigration status fails, applicants generally have 90 days to provide supporting documentation. During this time, if otherwise eligible, applicants are enrolled in the program for which they seem to qualify based on information the application filers provided.
  - Medicaid applicants aren't required to provide documentation to support eligibility when documentation doesn't exist or isn't available because of homelessness, domestic violence, or natural disasters.
- Employer and income information for everyone in the family (e.g., paystubs, W-2 forms, or wage and tax statements)
- Policy numbers of any current health coverage
- Information about any job-related health insurance available to the family

Also remember to review the application requirements in your state which may have additional details not provided here.

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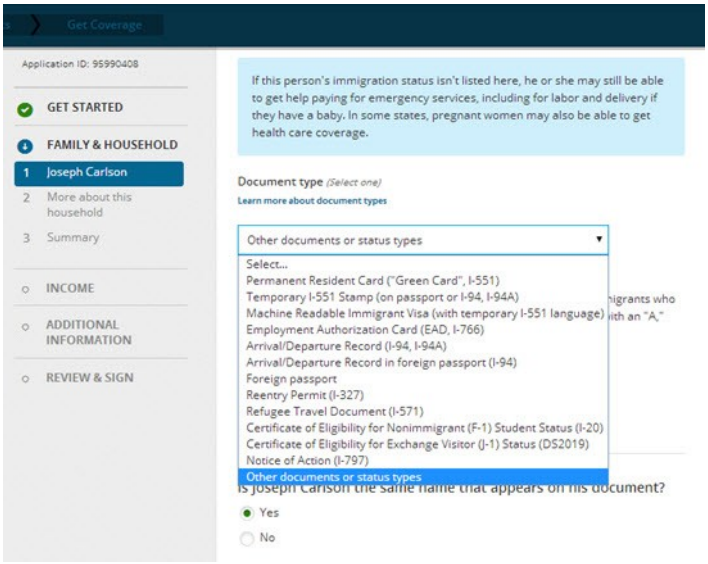
Documents Used to Verify Immigration Status

When filling out an application at HealthCare.gov for Marketplace coverage, consumers may be asked questions about their immigration status and need to attest to being in an eligible immigration status. Here's a list of the documents that can be used to show immigration status. Consumers should select the document type from the drop-down list that corresponds with their most current documentation and status.



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Graphic -- Alt Text:
Screen shot of drop-down list on HealthCare.gov

Popup 1
Documents to Show Immigration Status

Popup Text:

Document	Description
Permanent Resident Card, "Green Card," (I-551)	Issued to lawful permanent resident (LPR), which is a person who isn't a citizen of the U.S., but who's residing in the U.S. under legally recognized and lawfully recorded permanent residence as an immigrant
Reentry Permit (I-327)	Allows permanent residents to leave and re-enter the U.S.
Refugee Travel Document (I-571)	Issued to refugees and asylees for travel purposes
Employment Authorization Card (I-766)	Issued to some people who are authorized to work temporarily in the U.S.
Machine Readable Immigrant Visa (with temporary I-551 language)	Indicates permanent resident status
Temporary I-551 Stamp (on passport or I-94/I-94A)	Can be used to attest to permanent resident status
Arrival/Departure Record (I-94/I-94A)	Issued to foreign travelers when they enter the U.S.

Foreign Passport	Used when entering the U.S.
Certificate of Eligibility for Nonimmigrant Student Status (I-20)	Documents that support applications for student visa statuses (F-1s or F-2s)
Certificate of Eligibility for Exchange Visitor Status (DS2019)	Documents that support applications for exchange visitor visa statuses (J-1s or J-2s)
Notice of Action (I-797)	Communication from U.S. Citizenship and Immigration Service about immigration benefits

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Immigrants Who Aren't Lawfully in the United States

The Affordable Care Act's individual shared responsibility requirement doesn't apply to immigrants who aren't lawfully present in the U.S. They aren't required to have health coverage and won't have to pay a fee if they don't have health coverage.

Consumers who aren't lawfully present are generally NOT eligible for:

- Health coverage through the Marketplace, even at full price
- The premium tax credit or cost-sharing reductions

Consumers who aren't lawfully present ARE eligible for:

- Emergency medical assistance (Emergency Medicaid) for emergency treatment
- Prenatal care through CHIP, in some states
- Public health programs, community health centers, and hospital care
- Health coverage offered outside the Marketplace, Medicaid, and CHIP

Here's a key tip you should remember about helping consumers who aren't lawfully present in the U.S.

Graphic -- Alt Text:
A father, mother, and baby girl

Popup 1
Key Tip

Popup Text:
You should explore other health care programs in your state that might provide services to consumers who aren't lawfully present in the U.S.

