GEORGIA ACCESS

Office of Commissioner of Insurance and Safety Fire
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COMMISSIONER JOHN F. KING

Georgia Access Certification Training for Plan Year 2025

Policies & Procedures Training Manual

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1 Module Introduction

1.1 Module Objectives

a. Learn about Georgia Access policies and consumer eligibility.
b. Understand Georgia Access procedures.
c. Gain knowledge to provide consumers with informed assistance when applying for health coverage.

2 Introduction

2.1 Georgia Access Overview

a. The Georgia Office of Commissioner of Insurance and Safety Fire (OCI) launched the Georgia Access Division in 2023. Georgia Access is the State's program for Georgians to shop for and enroll in health insurance. Georgia Access will launch a State-based Exchange (SBE) on November 1, 2024, for Open Enrollment (OE) 2025. The goals of Georgia Access are to:
   i. Increase the number of insured Georgians.
   ii. Bring revenue back to the State.
   iii. Incentivize private sector investment and innovation.
b. Georgia Access offers several types of plans and financial assistance to help consumers enroll in affordable, quality health coverage on the Exchange.
c. Types of Plans
   i. Qualified Health Plans (QHPs)
   ii. Catastrophic health plans
   iii. Stand-alone Dental Plans (SADPs)
d. Types of Financial Assistance
   i. Premium Tax Credit (PTC)
   ii. Advanced Premium Tax Credits (APTC)
   iii. Cost-sharing Reductions (CSRs)

2.2 Enrolling in a Healthcare Plan

a. There are two types of enrollment periods for Exchanges: OE and Special Enrollment Periods (SEPs). Georgia Access is designed to meet the needs of Georgia residents by increasing access to affordable, quality health insurance coverage across the state. Consumers may choose to shop for and enroll in coverage with a certified agent, web broker, insurance company, or through the Georgia Access consumer portal. To view the full list of Georgia Access enrollment options, visit GeorgiaAccess.gov.
b. **Note**: Regardless of how the consumer applies, their information is sent and stored in the Georgia Access Eligibility and Enrollment system. The costs of the plan premiums and eligibility for financial assistance also remains the same.

2.3 Georgia Access Enrollment Options

a. Certified agents, web brokers, and insurance companies support consumers with plan shopping and enrollment on Georgia Access. Their services are free to consumers. Agents must be licensed and certified to enroll consumers in plans on Georgia Access. The state certifies web brokers and insurance companies as Enhanced Direct Enrollment (EDE) partners if they provide an approved online consumer application for plan shopping and enrollment on Georgia Access. Consumers that shop on EDE platforms receive the same eligibility results and see the same premium prices

as consumers on the Georgia Access consumer portal. Consumers may change their EDE at any time.

b. Overview of Certified Agents
    i. Obtain and document consumer consent prior to assisting with or facilitating consumer enrollment.
    ii. Inform consumers of the plan options available to them.
    iii. Recommend specific plans that are most appropriate and/or best suited for consumers and their families.
    iv. Enroll consumers in plans on Georgia Access.
    v. Remain in ongoing contact with consumers during the enrollment process and respond to questions as needed either online, over the phone, or in-person.
c. Overview of Web Brokers
    i. Provide consumers with an online platform for plan shopping, selection, and enrollment.
    ii. Display all certified QHPs and Catastrophic plans available to consumers on Georgia Access (many also display SADPs).
    iii. Offer the same plan shopping and consumer assistance as the Georgia Access consumer portal.
    iv. Offer a similar plan shopping, comparison, and enrollment experience as the Georgia Access consumer portal.
    v. Display the same plan premiums and eligibility for financial assistance as the Georgia Access consumer portal.
d. Overview of Insurance Companies
    i. May provide consumers with a certified online platform for plan shopping, selection, and direct enrollment.
    ii. Provide certified insurance products (QHPs, Catastrophic Plans, or SADPs) sold on Georgia Access.
    iii. Display the same premiums to consumers as they find on the Georgia Access consumer portal but display only their specific plans.

2.4 Georgia Access Assisters

a. Georgia Access also has two Assister programs: a Navigator program and Certified Application Counselors (CACs) program. These programs provide outreach and application assistance to consumers, focusing on reaching vulnerable and underserved communities. Navigators and CACs must be certified and licensed to support consumers on Georgia Access.
b. Navigators
    i. A Navigator is an individual who is licensed and certified by the State to support consumers with applying for coverage on Georgia Access.
    ii. Navigators provide outreach and education to all consumers, including underserved or vulnerable populations.
    iii. Navigators are not permitted to advise consumers on which health plan is best.
    iv. Navigators are affiliated with Navigator Grantee organizations (or “Navigator Grantees”) either as employees or volunteers.
    v. Navigator Grantees receive state grants to fund Navigator operations.
c. CACs
    i. A CAC is an individual who is licensed and certified by the State to support consumers with applying for coverage on Georgia Access.
    ii. CACs provide unbiased support and educate consumers on healthcare options.
    iii. Like Navigators, CACs are not permitted to advise consumers on which health plan is best.

iv. CACs are required to be affiliated with a Certified Application Counselor Designated Organization (CDO), either as an employee or volunteer.
v. CDOs are organizations that voluntarily participate in Georgia Access and do not receive grant funding.

2.5 The Consumer Journey

a. Regardless of how a consumer applies for coverage on Georgia Access (i.e., through a certified agent, web broker, insurance company, or the Georgia Access consumer portal), the Georgia Access eligibility and enrollment system determines consumer eligibility and stores the application and enrollment information. Consumers can also change how they enroll at any time.
b. The following outlines the consumer journey when applying for coverage on Georgia Access:
    i. *Application*. Submit an application for plan and financial assistance eligibility through a certified agent, web broker, insurance company, or Georgia Access consumer portal. The application can also be submitted over the phone or sent via mail to the Georgia Access contact center.
    ii. *Information Verification*. Automatic verification by the Georgia Access eligibility & enrollment system through electronic data sources. Receive a Data Matching Issue (DMI) notice if a discrepancy is identified.
    iii. *Eligibility Determination*. Assess eligibility for QHP, Medicaid, APTCs, and CSRs. If eligible for Medicaid, they are referred.
    iv. *Plan Shopping*. View plan options and premiums prices with APTC and CSRs, if eligible.
    v. *Enrollment*. Enroll in health plan: Select and enroll in health insurance coverage and choose to apply APTC, if eligible.
    vi. *Effectuation*. Pay the first month's premium to effectuate enrollment.
    vii. *Monthly Payments*. Continue to pay monthly premium to the insurance company to maintain coverage.
    viii. *Tax Reconciliation*. Receive a 1095-A from Georgia Access and file federal income taxes with the IRS, reconciling the amount of APTCs received throughout the year with the total claimed PTCs.
c. Providing nondiscriminatory access to healthcare is critical to the success of Georgia Access. Section 1557 of the Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities and extends these protections to individuals participating in an SBE, and all plans offered by insurance companies that participate in the SBE. Please refer to the HHS Office for Civil Rights for more information on Section 1557.

2.6 Knowledge Check

a. After shopping for a health coverage plan, what is the next step in the consumer journey?
    i. Information Verification
    ii. Tax Reconciliation
    iii. Enrollment
    iv. Eligibility Verification

3 Enrollment Periods

3.1 Enrollment Periods

a. Enrollment periods are defined periods of time during which a consumer may enroll in an insurance plan. There are two types of enrollment periods for Exchanges: Open Enrollment (OE) and Special Enrollment Periods (SEPs).

