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GEORGIA ACCESS

Consumer Eligibility, Enrollment, and Support Policies for PY 2027

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Change Log

Date	Modified By	Sections	Program Change Description
10/01/2024	Georgia Access	All	Initial publication.
10/29/2024	Georgia Access	2.2.1.1	Clarified how consumers can determine whether they qualify for financial assistance.
11/14/2024	Georgia Access	2.1.2	Updated the list of requirements to be considered lawfully present status.
2/27/2025	Georgia Access	2.3.1.1	Removed U.S. Birth Certificate from items sufficient to prove citizenship alone and clarified which forms of documentation can prove citizenship alone.
7/14/2025	Georgia Access	2.3.1.1	Added, “state issued Real ID”, to the items sufficient to prove citizenship.
04/01/2026	Georgia Access	2.4.10.1	Updated retroactive disenrollment section to include UE/UPS and added 2026 Affordability Percentage
09/30/2026	Georgia Access	2.1.2, 2.2.4, 2.4.1	• Updated Open Enrollment Dates • Updated HHS poverty guidelines for 2027 • Updated definition of lawfully present for individuals who are eligible for APTCs and full cost QHPs

1 Overview

1.1 Purpose

This document outlines the policies related to consumer eligibility, enrollment, and support for Georgia's State-based Exchange (SBE), Georgia Access. This document is updated at least annually.

1.2 Background

Georgia Access is a division within the Office of Commissioner of Insurance and Safety Fire (OCI). The Georgia Access Division is responsible for operating and managing the State's SBE. Georgia Access operated as a State-based Exchange on the Federal Platform (SBE-FP) for Plan Year (PY) 2024 and transitioned to a full State-based Exchange in PY2025. Consumers can shop for and enroll in coverage through Georgia Access (GeorgiaAccess.gov). Consumers can also work with a web broker, insurance company, or certified agent to shop for and enroll in coverage.

1.3 Key Terms

Advanced Premium Tax Credit (APTC): An advance of the Premium Tax Credit (PTC) paid to an insurance company to reduce the cost of monthly premiums for eligible individuals buying Qualified Health Plans (QHPs). The APTC amount is based on the consumer's household size and estimated income.

Affordability Exemption: An exemption to allow a consumer aged 30 and over to enroll in Catastrophic coverage based on lack of affordable health coverage, either offered through an employer or through a healthcare Exchange (such as Georgia Access). Coverage is considered unaffordable if costs are more than the affordability threshold related to projected household income, published annually by the Internal Revenue Service (IRS).

Affordable Care Act (ACA): The comprehensive federal health care reform law enacted to provide access to affordable coverage through access to financial subsidies and Health Insurance Marketplaces in each state.

Appeal Request: A petition by a Georgia Access applicant, enrollee, employer, or small business employer to have any eligibility determination or redetermination reviewed by Georgia Access or the Centers for Medicare & Medicaid Services (CMS). Georgia Access applicants typically have 90 days to file an appeal against their associated Georgia Access eligibility determination or redetermination.

Binder Payment: The first month's premium payment a consumer makes to an insurance company to effectuate the health plan they selected. The binder payment covers the cost of the consumer's first month's premium and is due based on the insurance company's binder payment policy (due no sooner than the first day of coverage and no later than 30 days after the first day of coverage). If a consumer does not make the payment by the deadline, their policy will not take effect, and they will not be enrolled in coverage.

Catastrophic Health Plans: A certified plan offered through Georgia Access that covers Essential Health Benefits (EHBs) and requires the highest level of cost sharing allowable for EHBs. Only consumers under the age of 30 can purchase a Catastrophic health plan; consumers 30 or older must have an approved hardship or affordability exemption to purchase a Catastrophic health plan if over the age of 30. Catastrophic health plans tend to have low monthly premiums but high deductibles.

Certified Georgia Access Agents ("certified agents" or "agents"): Individuals licensed to sell health insurance products in Georgia who are certified by Georgia Access. Certified agents assist consumers with the consumer application and enrollment processes. Certified Agents are appointed by Georgia Access

companies to sell health insurance plans and are compensated via commission.