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Medicaid and CHIP Eligibility Requirements for Immigrants

Mixed immigrant status families may be eligible to get Medicaid and CHIP coverage. You should be aware that being eligible for these programs is different from being eligible for a QHP through the Marketplace. You must learn to recognize which consumers might be eligible for Medicaid and CHIP.

Eligible consumers include:

- Lawful Permanent Residents (LPR) or Green Card holders
- Refugees and persons granted asylum or "withholding of deportation/removal"
- Immigrants paroled into the U.S. for at least one year
- Cuban and Haitian entrants
- Certain victims of domestic violence, including:
  - A non-citizen who meets the requirements upon first review or has an approved visa petition filed by a spouse or parent who's a U.S. citizen or an LPR
  - A non-citizen who has filed his or her own petition under the Violence Against Women Act (VAWA), or who has applied for a "cancelation of removal/suspension of deportation" under VAWA
  - A non-citizen who's the parent of a battered child or the child of a battered spouse

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Graphic -- Alt Text:
Green Card with pamphlet welcoming to United States in the background

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Additional Medicaid and CHIP Eligibility Requirements for Immigrants

Other eligible consumers include:

- Consumers with conditional entrant status, granted U.S. entry because of a natural catastrophe, or because they fear persecution in their home country due to race, religion, and/or political opinion
- Certain victims of human trafficking:
  - If the non-citizen is age 18 or older, they must be certified by the Department of Health & Human Services (HHS) as a victim of trafficking. Children under age 18 need an HHS eligibility letter.
  - T-visa (a special visa for victims of human trafficking and their families) holder's spouse and/or child are also eligible for Medicaid and CHIP.
- Lawfully present children and pregnant women (five-year waiting period doesn't apply). Eligibility for this group varies by state (approximately half of the states and Washington, D.C. grant eligibility to this group).
- Immigrants whose preliminary information indicates that they're eligible for Medicaid or CHIP
- Supplemental Security Income (SSI) recipients in most states
- Immigrants in need of prenatal care under CHIP in some states

You'll learn more about this subject later in the training.

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Graphic -- Alt Text:
A young mother and daughter on a ship

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Medicaid and CHIP Five-Year Waiting Period

Qualified immigrants are eligible for non-emergency Medicaid, CHIP, and other major federal programs with certain conditions and restrictions. One important restriction is a five-year waiting period for those who entered the U.S. after August 22, 1996. The relevant date is the date on or after when the immigrant first received lawful status.

State policies aren't all the same. A few states don't offer federal Medicaid to immigrants even if the five-year waiting period has passed, while some states provide Medicaid to refugees, those seeking asylum, and persons granted "withholding of removal" only for five to seven years. About one-half of states provide some coverage to some groups of immigrants who are ineligible for federal coverage. There's no time requirement for state residency. About one-half of states cover lawfully present children and/or provide prenatal care without a waiting period.

With a mixed immigration status family like Pierre and LaGrande's, the five-year waiting period won't apply to Matou because she's a U.S. citizen, and depending on the family's income, she may qualify for public coverage programs. Remember that eligibility will also depend on the state in which a consumer lives. As for Pierre and LaGrande, they'll only qualify for Medicaid if they're refugees or fall into the other eligibility categories previously described.

Graphic -- Alt Text:
A smiling child

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Knowledge Check

Recall that Pierre and LaGrande aren't lawfully present in the United States (U.S.), but their daughter, Matou was born in the U.S. Which of the following statements are correct about this family's eligibility status?

Select **all that apply** and then click **Check Your Answer**.

- ☐ **A.** Since Matou is a U.S. citizen, she's required to have health coverage or instead pay a fee.
- ☐ **B.** Pierre and LaGrande may be eligible for some types of Medicaid based on their income.
- ☐ **C.** Pierre and LaGrande aren't eligible to buy coverage through the Marketplace, even at full price.
- ☐ **D.** To qualify for the Children's Health Coverage Program (CHIP), Matou will be subject to a five-year waiting period.

Check Your Answer | Reset

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Question:

Recall that Pierre and LaGrande aren't lawfully present in the United States (U.S.), but their daughter, Matou was born in the U.S. Which of the following statements are correct about this family's eligibility status?

Correct Answers:

A ,B ,C

Feedback for Correct Answer:

Correct! Since Matou is a U.S. citizen, she's required to have health coverage or her family must pay a fee. Pierre and LaGrande may be eligible for some types of Medicaid based on income. Pierre and LaGrande aren't eligible to buy health coverage through the Marketplace. Because Matou is a citizen, she won't be subject to a five-year waiting period to qualify for CHIP.