3.2 Open Enrollment (OE)

a. OE, also known as an Open Enrollment Period (OEP), is the annual period when all consumers may enroll in an individual market health insurance plan on the Exchange for the upcoming Plan Year (PY). The Georgia Access OEP for 2025 is November 1, 2024, through January 15, 2025. A consumer cannot enroll in health coverage through Georgia Access after OE unless they are eligible for a SEP.
b. Open Enrollment Dates for Georgia Access:
    i. *November 1*. Open Enrollment begins for health coverage for the next plan year. This is the first day consumers can enroll, re-enroll, or change health plans through Georgia Access. Coverage can start as soon as January 1.
    ii. *December 15*. Last day to enroll in or change plans for coverage to start January 1.
    iii. *January 1*. Coverage starts for those who enrolled in or changed plans by December 15 and paid their first premium.
    iv. *January 15*. Open Enrollment ends. This is the last day to enroll in or change health plans for coverage to begin February 1.
    v. *February 1*. Coverage starts for those who enrolled in or changed plans December 16 through January 15 and paid their first premium.

3.3 SEPs

a. A SEP is a time outside of OE when a consumer can sign up for health insurance if they experience a Qualifying Life Event (QLE). A QLE refers to a change in a consumer's situation which makes them eligible to enroll in coverage on the Exchange mid-year. Depending on the SEP type, consumers have either 60 or 90 days before or after the event to enroll in a plan. Information about SEPs may be found on GeorgiaAccess.gov.
b. Qualifying life events include:
    1. Changes in Household
        2. Pregnancy
        3. Marriage
        4. Birth or adoption of a child
        5. Gaining or becoming a dependent due to child support or other court order
        6. Divorce, legal separation, or having a death in the family that results in the loss of coverage
        7. Changes in lawful presence
        8. Leaving incarceration
        9. Gaining membership in a federally recognized tribe
        10. Becoming a U.S. citizen
    ii. Changes in Residency
        1. Moving to the U.S. from a foreign country or United States territory
        2. Moving to or from the place the individual attends school
        3. Moving or from the place the individual lives and works as a seasonal worker

4. Moving to or from a shelter or other transitional housing
5. Moving to a new home in a new zip code or county where new Qualified Health Plans (QHPs) are available
6. **Note:** Moving only for medical treatment or staying somewhere for vacation does not qualify consumers for a SEP.
7. **Note**: Generally, consumers only qualify for an SEP if they had qualifying health coverage for at least 1 day in the 60 days before the move.

iii. Loss of Minimum Essential Coverage (MEC)
1. Loss of employer sponsored coverage
2. Loss of Medicare, Medicaid, PeachCare for Kids®, or TRICARE
3. Loss of coverage offered by other government organizations such as the Veteran's Administration or Peace Corps
4. Loss of coverage purchased in the individual market
5. Discontinuation of Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage
6. Loss of parent or guardian's insurance plan due to the dependent turning 26

iv. Other Types of QLEs
1. An employer newly offers an Individual Coverage Health Reimbursement Arrangements (ICHRA)
2. An employer newly offers a Qualified Small Employer Health Reimbursement Arrangements (QSEHRA)
3. The consumer experiences changes in household income or has an estimated annual household income below 150% of the Federal Poverty Level (FPL)
4. The consumer begins or ends AmeriCorps service
5. The consumer experienced an exceptional circumstance that prevented them enrolling in coverage during Open Enrollment (e.g., being incapacitated, natural disaster)
6. The consumer is a victim of domestic abuse or spousal abandonment and wants to enroll in a health plan separate from the abuser or abandoner

3.4 Exchange-Related SEPs

a. In addition to the QLEs previously described, consumers are also eligible for a SEP on Georgia Access if they:
   i. Are deemed ineligible for Medicaid or PeachCare for Kids® outside of OE or past the deadline to apply for a SEP after experiencing a QLE. ***Note****: This is only applicable if the consumer applied during OE or during the 60–90-day period after experiencing the QLE.*
   ii. Are terminated from health coverage on the Exchange after submitting documentation to resolve a Data Matching Issue (DMI)
   iii. Do not receive timely notice and/or were unaware of a triggering event for enrolling in coverage on the Exchange
   iv. Did not enroll or were incorrectly enrolled in a plan due to:
      1. Misinformation, misrepresentation, misconduct, or inaction by someone working in an official capacity to help the individual enroll
      2. Technical error or another Exchange-related enrollment delay
      3. Plan Display Error (PDE)
   v. Demonstrate a violation of a material provision in the insurance plan's contract
   vi. Receive an appeal decision confirming their ability to enroll in coverage

3.5 SEP Requirements and Restrictions

a. SEP requirements and restrictions include:

i. *SEP Verification*. When a consumer applies for a SEP, they must attest that the information they provided on their application is accurate. They may also be required to submit documentation that confirms their QLE within 30 days.
ii. *SEP Plan Category Limitations*. If a consumer is currently enrolled in a plan on Georgia Access and experiences a QLE which makes them eligible for a SEP, they typically must select a plan within their same metal level. There are some exceptions to this rule.
iii. *SEP Coverage Effective Dates*. Coverage for an SEP typically starts on the first day of the month following plan selection. Coverage begins on the first day of the month following the loss of MEC. Coverage for some SEPs may be retroactive to the date of the QLE, such as for birth, adoption, or court ordered changes.

3.6 Knowledge Check

a. Which of the following experiences does not qualify an individual for a Special Enrollment Period (SEP)?
   i. Change in household
   ii. Loss of qualifying health coverage
   iii. Change in Primary Care Physician
   iv. An employer offers to help with the cost of coverage

4 Consumer Subsidies

4.1 Overview

a. Health insurance is expensive and can be unaffordable for people with low to moderate income. In response, the Affordable Care Act (ACA) established consumer subsidies, including Premium Tax Credits (PTCs) and Cost-sharing Reductions (CSRs), to lower Out-of-Pocket (OOP) costs. Consumer eligibility is based on the Federal Poverty Level (FPL) and estimated household Modified Adjusted Gross Income (MAGI). Georgia Access uses the FPL to determine eligibility for certain programs including Medicaid and PeachCare for Kids® (PCK). For more information regarding the most recent FPL guidelines, visit the U.S. Department of Health and Human Services Poverty Guidelines website.

4.2 Premium Tax Credit (PTC) & Advance Premium Tax Credit (APTC) Overview

a. A PTC is a federal income tax credit for eligible consumers enrolled in a QHP. The tax credit each consumer is eligible for is based on the household MAGI, the affordability threshold for health insurance set by the IRS for the associated FPL, and the cost of the Second Lowest-cost Silver Plan (SLCSP) in the consumer's county.
b. APTC, also known as payment assistance or a financial subsidy, is a payment made in advance by the federal government to the insurance company each month on behalf of the consumer to lower their monthly premium costs. It is based on their estimated MAGI and PTC for the year. Consumers must reconcile the amount of APTC they received with their actual PTC eligibility when filing income taxes with the IRS.
c. The American Rescue Plan Act of 2021 (ARPA) temporarily expanded eligibility for PTC and the Inflation Reduction Act (IRA) extended this provision through the 2025 Plan Year (PY). Under the IRA, PTC is enhanced for all consumers otherwise eligible for QHPs and is also available for those with estimated household incomes over 400 percent of the FPL.

4.3 The Difference Between APTC & PTC

a. APTC
   i. Is paid each month throughout the year to the consumer's health insurance company on their behalf.
   ii. Reduces the consumer's monthly insurance premium cost.
   iii. Is based on the consumer's estimated MAGI for the year.
b. PTC
   i. Is a federal tax credit established by the ACA.
   ii. Reduces the federal taxes owed or increases the consumer's tax refund.
   iii. Is based on actual MAGI for the year.