Certified Georgia Access Enrollment Partners: Private sector entities or individuals that have been certified to participate in Georgia Access. They enable consumers to shop for and enroll in a health insurance coverage and financial assistance programs. These partners include web brokers, insurance companies, and Certified Agents.

Data Matching Issue (DMI): A discrepancy between a consumer's reported information on their QHP consumer application and the information verified through other electronic data sources.

Essential Health Benefits (EHBs): Services that health insurance plans must cover under the ACA. All insurance plans certified by Georgia Access are required by federal law to include EHBs. These include ambulatory patient services; emergency services; hospitalization; pregnancy, maternity, and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventative and wellness services including chronic disease management; pediatric services, including dental and vision care; birth control coverage; and breastfeeding coverage.

Georgia Access Contact Center: The contact center that provides extensive support to consumers, Georgia Access Enhanced Direct Enrollment (EDE) Partners, insurance companies, and certified agents.

Georgia Access Enhanced Direct Enrollment (EDE) Partner: An organization that is certified to provide a technology platform for consumers to shop for and enroll in QHPs and Stand-alone Dental Plans (SADPs). These partners include technology providers, web brokers, and insurance companies. All Georgia Access EDE partners must hold an FFE EDE certification.

Georgia Access Insurance Companies: Also known as “issuers” or “carriers”, insurance companies are licensed by OCI to engage in the business of selling, soliciting, or negotiating insurance in Georgia. They are responsible for plan management activities and back-end enrollment and reconciliation activities. Insurance companies may also be certified as EDE partners. For Small Business Health Options Program (SHOP), insurance companies offer SHOP plans, process SHOP applications, and enroll employers in SHOP plans.

Georgia Access Certified Application Counselors (CACs): Personnel affiliated with a Certified Application Counselor Designated Organization (CDO) (either employees or volunteers) who are licensed by the State and certified by Georgia Access to help consumers apply for and understand their health coverage options, but who cannot advise on which QHP to select. CACs are required to provide consumers with fair, accurate, and impartial information about health coverage options and available financial assistance.

Georgia Access Certified Navigators: Individuals affiliated with a Navigator Grantee Organization either as an employee or volunteer, who are licensed by the State and certified by Georgia Access to help consumers apply and understand their health coverage options, but who cannot advise on which QHP to select. Navigators are required to provide consumers with fair, accurate, and impartial information about health coverage options and available financial assistance. Navigators also provide outreach and education to underserved and vulnerable populations.

Georgia Access Consumer Portal: The state-run online portal that allows consumers to apply for, shop for, and enroll in coverage through Georgia Access. The Georgia Access Portal is one of the enrollment options available to consumers in Georgia.

Georgia Access Small Business Health Options Program (SHOP): Georgia Access SHOP assists qualified employers in providing health insurance coverage to their employees. Georgia Access reviews and certifies small group plans as QHPs or SADPs, which Georgia Access insurance companies offer to qualified employers as Georgia Access SHOP plans. Employers work directly with insurance companies or agents to enroll in SHOP plans. Qualified employers may be eligible for the Small Business Health Care Tax Credit if they offer a SHOP plan to their employees.

Georgia Access Website: A publicly available website (GeorgiaAccess.gov) providing information on Georgia Access programs and services, how to access health care coverage, and how to get assistance with applying for coverage.

Hardship Exemption: A type of exemption that consumers aged 30 years old and over can apply for if they have experienced a financial hardship or other event that prevented them from getting health coverage. An approved hardship exemption allows a consumer the opportunity to enroll in a Catastrophic health plan.

Metal Tier: Levels used to indicate how much medical cost a health insurance plan will cover. Health insurance plans are divided into four tiers named after metals: bronze, silver, gold, and platinum. These levels differ based on how the cost of health care services are split between consumer and insurer. Bronze level plans have the lowest monthly premium but highest costs for care while platinum plans have the highest monthly premiums but lowest costs for care.