Feedback for Incorrect Answer:

Incorrect. The correct answers are A, B, and C. Since Matou is a U.S. citizen, she's required to have health coverage or her family must pay a fee. Pierre and LaGrande may be eligible for some types of Medicaid based on income. Pierre and LaGrande aren't eligible to buy health coverage through the Marketplace. Because Matou is a citizen, she won't be subject to a five-year waiting period to qualify for CHIP.

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Immigration-Related Rules in the SHOP Marketplace

The SHOP Marketplace is designed to help small employers find health coverage for their employees. You should know that the immigration eligibility rules that apply in the Individual Marketplace don't apply in the SHOP Marketplace. Disclosure of citizenship and immigration status isn't required as part of the SHOP Marketplace eligibility application for employers or employees.

When you interact with a small employer, you shouldn't:

- Ask for the citizenship and immigration status of employees.
- Ask the employer anything about the employee's spouse or dependents, other than name, address, and birth date

When you interact with a small employer, you should:

- Ask the small employer for:
  - Business name, location, number of employees
  - Employer Identification Number (EIN)
  - A list of qualified employees and their Taxpayer Identification Numbers (TINs)
- Comply with the Affordable Care Act privacy requirements

Graphic -- Alt Text:
A shop owner hanging an open sign in the window

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Knowledge Check

The immigration eligibility rules that apply in the Marketplace don't apply in the Small Business Health Options Program (SHOP) Marketplace. When a small employer comes to you for information on applying for health insurance for their employees in the SHOP Marketplace, which of the following is NOT recommended? Select all that apply.

Select **all that apply** and then click **Check Your Answer**.

- ☐ **A.** Ask for citizenship and immigration status information of employees
- ☐ **B.** Request the business name, location, and number of employees
- ☐ **C.** Disclose to the employer information about an employee's spouse or dependents, other than name, address and date of birth
- ☐ **D.** Ask the employer for a list of qualified employees and their Taxpayer Identification Numbers (TINs)

Check Your Answer | Reset

Question:

The immigration eligibility rules that apply in the Marketplace don't apply in the Small Business Health Options Program (SHOP) Marketplace. When a small employer comes to you for information on applying for health insurance for their employees in the SHOP Marketplace, which of the following is NOT recommended? Select all that apply.

Correct Answers:

A ,C

Feedback for Correct Answer:

Correct! When a small employer applies for health insurance for their employees in the SHOP Marketplace, there's no need for you to ask for citizenship and immigration status information of employees, because the SHOP Marketplace isn't permitted to collect that information through the SHOP Marketplace application. It's also strongly recommended that you not disclose to the employer any information about an employee's spouse or dependents, other than name, address, and birth date, because the SHOP Marketplace is prohibited from doing so. You can, however, request the business name, location, and number of employees, as well as ask for a list of qualified employees and their TINs, if necessary to assist a small employer with applying to participate in the SHOP Marketplace and offering SHOP Marketplace coverage to employees.

Feedback for Incorrect Answer:

Incorrect. The correct answers are A and C. When a small employer applies for health insurance for their employees in the SHOP Marketplace, there's no need for you to ask for citizenship and immigration status information of employees, because the SHOP Marketplace isn't permitted to collect that information through the SHOP Marketplace application. It's also strongly recommended that you not disclose to the employer any information about an employee's spouse or dependents, other than name, address, and birth date because the SHOP Marketplace is prohibited from doing so. You can, however, request the business name, location, and number of employees, as well as ask for a list of qualified employees and their TINs, if necessary to assist a small employer with applying to participate in the SHOP Marketplace and offering SHOP Marketplace coverage to employees.

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Key Points

When immigrant parents not lawfully present in the U.S. give birth to a child in the U.S., that child is a U.S. citizen and eligible for health coverage through the Marketplace.

You may be violating Title VI of the Civil Rights Act if you ask questions regarding the citizenship status, immigration status, or SSN of non-applicants and thus deter, delay, or deny eligible consumers from getting health coverage.

Immigrants not lawfully present can still purchase health coverage outside of the Marketplace and may be eligible for Medicaid in certain situations.

Unlawfully present immigrants don't have to pay a fee if they don't have health coverage.

The immigration eligibility rules that apply in the Individual Marketplace don't apply in the SHOP Marketplace.

You've successfully completed this course.

*Click **Exit** to leave the course and take the Serving Vulnerable and Underserved Populations exam.* Once you've started an exam, you must complete it. If you need to stop and return to it later, your progress won't be saved. You'll need to start the exam over from the beginning.