4.4 APTC/PTC Eligibility

a. To be eligible for APTC/PTC, consumers must meet the following criteria:
   i. Must be a U.S. citizen or lawfully present immigrant.
   ii. Cannot be claimed as a dependent on another person's tax return.
   iii. Tax filing status cannot be "married filing separately." ***Exceptions may apply for survivors of domestic abuse or spousal abandonment.***
   iv. Cannot be eligible for or enrolled in other Minimal Essential Coverage (MEC).
   v. Must be enrolled in a health plan bought on Exchange for at least one month in the year.
   vi. Must meet income eligibility requirements.

4.5 Requirements to Reconcile

a. When the consumer files their taxes, the amount of APTC they received for the year will be reconciled with the PTC the consumer is eligible for based on actual household income and size for the tax year. If a consumer receives more APTC throughout the year than they qualify for based on actual MAGI during tax filing, they must repay the difference to the IRS when they file their federal income tax return. If a consumer receives less or no APTCs throughout the year than they qualify for based on actual MAGI during tax filing, they will receive the difference as a refundable credit when they file their taxes.

4.6 Failure to File and Reconcile (FTR)

a. Consumers may not be eligible for APTC if the tax filer for the household did not file federal income taxes for the most recent year in which the consumer is applying for coverage on the Exchange or for a year in which APTC was paid.

4.7 Knowledge Check

a. The amount of Advance Premium Tax Credit (APTC) a consumer is qualified for is based on their:
   i. Job status
   ii. Level of education
   iii. Income and household size
   iv. Medical condition

4.8 Cost-sharing Reductions (CSRs) Overview

a. CSRs are discounts that lower the Maximum Out-of-Pocket (MOOP) that consumers pay for health services under the plan (including deductibles, copayments, and coinsurance). CSRs are often called "extra savings." Unlike APTC, CSRs are not tax credits and do not need to be reconciled at the end of the year.
b. Those eligible for CSRs include:

i. All consumers 100 - 250% of FPL are eligible for reduced MOOP compared to the normal QHP limit when enrolling in a silver plan.
ii. Consumers who identify as American Indian or Alaskan Native (AI/AN) are eligible for $0 MOOP if they are members of a federally recognized tribe within the state and may enroll in any metal level plan.

4.9 Knowledge Check

a. Gracie Smith (30) is single with no dependents and works part time at a local coffee shop. Gracie's current annual income is 220% of the Federal Poverty Level (FPL). Her employer does not offer health insurance. Gracie has asked for your help in applying for health coverage and financial assistance. Based on her situation, what is Gracie likely eligible for?
   i. Catastrophic health plan
   ii. Stand-alone Dental Plans (SADPs)
   iii. Advance Premium Tac Credit (APTCs)
   iv. Qualified Health Plans (QHPs)
   v. Cost-sharing Reduction (CSRs)

5 Medicaid Programs

5.1 What is Medicaid?

a. Medicaid is a joint federal and state health insurance program administered by states that provides health coverage at little to no cost to those that meet eligibility requirements. The Georgia Department of Community Health (DCH) is the lead agency for Medicaid in the state working closely with the Department of Human Services (DHS). Each Medicaid program has its own eligibility requirements which will be covered later in this section. For a full list of programs offered in Georgia, please visit the Georgia Medicaid website.
b. There are generally two types of Medicaid:
   i. *Family Medicaid*: Family Medicaid, also known as Georgia Families®, is a program that provides health care services to low-income families with children under age 19. Consumer eligibility is based on MAGI and eligibility requirements.
   ii. *Aged, Blind and Disabled (ABD) Medicaid*: The Aged, Blind and Disabled (ABD) Medicaid Program in Georgia serves individuals who are age 65 and older, individuals who are legally blind or individuals who are disabled, as defined by the Social Security Act.

5.2 Who is eligible for Medicaid?

a. Georgians may be eligible for Medicaid if they are low-income and match one of the following descriptions:
   i. Are pregnant
   ii. Are a child or teenager
   iii. Are aged 65 or older
   iv. Are legally blind
   v. Have a disability
   vi. Need nursing home care
b. Georgia also provides another Medicaid program called Pathways to Coverage. Georgia Pathways offers healthcare coverage to residents who are not otherwise eligible for traditional Medicaid. Georgians ages 19-64 who have a household income of up to 100% FPL, are not otherwise eligible for traditional Medicaid, and engage in qualifying activities. Pathways is another category of Medicaid under the state's ACA Section 1115 Waiver.

c. Georgia Access uses the Federal Poverty Level (FPL) to determine eligibility for certain programs including Medicaid and PeachCare for Kids® (PCK). For more information regarding the most recent FPL guidelines, visit the U.S. Department of Health and Human Services Poverty Guidelines website.
d. Each Medicaid program has its own eligibility requirements which will be covered later in this section. For a full list of programs offered in Georgia, please visit the Georgia Medicaid website.
e. No Wrong Door: When consumers apply for financial assistance on Georgia Access, they are first assessed for Medicaid and PCK, and then automatically transferred to the State's Medicaid eligibility system (Georgia Gateway). When consumers apply on Georgia Gateway, they are referred to Georgia Access if they are not eligible for Medicaid or PCK needs, in order to determine eligibility for Exchange coverage with financial assistance. This is to uphold the "no wrong door" system enacted through the Affordable Care Act (ACA). Consumers will be assessed and transferred regardless of what application they used to apply.
f. PeachCare for Kids: PeachCare for Kids® began covering children in 1998 and provides comprehensive coverage to uninsured children. The health benefits include primary, preventive, specialist, dental care and vision care. PeachCare for Kids® also covers hospitalization, emergency room services, prescription medications and mental health care. Each child in the program has a Georgia Families Care Management Organization (CMO) who is responsible for coordinating the child's care.

5.3 How do consumers apply for Medicaid?

a. Consumers seeking Medicaid coverage can apply at any time and in the following ways:
    i. Online through Georgia Gateway.
    ii. By mail to "Division of Family and Children Services, Customer Contact Center, P.O. Box 4190, Albany, GA 31706".
    iii. By phone at 1-877-423-4746.
    iv. In person at their county Division of Family and Children Services (DFCS) office.

5.4 Georgia Families/Family Medicaid

a. Georgia Families is Georgia's Family Medicaid Program for people enrolled in Medicaid, PeachCare for Kids® (PCK), and Pathways to Coverage. Most Medicaid and PCK members must enroll in Georgia Families and join a health plan and choose a provider. The program is a partnership between Georgia DCH and private Care Management Organizations (CMOs).
b. The Modified Adjusted Gross Income (MAGI) methodology is used to determine income eligibility for Medicaid, PCK, and financial assistance for health insurance plans sold on Georgia Access. Georgia Access uses the MAGI methodology to determine countable income for Family Medicaid.
c. The following are common types of Medicaid and their eligibility criteria. For a full list of programs, visit the Georgia Medicaid website.
    i. *Medicaid for Pregnant Women*. Medicaid for Pregnant Women pays for medical care for pregnant women, including labor and delivery, and postpartum care for up to 12 months after they give birth. Consumers who qualify are entitled to the full range of Medicaid-covered services. Some services include physician's visits, prescription drugs, and inpatient and outpatient hospital services.
        1. Eligibility requirements:
            i. Must be a Georgia resident
            ii. Must be a U.S. citizen or legal resident
            iii. Must be pregnant or in the postpartum period

iv. Income cannot exceed 220% of the Federal Poverty Level (FPL) limit

2. **Note**: Pregnant women are counted as a minimum of two people in the calculation of family size and their infant(s) will receive Medicaid until the infant reaches their first birthday.

ii. *Medicaid for Children Under 19*. Medicaid for Children Under 19 pays for medical care for children ages 0 through the month of their 19th birthday. These children may qualify at various income levels depending on age, family size, and income. Children who qualify are entitled to the full range of Medicaid-covered services including doctors' visits, health checkups, immunizations, dental, and vision care.