Minimum Essential Coverage (MEC): Also known as "qualifying health coverage," MEC is any type of insurance plan that meets the ACA requirement for having health coverage. Consumers must be enrolled in a plan that qualifies as MEC. Examples of plans that qualify include Marketplace plans, job-based plans, Medicare, Medicaid, and PeachCare for Kids®.

Open Enrollment (OE): The annual period when consumers may enroll in an individual health insurance plan for the upcoming plan year. Generally, this will begin November 1 through January 15 of each year.

Periodic Data Matching (PDM): Periodic examination of data sources to identify consumers enrolled in Exchange plans with financial subsidies while eligible or enrolled in Medicare Part A or Part C, Medicaid/PeachCare for Kids® PDM is conducted to avoid duplication of benefits.

Plan Year (PY): The 12-month period of benefit coverage under a health plan. For Georgia Access, a Plan Year begins January 1st of each year and runs through December 31st of the same year.

Premium Tax Credit (PTC): A refundable tax credit that helps eligible individuals and family members cover the premiums for your health insurance purchased through Georgia Access. A PTC can be accepted as a one-time credit upon tax filing or spread throughout the year if taken upfront as an APTC and paid directly to your health insurance company to lower your monthly premium. The PTC amount is based on the income estimate and household information an individual puts in their Exchange application.

Qualified Health Plan (QHP): An insurance plan that is certified by Georgia Access, provides EHBs, follows established limits on cost sharing, and meets other requirements outlined by the Exchange.

Qualifying Life Event (QLE): A change in a consumer's situation, such as getting married, having a baby, or losing health coverage, that can make a consumer eligible for a Special Enrollment Period (SEP), allowing a consumer to enroll in health insurance outside the yearly Open Enrollment Period.

Reasonable Opportunity Period (ROP): The period for a consumer to provide proof of attested information for verification by Georgia Access. If a consumer fails to provide adequate proof of attestation within the ROP, any QHP enrollment or associated federal subsidies such as APTC and/or Cost-sharing Reduction (CSR) may be automatically revoked by the Exchange. The length of an ROP for a DMI generated due to a consumer submitted application is 90 days and 30 days if the DMI was generated due to automated program integrity functions such as PDM.

Special Enrollment Period (SEP): A time outside of OE when consumers can sign up for health insurance if they experience a QLE. Consumers can qualify for an SEP if they've experienced certain life events such as moving, getting married, having a child, or losing job-based coverage.

Special Enrollment Period Verification Issue (SVI): A check performed to confirm a consumer has experienced a QLE when applying for an SEP outside of OE.

Stand-alone Dental Plan (SADP): A type of dental plan offered on-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 available for consumers to buy without being enrolled in a QHP, except when enrolling through an EDE partner.

2 Consumer Eligibility Policies

2.1 Eligibility Overview

Georgia Access must determine a consumer's eligibility for Marketplace coverage before a consumer may enroll in a health plan offered through Georgia Access. Eligibility-related policies determine how the Exchange assesses and determines consumer eligibility.

2.1.1 Qualified Health Plan (QHP) Eligibility

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.305

To be eligible to enroll in a QHP in Georgia Access, a consumer must be able to attest to and verify the following criteria. These standards apply whether financial assistance is provided or not.

- The consumer is a U.S. citizen, national, or a non-citizen deemed lawfully present within the United States.
- The consumer is not incarcerated, other than incarceration pending the disposition of charges.
- The consumer is a resident of the State of Georgia.