1. Eligibility requirements:
    i. Must be a Georgia resident
    ii. Must be a U.S. citizen or legal resident
    iii. Child(ren) must be under the age of 19
    iv. Must meet income requirements based on family size

iii. *Medicaid for Parents or Caretakers with Children*. Medicaid for Parents or Caretakers with Children provides Medicaid benefits for eligible children under age 19 and their eligible adult caretakers who meet tax filer or non-tax filer status for the children and are within certain income limits.

1. Eligibility requirements:
    i. Must be Georgia residents
    ii. Must be U.S. citizens or legal residents
    iii. Child(ren) must be under the age of 19
    iv. Must meet income requirements based on family size
    v. Parent/Caretaker must apply or agree to apply for and accept other benefits to which they may be entitled

iv. *CHAFEE Independence Program for Medicaid & Former Foster Care Medicaid*. CHAFEE Independence Program Medicaid became effective July 1, 2008, and extends Medicaid coverage to individuals who age out of foster care the month of their 18th birthday up until their 21st birthday. Former Foster Care Medicaid extends Medicaid coverage to individuals who age out of foster care or age out of Chafee Independence Program Medicaid, through the last day of the month in which the individuals reach 26 years of age.

1. Eligibility requirements:
    i. Must be a Georgia resident
    ii. Must have been in foster care (in Georgia or any other state) and received benefits on their 18th birthday
    iii. Under 21 years old (Chafee Independence Program Medicaid only)
    iv. Under 26 years old (Former Foster Care Medicaid only)
    v. Must have a Social Security Number or an application for a Social Security Number
    vi. There are no income or resource limits
2. Individuals who were in foster care under Title IV-B or Title IV-E of the Social Security Act are exempt from providing additional documentary evidence of citizenship/ immigration status/identity as long as they were in foster care in Georgia. **Note**: Applicants may not be determined ineligible based on a diagnosis or pre-existing condition.
3. For more information about Former Foster Care and Chafee Independence Program Medicaid visit the Georgia Division of Family and Children Services Child Welfare Policy Manual.

v. *Women's Health Medicaid*. Women's Health Medicaid pays for cancer treatments for uninsured or under-insured women diagnosed with breast or cervical cancer who cannot afford to pay for treatment. The Georgia Department of Public Health administers the program.
    1. Eligibility requirements:
        i. Must be a Georgia resident
        ii. Must be a U.S. citizen or legal resident
        iii. Under 65 years old
        iv. Must meet income requirements based on family size
        v. Must have breast or cervical cancer; this may include precancerous conditions of the breast or cervix
        vi. Cannot have health insurance that pays for cancer treatments and cannot be currently receiving Medicaid or Medicare

vi. *Georgia Pathways to Coverage*. Georgia Pathways to Coverage is a program to help low-income Georgians qualify for Medicaid. Consumers can apply if they are working or doing other qualifying activities.
    1. Eligibility requirements:
        i. Must be a Georgia resident
        ii. Must be a U.S. citizen or legal resident
        iii. Must be between ages 19 - 64
        iv. Must have a household income of up to 100% of the FPL
        v. Cannot qualify for any other type of Medicaid
        vi. Cannot be incarcerated
        vii. Must be engaged in employment, on-the-job training, job readiness assistance program, community service, vocational training, the Georgia Vocational Rehabilitation Agency (GVRA), or higher education for at least 80 hours per month
    2. Visit the Pathways website to learn more about qualifying activities.

vii. *PeachCare for Kids® (PCK).* PeachCare for Kids® (PCK) is a comprehensive healthcare program for uninsured children living in Georgia. It provides benefits that include primary and specialist care, preventative care, dental, and vision care. The main difference between Medicaid and PCK is the income level. PCK serves working families whose income is more than that set by the Medicaid program but does not exceed the income limit based on the Federal Poverty Level (FPL). A child that is eligible for the Medicaid program cannot qualify for the PCK program.
    1. Eligibility requirements:
        i. Must be a Georgia resident
        ii. Must be a U.S. citizen or legal resident
        iii. Family's income cannot exceed 247% of the Federal Poverty Level (FPL).
        iv. Must pay a monthly premium ranging from $0 - $70 for coverage of children aged 6 and older
        v. Cannot have any other major medical health insurance (dental and vision are allowed)
    2. **Note**: Children who are members of federally recognized American Indian or Alaskan Native (AI/AN) tribes may be eligible for free coverage. Foster children are exempt from premium payments.

5.5 Aged, Blind and Disabled (ABD) Medicaid

a. ABD Medicaid is available to consumers who are ages 65 or older, legally blind, and/or totally disabled. ABD Medicaid does not use MAGI as a basis of eligibility. To be eligible, consumers must meet the requirements below.
b. Eligibility requirements:
    i. Must be age 65 or older, totally disabled, or blind
    ii. Must be a Georgia resident
    iii. Must be a U.S. citizen of lawfully admitted immigrant
    iv. Must agree to assign all health insurance benefits to DCH
    v. Must apply for and accept all other monetary benefits, payments, or allotments
    vi. Cannot exceed specified income and asset limits
    vii. The MAGI methodology is NOT used for ABD Medicaid. ABD Medicaid requires additional information for eligibility determination
c. Types of ABD Medicaid:
    i. *Institutional Long-Term Care*. Medicaid covers certain inpatient, comprehensive services as institutional benefits. In Medicaid coverage, institutional services refer to specific benefits authorized in the Social Security Act. These are hospital services, Intermediate Care Facilities for People with Intellectual disability (ICF/ID), Nursing Facility (NF), Preadmission Screening & Resident Review (PASRR), Inpatient Psychiatric Services for Individuals Under Age 21, and Services for individuals aged 65 or older in an institution for mental diseases.
        1. ICF/ID includes:
            i. Nursing home, hospice, and hospital stays of 30 days or more
            ii. Community Care Services
            iii. The Mental Retardation Waiver program
            iv. Community Habilitation and Support Services
    ii. *Qualified Medicare Beneficiaries (QMB).* Provides coverage of Part A and Part B premiums and cost-sharing to low-income Medicare beneficiaries. In 2021, over 168,000 Georgians were in the QMB program. QMB coverage pays for a consumer's Medicare premium as well as Medicare coinsurance and deductibles. **Note:** Prescription drugs are not covered.
    iii. *Specified Low-Income Medicare Beneficiaries (SLMB)*. Help consumers save money by covering the monthly premium for Medicare Supplemental Medical Insurance Part B. **Note:** This COA does not offer Medicaid benefits.
    iv. *Adult Medically Needy*. For seniors who have income over Medicaid's income limit, yet also have high medical expenses. Essentially, a senior can qualify for Medicaid by spending "excess" income on their medical expenses. This program has no income maximum. Individuals are allowed to use medical expenses to "spend down" the difference between their income and the Medically Needy Income Level (MNIL). MNIL is calculated on a monthly basis, and only pays for medical bills incurred after the spend-down is met.
    v. *Home and Community Based Services Waiver Programs*. Help people who are elderly or have disabilities live in their home or community instead of an institution such as a nursing home or intermediate care facility for people with intellectual or developmental disabilities.
        1. Each program offers several "core" services:
            i. Service coordination (help with managing care needs and services)
            ii. Personal support (assistance with daily living activities, i.e. bathing, dressing, meals, and housekeeping)
            iii. Home health services (nursing, home health aide, and occupational, physical, and speech therapy)

iv. Emergency response systems
v. Respite care (caregiver relief)

2. For more information on waiver programs visit https://medicaid.georgia.gov/programs/all-programs/waiver-programs.

d. Sometimes, consumers are enrolled in both Medicaid and Medicare. These consumers are often called "Dual Eligibles."

5.6 Reporting Medicaid Fraud

a. Committing insurance fraud in the State of Georgia is a felony offense. If you suspect fraud with Medicaid programs is being committed, contact Georgia's Office of Inspector General (OIG) through one of the following ways:
   i. By phone at 1-866-HELPING (1-866-435-7644)
   ii. By filing a complaint online.
   iii. By mailing information to: Office of the State Inspector General, 2 M.L.K. Jr. Drive SW, 1102 West Tower, Atlanta, Georgia 30334
b. Agents, Navigators, and CACs in Georgia Access may serve consumers who are eligible for Medicaid rather than coverage on the Exchange. They are expected to understand the general requirements of Medicaid and to support consumers with applying for Medicaid if needed.

5.7 Knowledge Check

a. The main difference between Medicaid and PeachCare for Kids® (PCK) is the income level. PCK serves working families whose income is more than that set by the Medicaid program but does not exceed the income limit based on the Federal Poverty Level (FPL). [Fill in the Blank] To qualify for PCK, a family's income cannot exceed ___ of the FPL limit.
   i. 150%
   ii. 247%
   iii. 75%
   iv. 260%

6 Qualified Health Plans (QHPs)

6.1 Qualified Health Plan (QHP) Overview

a. A Qualified Health Plan (QHP) is an individual market plan that is certified to be sold on the Exchange. QHPs must follow state and federal requirements for covering essential health benefits, plan design, and network adequacy.

6.2 Essential Health Benefits (EHBs)

a. Essential Health Benefits (EHBs) are services that health insurance plans must cover under the Affordable Care Act (ACA). These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more. Review the chart below and visit www.healthcare.gov/coverage/what-marketplace-plans-cover/ to learn more about the services health insurance plans are required to cover under ACA.
b. Essential Health Benefits:
   i. Ambulatory patient services
   ii. Pregnancy, maternity, and newborn care
   iii. Hospitalization
   iv. Emergency services
   v. Mental health and substance use disorder services

vi. Rehabilitative and habilitative services and devices
vii. Prescription drugs
viii. Laboratory services
ix. Preventative and wellness services and chronic disease management
x. Pediatric services (including oral and vision care)

c. Additional Benefits:
   i. Birth control coverage
   ii. Breastfeeding coverage

6.3 QHP Metal Levels

a. QHPs are categorized and labeled by metal levels to help consumers compare plans. The four metal levels are: Bronze, Silver, Gold, and Platinum. The four metal levels are based on each plan's Actuarial Value (AV) - that is, the percentage of total average costs for covered benefits that a plan will cover. Metal levels do not reflect the quality or amount of care the plans provide.
   i. Bronze
      1. Medical costs: Insurance company pays 60%, consumer pays 40%
      2. Lowest monthly premium
      3. Highest costs when a consumer needs care
   ii. Silver
      1. Medical costs: Insurance company pays 70%, consumer pays 30%
      2. Moderate monthly premium
      3. Moderate costs when a consumer needs care
      4. **Note**: If a consumer qualifies for Cost-sharing Reductions (CSR), also known as special discounts, they must pick a Silver plan to get the extra savings. If a consumer loses their CSR, they will qualify for a Special Enrollment Period (SEP).
   iii. Gold
      1. Medical costs: Insurance company pays 80%, consumer pays 20%
      2. High monthly premium
      3. Low costs when a consumer needs care
   iv. Platinum
      1. Medical costs: Insurance company pays 90%, consumer pays 10%
      2. Highest monthly premium
      3. Lowest costs when a consumer needs care
b. The percentage a consumer pays for benefits in each metal level is an "average" for a typical population. These percentages do not necessarily reflect the exact amount a consumer will pay for a particular service when using a specific plan.

6.4 QHP Eligibility

a. To be eligible to purchase a QHP through Georgia Access, consumers must meet the following requirements:
   i. Be a U.S. citizen
   ii. Be a U.S. national or lawfully present non-citizen who is reasonably expected to be so for the entire time they plan to have health coverage
   iii. Not be incarcerated (unless pending the disposition of charges)
   iv. Live and plan to stay in Georgia

6.5 How Age Impacts eligibility

a. Age is one of the determining factors for Georgia Access eligibility.

i. *Consumers turning 26 on a family plan*. If a consumer receives health coverage benefits from their parent/caretaker through Georgia Access, their health coverage will discontinue at the end of the year of their 26th birthday. The consumer may enroll in their own health insurance plan during the next Open Enrollment period. If the consumers' parent/caretaker's health insurance coverage was not purchased through Georgia Access and they lose coverage before the end of the year of their 26th birthday, they may enroll in health insurance coverage through a SEP. The SEP begins 60 days before their 26th birthday and lasts 60 days afterward.

ii. *Consumers turning 65*. At age 65, consumers are eligible for Medicare and can cancel their plan on Georgia Access. Individuals who do not report a change to transition to Medicare are picked up by the system batch which runs on the second day of each month and picks up any consumer turning 65 that month. When consumers transition to Medicare, their eligibility will be re-determined. It is important to enroll in Medicare in a timely manner. Consumers will also be evaluated for dual eligibility for Medicaid and Medicare. For more information on Medicare please visit https://www.medicare.gov/basics/get-started-with-medicare.

1. **Note**: Consistent with the longstanding prohibition on the sale of duplicate coverage to Medicare beneficiaries, it is illegal to sell or issue a QHP to a Medicare beneficiary with the knowledge that the QHP duplicates the beneficiary's Medicare benefits. Receipt of Medicare, or other minimum essential coverage, must be reported by the consumer as part of third-party liability requirements. Medicare-eligible consumers should visit https://www.medicare.gov/for more information about the Medicare enrollment process and timeframes.

6.6 Stand-Alone Dental Plans (SADPs)

a. Stand-alone Dental Plans (SADPs) are a type of dental plan offered on the Exchange that only includes insurance coverage for dental benefits. Consumers typically select these plans if dental benefits are not included within their QHP. SADPs are categorized as "low" or "high," depending on the level of coverage the plan provides.

b. *Choosing Plans*. Consumers can choose from a variety of SADPs. They choose a plan through insurance companies who offer dental plans or web brokers who display them or if they are seeking a different dental coverage.

c. *Pediatric Dental*. Consumers with leftover APTC from their QHP premium may apply the remaining APTC amount to the cost of the pediatric dental EHB portion of an SADP premium. For multi-member household applications, leftover APTC may only be applied to the pediatric dental EHB portion of their SADP. **Note**: Consumers who are disenrolled from their QHP during the year will be allowed to keep their SADP. Those consumers' dental plans will not be auto renewed for the next year. This is applicable for PY 2025. SADP display requirements may change for PY 2026 and beyond.

6.7 Catastrophic Plan Coverage

a. Catastrophic plans are high-deductible plans with low premiums that cover Essential Health Benefits (EHBs). Catastrophic plans provide coverage for a minimum of three (3) primary care visits before the deductible is met, preventative services with no cost-sharing, and no other benefits for the Plan Year (PY) until the consumer has incurred cost-sharing expenses in an amount equal to the annual limit.

b. If a consumer buys a Catastrophic plan, they are not eligible to receive financial assistance (such as Advance Premium Tax Credits (APTC) and Cost-Sharing Reductions (CSR). The consumer pays

the total premium. Only consumers under the age of 30 are eligible to purchase a CHP unless they apply for a hardship exemption.