2.1.2 Lawfully Present Criteria

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.300; 45 CFR 155.305; 26 CFR 1.36-B (2); 45 CFR 152.2

Effective PY 2027, Georgia Access will implement changes finalized under Section 71301 of the One Big Beautiful Bill Act (OBBBA), which is part of the Budget Reconciliation legislation, H.R.1. It amends Section 36B of the Internal Revenue Code to restrict who can receive Premium Tax Credits. Only the following groups are considered lawfully present for Premium Tax Credit (PTC) eligibility:

- Lawful Permanent Resident (LPR) (without having met the 5-year bar)
- Cuban/Haitian entrant
- Compact of Free Association (COFA) Migrants (Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau)

Consumers with the following statuses, and meet one or more of the following requirements are considered lawfully present and may enroll in a Qualified Health Plan (QHP) through Georgia Access. However, they are required to pay full cost, without financial assistance such as PTC (Premium Tax Credit) or Cost Share Reduction (CSR):

- Paroled into the U.S.
- Conditional entrant (granted before 1980)
- Battered spouse, child, or parent
- Victim of trafficking and their spouse, children, siblings, or parents
- Granted withholding of deportation or withholding of removal (under immigration laws or under Convention Against Torture (CAT))
- Temporary Protected Status (TPS)
- Individual who is seeking, or has been granted, political asylum
- Refugee
- Lawful Temporary Resident
- Individual with non-immigrant status (includes worker visas, student visas)
- Administrative order staying removal issued by the Department of Homeland Security
- Member of federally recognized Indian tribe or American Indian born in Canada
- Resident of American Samoa
- Deferred Enforced Departure
- Deferred action status
- Noncitizen who has been granted work authorization
- Beneficiary of the Family Unity Program under the LIFE Act Amendments of 2000
- Child with approved petition for Special Immigrant Juveniles (SIJ) status
- Adjustment to, not including removal of, LPR status
- TPS with employment authorization
- SIJ status
- Victim of trafficking visa
- Asylum (see NOTE below)
- Withholding of deportation or withholding removal (under immigration laws or under CAT)
- Child under 14 who has a pending application for asylum, withholding of removal, or relief under the Convention Against Torture, no longer subject to a 180-day waiting period

NOTE: Applicants for asylum are eligible for Georgia Access coverage only if they've been granted employment authorization or are under the age of 14 and have an asylum application pending.

A consumer is also considered lawfully present if they have employment authorization along with one of the following:

- Registry applicants
- Order of supervision
- Applicant for cancellation of removal or suspension of deportation
- Applicant for legalization under Immigration Reform and Control Act
- Legalization under the Legal Immigration Family Equity Act

2.1.3 Residency Status

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.305(A)

All Georgia Access applicants must prove residency by providing a physical address on their application.

Consumers who lack a physical address may complete their application using the address of their local shelter, social service office, friend, or family member's home, etc. as to fulfill the application's address requirement. Consumers may attest by phone, by calling the Georgia Access contact center (or their

Certified Georgia Access Enrollment Partner) and verbally attesting that they reside in Georgia, but do not have a physical address.

2.1.4 Stand-alone Dental Plan (SADP) Eligibility

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.305

To be eligible to shop for and enroll in a SADP on Georgia Access, a consumer must meet QHP eligibility criteria.

The documents needed for SADP eligibility verification are the same as those needed for QHP verification and can be found in *Section 2.3 Data Verification*.

2.1.4.1 Pediatric Dental Age Limits

Anyone 18 years of age or under is eligible for enrollment in a pediatric dental plan.

2.1.4.2 Open Enrollment (OE)

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.410

The OE and SEP dates for enrolling in an SADP are the same as QHP dates.

2.1.4.3 Premiums

Georgia Access calculates the household dental premium by adding the premiums of adult members of the household and the premiums of the three oldest children together. Household members are considered adults after turning 19 years old and may be included as a dependent in the household until the age of 26 years old.

2.1.4.4 Pediatric Dental Plans

Households with dependents are not required to purchase QHPs with embedded pediatric dental or child-only SADPs.

2.1.4.5 Disenrollment

Consumers can terminate QHP coverage without terminating dental coverage, they will be disenrolled from their dental coverage at re-enrollment if they are no longer eligible for QHP.