6.8 QHP Enrollment

a. Consumers seeking affordable health coverage may enroll in a QHP via Georgia Access. Consumers may apply for QHPs at any time during the year, but consumers can only enroll in a QHP during OE or during a SEP if they are eligible.
b. *Disenrolling from or canceling a plan*. To disenroll from or cancel a plan, consumers must act before the Coverage Effective Date or select a date to be disenrolled. **Note**: While the consumer can disenroll at any point throughout the year, they are still liable for payments up to the final month of coverage.
c. *Canceling a Plan*. A consumer can cancel their plan up until the Coverage Effective Date. The Coverage End Date will be automatically populated, and the plan will be disabled entirely with **no days of coverage**.
d. *Disenrolling from a plan*. When a consumer disenrolls from a plan, they may select a Coverage End Date for their health plan. Once they're disenrolled, they have **at least one day of coverage**.
e. *Ending coverage for a household vs an individual*. If a consumer ends coverage for everyone in the household, the termination can take effect as soon as the day the plan is cancelled, or the consumer can select the Coverage End Date. If the consumer ends coverage for just some people in the household, in most cases the coverage will end immediately. However, in some cases, coverage will not end immediately, including when the household members who remain enrolled in coverage qualify for a SEP. The best way to make sure coverage ends on the right date is to contact the Georgia Access Contact Center and request the change.

6.9 Periodic Data Matching (PDM)

a. Ending coverage for a household vs an individual Exchanges are required by 45 CFR 155.330(d) to conduct periodic examinations of data sources to check for changes in consumer status - mainly, if a consumer has passed away or become eligible for non-Exchange coverage (e.g., Medicare). Periodic Data Matching (PDM) is conducted at least twice a year and will occur for Georgia Access in March and September. The data sources will be the Georgia Access Eligibility System and the Federal Data Services Hub. If PDM indicates a consumer no longer qualifies for Qualified Health Plans (QHPs) or consumer subsidies, the PDM will generate a notice to applicable consumers. **Note**: Individuals must report the changes in their status.

6.10 Knowledge Check

a. Qualified Health Plans (QHPs) are _____ certified by Georgia Access that meet Affordable Care Act (ACA) requirements. These plans are offered at full premium cost or with financial assistance for eligible consumers.
    i. Medicare plans
    ii. Health coverage plans
    iii. Life insurance policies
    iv. Health Savings Accounts

7 Modified Adjusted Gross Income (MAGI)

7.1 What is Modified Adjusted Gross Income (MAGI)?

a. Established through the Affordable Care Act (ACA), Modified Adjusted Gross Income (MAGI) is a standardized methodology to determine income eligibility for Medicaid and financial assistance on the Exchange. MAGI is Adjusted Gross Income (AGI) plus these, if any: untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest.
b. On Georgia Access, MAGI is used to:
    i. Assess potential eligibility for Family Medicaid, PeachCare for Kids®, and Pathways to Coverage.
    ii. Determine eligibility for Advance Premium Tax Credits (APTC) / Premium Tax Credit (PTC).
    iii. Determine eligibility for Cost-sharing Reductions (CSRs).
c. The MAGI methodology follows a formula that combines a consumer's taxable income with certain non-taxable income then subtracts any applicable deductions.
    i. *Taxable Income*: If an income type is taxable and included on the consumer's federal income tax form, then it counts as part of MAGI. Some examples include:
        1. Wages, salaries, and bonuses
        2. Self-employment income
        3. Tips and gratuities
        4. All Social Security retirement and disability income
    ii. *Certain non-taxable Income*: A few non-taxable income types are also included in MAGI. Most households don't have these other income types:
        1. Non-taxable Social Security benefits
        2. Tax-exempt Interest
        3. Excluded foreign income
    iii. *Deductions*: A consumer might also have expenses that reduce their adjusted gross income and are taken into account in the household income calculation. These are called deductions or adjustments. There are only a few deduction types that can be included on a health insurance application, including:
        1. Alimony paid
        2. Student loan interest
        3. Educator expenses
        4. Charitable contributions up to IRS limit

7.2 Tax Filer and Non-Tax Filer

a. You will assist consumers with different tax filing statuses. Tax filing status is used in determining eligibility; therefore, it is essential that you receive accurate information from consumers regarding their status. Once designated either a Filer or Non-Filer, a household size can be determined for each eligible consumer applying for coverage.
    i. *Tax Filer*. A consumer who intends to file an income tax return for the current benefit year cannot be claimed as a dependent by another consumer.
    ii. *Non-Tax Filer*. A consumer who does not intend to file taxes for the current benefit year.
b. **Note**: All applicable consumers must be included in the household regardless of if they are applying for assistance.

7.3 Knowledge Check

a. True or False: MAGI is used to assess potential eligibility for Medicaid/PeachCare for Kids®.
    i. True

ii. False

8 Exemptions

8.1 Exemptions

a. The Affordable Care Act (ACA) included exemptions to allow certain consumers to avoid the federal health insurance mandate and associated federal tax penalty, or to allow consumers who are not typically eligible to enroll in a Catastrophic health plan. Since the federal tax penalty for the individual mandate was set to $0 in 2019, exemptions are only applicable to consumers who are 30 years of age or older and want to enroll in a Catastrophic health plan. These consumers must meet hardship or affordability requirements to be eligible and apply for an exemption.
b. *Hardship Exemptions*. This exemption is for consumers who have experienced a financial hardship or other qualifying circumstances that prevented them from purchasing health coverage.
    i. Examples of Qualifying Circumstances
        1. Homelessness
        2. Evection/foreclosure
        3. Shut-off notice
        4. Domestic violence
        5. Death of family member
        6. Disaster
        7. Bankruptcy
        8. Medical expenses
        9. Increase in expenses to care for family member (s)
        10. Medical support for child
        11. Eligibility appeals decision
        12. Eligibility for Medicaid due to non-expanded state
        13. Other hardship
c. *Affordability Exemptions*. This exemption is for consumers who lack an affordable health coverage option. There are two circumstances in which affordability exemptions are applicable:
        1. *Exchange Affordability Exemption*: Lowest-price Bronze-level plan available costs more than 8.39% of the consumer's projected household income.
        2. *Job-Based Affordability Exemption*: The annual job-based health insurance premium for an employee in a self-only plan, or an employee's spouse or dependent for a family plan, is more than 8.39% of their annual household income.
d. Georgia Access defers exemption applications and reviews to the Federal Exchange.
e. Exemption Review Process:
    i. *Accessing and filing an exemption*. The Affordability Exemption Request Form and the Hardship Exemption Request Form are available on the HealthCare.gov website.
    ii. *Exemption request form*. The consumer would like to enroll in a Catastrophic health plan but requires an exemption to do so. The consumer must identify whether they are requesting an Affordability Exemption or Hardship Exemption and access the applicable form on the Georgia Access or HealthCare.gov websites. The consumer fills out the form and supplies proof of income or hardship, if applicable. Proof of income or hardship depends on the exemption type. Some hardship requests do not require any proof of hardship.
    iii. *Exemption submission*. The consumer submits the form by mail. The consumer, or certified agent working on their behalf, submits the form by mail to: Health Insurance Marketplace, Attn: Exemption Processing, 465 Industrial Blvd, London, KY 40741

iv. *Exemption decision*. A representative of the Federally-facilitated Exchange (FFE) determines if the consumer is eligible for the exemption. Approved consumers receive an Exemption Certificate Number (ECN), allowing them to enroll in a Catastrophic health plan. Consumers enter the ECN within their Georgia Access application in order to review and enroll in a Catastrophic health plan.
v. *Appealing an exemption decision*. The consumer may file an appeal with the FFE if their exemption is denied. The appeal must be completed and submitted within 90 days of when the notice is generated. If the appeal is approved, the FFE will notify Georgia Access of the decision and corrective actions if needed.

8.2 Knowledge Check

a. Which of the following is not an example of a qualifying circumstance for a hardship exemption?
   i. Bankruptcy
   ii. Fire, flood, or other disaster
   iii. Homelessness
   iv. None of the above

9 Appeals

9.1 Appeals

a. Consumers may file an appeal if they believe a result from Georgia Access regarding eligibility, financial assistance or amount, enrollment, or timing was made in error. Consumers must receive an Eligibility Determination Notice (EDN) to file an appeal. Consumers have 90 days from the receipt of notice to file an appeal. For citizenship and immigration issues, consumers have 95 days from the date of their EDN to file the appeal. To best support consumers, you are expected to review their application and notices prior to filing an appeal. Most appeals can be easily resolved by correcting data issues. If you are assisting a consumer that has missed the appeal deadline, they may be granted a good cause extension.
b. Consumers have the right to file an appeal if they believe an eligibility determination was made in error. They may appeal the following eligibility results:
   i. Not eligible for Advance Premium Tax Credit (APTC) or Cost-sharing Reductions (CSRs)
   ii. Eligible for APTC, but the amount is wrong
   iii. Not eligible for a Special Enrollment Period (SEP)
   iv. Not eligible for a Qualified Health Plan (QHP) or Stand-alone Dental Plan (SADP)
   v. Cancellation or termination of a plan by Georgia Access
   vi. Denial to change the enrollment coverage end date or effective date
   vii. Denial of coverage reinstatement request
   viii. Denial of health insurance hardship or affordability exemption request (e.g., not eligible to choose a Catastrophic plan)
   ix. Eligibility determination due to life change that affects health insurance coverage or savings (e.g., a change in income, household size, or health coverage status)
   x. Eligibility determination and noticing was not timely
   xi. Another Georgia Access eligibility result not listed above

9.2 Filing an Appeal Request

a. Once the consumer receives the EDN and decides to appeal the outcome, they need to access the Appeal Request Form. Consumer can get assistance from certified agents to file the appeal on their behalf or reach out to the Georgia Access contact center for help.
b. *Georgia Access Consumer Appeal Request Form and Information Sheet*. Consumers may access the Georgia Access Consumer Appeal Request Form and Information sheet online at the Georgia Access website and submit it through their account.
c. *Submit online*. Consumers may upload their appeal request form and supporting documentation electronically through the same online platform they used to submit their application (i.e., Georgia Access consumer portal or an EDE partner's portal). Or a certified agent can attach it to their application on their behalf.
d. *Submit through mail*. Consumers can send the request the form and supporting documentation via mail to: **Georgia Access Contact Center, Attn: Consumer Appeal, PO Box 12264, Birmingham, AL 35202**
e. **Note**: If a consumer wants to file an appeal electronically but does not have an online account, they may create an account on Georgia Access and update their application before filing the appeal online.

9.3 The Consumer Appeal Process

a. *Step 1*: Once a consumer files an appeal request, a Georgia Access Contact Center representative will review the appeal and work with the consumer, or their representative, to attempt to resolve the issue through informal resolution. This includes requesting additional information or documentation from the consumer, as needed.
b. *Step 2*: There are four potential outcomes from informal resolution with the Georgia Access Contact Center representative:
    i. The appeal is approved based on policy and the consumer is issued a new EDN
    ii. The appeal is denied based on policy and the consumer is not issued a new EDN
    iii. The appeal is deemed invalid based on policy and is withdrawn.
    iv. The appeal is not resolved, or not resolved timely.
c. *Step 3*: If the Contact Center representative is unable to resolve the issue, or the consumer disagrees with the outcome, the appeal request will be escalated to the Administrative Procedures Division within the Office of Commissioner of Insurance and Safety Fire (OCI). A hearing officer will be assigned, conduct a hearing, and issue a final decision from the State.
d. *Step 4*: If the consumer believes the final appeal decision from the State was made in error based on policy, they may request a Federal hearing from the Federally-facilitated Exchange (FFE).
e. **Note**: Many appeals are resolved by the Contact Center representative.
f. The outcome of the appeal could impact the eligibility of other members of the consumer's household.

9.4 What Consumers Should Know About Appeal

a. *Representation*. Consumers may represent themselves or appoint an authorized representative to assist with their appeal request. The representative may be a friend, relative, attorney, or other designated person. Consumers must submit documentation designating an authorized representative. Consumers may complete this documentation within their Georgia Access Consumer Appeal Request Form (either at the time of application for Georgia Access or by submitting Appendix C of the Georgia Access Consumer Paper Application Form to the Georgia Access Contact Center).

b. *Continuing benefits during the appeals process.* If a consumer has coverage, they should consider staying enrolled and paying their premiums during their appeal. If they drop or lose their coverage, they may have to wait to re-enroll (even if their appeal is successful). If the consumer is receiving a tax credit and is deemed ineligible for financial assistance or the amount is reduced through the appeals process, the consumer will have to pay back any excess PTCs on their federal income taxes. Georgia Access will notify the consumer of their eligibility to keep their coverage and to continue getting financial help during their appeal process.
c. *Requesting an expedited appeal*. Consumers may request an expedited appeal if they think waiting for a standard decision would put their health at risk. For example, if they're currently in the hospital or urgently need medication. Consumers must request an expedited appeal in their Appeals Request Form. Consumers must include the health reason or medical emergency that requires an expedited appeal.
d. *Submitting a late appeal*. If a consumer misses the 90-day deadline to file an appeal and can show good cause as to why they missed the deadline, they may receive an extension. Extension requests are considered on a case-by-case basis.
e. Georgia Access assesses only the potential eligibility for Medicaid and does not process appeals for determinations made for Medicaid or PeachCare for Kids®. Consumers must file appeals for these programs through the Georgia Department of Community Health.

9.5 Assisting Consumers With appeals

a. The vast majority of appeal requests can be easily answered by explaining eligibility requirements to consumers. Confirm that consumers understand their enrollment eligibility and appropriate next steps before filing an appeal. If the consumer would still like assistance appealing a decision, help them fill out the appropriate forms accurately and ensure they submit the required documentation.

9.6 Knowledge Check

a. Kristen was determined to be ineligible for APTC and would like to appeal this decision. After receiving support to understand why she was found ineligible, she completed and submitted an appeal request form. If she can afford it and wants health coverage, should she continue paying her insurance premiums until a decision has been made?
   i. **Yes, she should continue paying her insurance premiums until a decision is made on her appeal.**
   ii. No, she should stop paying her insurance premiums.

10 Health Reimbursement Arrangements (HRAs)

10.1 Health Reimbursement Arrangements (HRAs)

a. A Health Reimbursement Arrangement (HRA) is a type of account that an employer funds so that consumers can reimburse themselves for certain medical, dental, or vision expenses up to a maximum dollar amount for a specified coverage period. There are two types of HRAs used to purchase Qualified Health Plans (QHPs) on the Exchange: Individual Coverage Health Reimbursement Arrangements (ICHRAs) and Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs). HRAs are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. An employer may allow funds that remain in the HRA at the end of the year to be rolled over into the next year. Consumers must enroll in an Affordable Care Act (ACA) qualified individual health plan to be eligible to use an ICHRA or a QSEHRA.

10.2 Understanding ICHRAs & QSEHRAs

a. *ICHRA*: ICHRAs are a form of HRA in which employers provide contributions for an employee to purchase health insurance on the Exchange. ICHRAs are specific account-based health plans that allow employers to provide defined non-taxable reimbursements to employees enrolled in QHPs for qualified medical expenses, including monthly premiums and out-of-pocket costs.
b. *QSEHRA*: QSEHRAs are a form of HRA in which employers with fewer than 50 FTE employees can provide contributions for an employee to purchase health insurance. QSEHRAs are specific account-based health plans that allow employers to provide defined non-taxable reimbursements to employees enrolled in QHPs for qualified medical expenses, including premiums and out-of-pocket costs.

10.3 Difference Between ICHRAs & QSEHRAs

a. What type/size of business can offer the HRA?
    i. *ICHRA*: ICHRAs can be used by large employers (those with 50 FTE employees or more), as long as they have one employee who isn't a self-employed owner or the spouse of a self-employed owner.
    ii. *QSEHRA*: employers with 50 or fewer FTE employees that offer no employer group health plan may offer a QSEHRA.
b. How is affordability determined?
    i. *ICHRA*: The employee's self-only Lowest-cost Silver Plan premium (LCSP)
    ii. *QSEHRA*: The employee's self-only Second-Lowest-cost Silver Plan premium (SLCSP)
c. What employees can participate?
    i. *ICHRA*: All employees, or a particular class enrolled in an Exchange health plan.
    ii. *QSEHRA*: Employees enrolled in Minimum Essential Coverage (MEC) that are not participating in an employer group health plan.
d. Is there a cap on contributions?
    i. *ICHRA*: There are no employer contribution limits for ICHRAs.
    ii. *QSEHRA*: QSEHRA contributions cannot exceed annual maximums set by the IRS. For 2024, the limit was $6,150 for individual employees and $12,450 for employees with families.

10.4 How HRAs Impact Premium Tax Credit (PTC) Eligibility

a. Consumers who receive an ICHRA or a QSEHRA are ineligible for PTCs unless the funding their employer provided in the account is deemed unaffordable for purchasing coverage based on IRS affordability thresholds.
b. Here is how HRAs impact PTC eligibility:
    i. *ICHRAs*: If an ICHRA is deemed unaffordable using Internal Revenue Service (IRS) affordability thresholds, then a consumer may be eligible for PTCs. ICHRAs cannot be combined with PTCs; to claim the tax credit the consumer must opt out of the ICHRA and purchase a marketplace plan with non-ICHRA dollars.
    ii. *QSEHRAs*: If the offered QSEHRA is deemed unaffordable using IRS affordability thresholds, a consumer may be eligible to receive PTCs. The consumer may combine PTCs with their employer QSEHRA contribution, but the tax credit will be reduced by the amount of the employer contribution.
c. An employee can use funding in their ICHRA or QSEHRA to pay premiums and reimburse medical care expenses for themselves, as well as any covered dependents if permitted by the employer. To use an ICHRA/QSEHRA, an employee and any covered dependents must be enrolled in Minimum Essential Coverage (MEC).

10.5 How HRAs Impact SEPs

a. Consumers and their dependents who newly gain access to an ICHRA or who are newly provided a QSEHRA may qualify for a SEP to enroll in individual health coverage through Georgia Access. The triggering event is the first day on which coverage for the qualified consumer, enrollee, or dependent under the ICHRA can take effect, or the first day on which coverage under the QSEHRA takes effect.

10.6 Knowledge Check

a. A Health Reimbursement Arrangement (HRA) is a group health plan funded solely by:
   i. An employee's Health Savings Account
   ii. An employer's contributions
   iii. An employee's retirement fund
   iv. An employee's tax return

11 Fraud, Waste, & Abuse

11.1 Fraud, Waste, & Abuse Overview

a. *What is fraud?* Fraud is an act committed by any person who knowingly mistakes or misrepresents information to intentionally deceive an individual, organization, or system for gain or knowingly provides false information to profit or gain access to an unauthorized service or payment. Examples include illegal incentives used to market health insurance and enrolling consumers without their consent.
b. *What is waste?* Waste is the unnecessary spending or careless use of resources, whether intentional or unintentional, that result in unnecessary costs to the Exchange. Examples include duplication of services and excessively paying vendors for services or supplies.
c. *What is abuse?* Abuse is the intentional destruction, manipulation, mistreatment, or misuse of resources or the excessive use of a person's position or authority. Examples include billing for unnecessary services and excessively charging consumers.

11.2 Health Insurance Fraud

a. Committing insurance fraud in the State of Georgia is a felony offense. Common examples of fraud related to the Exchange are misrepresenting facts or providing false information to receive coverage or monetary benefits, using illegal incentives in health insurance marketing, lying about the details of a health insurance plan, or enrolling consumers in a plan without their consent.

11.3 Georgia Access Fraud, Waste, & Abuse Policy

a. Georgia Access prohibits fraud, waste, and abuse within its internal operations and among its external partners. The Exchange has processes in place to deter, prevent, identify, investigate, and resolve cases of fraud, waste, and abuse. In confirmed instances of fraud, waste, and abuse, Georgia Access coordinates across Office of Commissioner of Insurance and Safety Fire (OCI) divisions and state agencies to take action to correct the violation and prevent reoccurrence. Georgia Access conducts its operations in compliance with internal policies and procedures and all applicable provisions of federal and state laws and regulations regarding the detection and prevention of fraud, waste, and abuse.

11.4 Health Insurance Fraud Warning Signs

a. Consumers, agents, web brokers, insurance companies, and assisters can all commit fraud. It is important to be aware of the following warning signs:
   i. An agent uses intense sales pressure tactics, such as urging a consumer to buy a policy immediately, otherwise the price may change.
   ii. The premiums from one company are more than 15-20% lower than other companies' comparable coverage.
   iii. A company's contact information is not readily available or is difficult to track down.
   iv. An agent who has an excessively high number of enrollments.
b. Fraud can be intentional and unintentional. It is imperative to be diligent in ensuring fraud is not accidentally committed.

11.5 Reporting Suspected Fraud, Waste, & Abuse

a. All Georgia Access stakeholders, including agents, and assisters, must report suspected fraud, waste, and abuse related to Georgia Access through reporting mechanisms put in place by the Exchange, regardless of the individual or organization suspected of committing such wrongful actions. If you suspect or experience insurance fraud, waste, or abuse, you can report the incident through OCI's Criminal Investigation Division online portal. For more information on how to report suspected insurance fraud to CID, visit the OCI website. If you suspect fraud, waste, or abuse within Georgia Access, as part of the State of Georgia Executive Branch, you can report the incident through the State of Georgia Office of the Inspector General (OIG). For more information on how to report fraud, waste, or abuse within the Executive Branch of state government, visit the OIG website. Georgia Access takes steps necessary to correct violations of the Georgia Access Fraud, Waste, & Abuse policy and to prevent reoccurrence. Corrective action will reflect the severity of the violation and may range from a verbal warning up to and including termination from participating in the Exchange or other administrative action.

11.6 Knowledge Check

a. Which of the following groups can commit fraud, waste, & abuse?
   i. Consumers
   ii. Agents
   iii. Insurance companies and web brokers
   iv. All of the above

12 Additional Information & Resources

12.1 Additional Resources

a. Georgia Access Website
b. Georgia Department of Community Health Programs
c. Georgia Medicaid Website