For dependents under the age of 26:

- Consumers enrolled in a dental policy that offers only pediatric benefits are automatically disenrolled at the end of the year in which they turn 19.
- Consumers enrolled as dependents on a dental policy that includes adult coverage are automatically disenrolled at the end of the year in which they turn age 26.

2.1.4.6 Dental Advanced Premium Tax Credit

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.1030; 45 CFR 155.340; 26 CFR 1.36B-3(E)

APTC may only be applied to pediatric SADP premiums after being applied to QHP premiums. Tax credits cannot be applied toward SADP premiums for consumers over the age of 19. For households of two or more enrolled in a QHP and SADP, tax credits applied towards SADP premiums will not be taken away if one member of the household is terminated from the QHP.

2.1.4.7 SADP Offerings

Not all certified Georgia Access enrollment partners offer SADPs within their platforms. If a consumer is affiliated with an EDE partner that does not offer SADPs, but the consumer wants to enroll in an SADP, they may enroll separately with a certified agent, the consumer portal, or a second EDE partner that offers SADPs.

2.2 Financial Assistance

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.305 (F)(G); 45 CFR 155.335

Consumers who are eligible to shop for QHPs and SADPs through Georgia Access can apply for financial assistance to help pay for health insurance coverage. Financial assistance comes in two forms—PTC and Cost Sharing Reductions (CSRs). Consumers who qualify may choose to take the PTC at the time of tax filing or over the course of the year through Advanced Premium Tax Credits (APTC).

2.2.1 Advanced Premium Tax Credit (APTC)

To be eligible for an APTC consumers must meet the following requirements:

- Be in compliance with QHP Eligibility criteria.
- Be a household with modified adjusted gross income (MAGI) between 100% and 400% of the Federal Poverty Level (FPL).
- Be a tax filer who is married and filing jointly OR single and filing single.
- Not be eligible for affordable employer-sponsored coverage that provides Minimum Essential Coverage (MEC).
- Not be eligible for government-issued MEC including those listed in *Section 2.2.1.3 Minimum Essential Coverage Criteria*.

2.2.1.1 Income Eligibility Limits Criteria

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.320(C)

Consumers' MAGI must be at least 100% and no more than 400% of the FPL to be eligible to receive a tax credit inclusive of the 5% MAGI disregard, as designated by the IRS. A household can determine their APTC eligibility by completing the Georgia Access consumer QHP application. See *Section 2.2.1 Advanced Premium Tax Credit (APTC)* for the impacts of the ARP and the IRA on PTC eligibility.

2.2.1.2 Tax Filing Requirements Criteria

ASSOCIATED FEDERAL REGULATION: 45 CFR 155. 320 (C)(B); 45 CFR 155.335

To receive a tax credit (APTC/PTC), a consumer is expected to reconcile their taxes each year.

Consumers may file as "single" and be unmarried or divorced. Otherwise, they must file as "married filing jointly" if they are living with or apart from their spouse and they are filing taxes together (with their spouse).

2.2.1.3 Minimum Essential Coverage Criteria

ASSOCIATED FEDERAL REGULATION: 26 CFR 1.5000A-2

MEC describes health insurance coverage that meets requirements under the Affordable Care Act. The following plans are considered MEC[2], except as set forth in *Section 2.2.1.4 Exceptions to Eligibility Criteria*:

- Employer-sponsored coverage, including self-insured plans, Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage, and retiree coverage

[1] *See Federal Poverty Level (FPL) - Glossary | HealthCare.gov for more information.*

[2] *See Minimum Essential Coverage (MEC) | CMS.gov for more information.*

- Coverage purchased in the individual market, including a QHP offered by Georgia Access, health insurance offered by certain student health plans, and Catastrophic health coverage
- Coverage under government-sponsored programs including Medicare Part A coverage and Medicare Advantage plans
- Most Medicaid coverage[3]
- PeachCare for Kids® (Child Health Insurance Program) coverage
- Certain types of veterans' health coverage administered by the Veterans Administration
- TRICARE
- Coverage provided to Peace Corps volunteers
- Coverage under the Non-appropriated Fund Health Benefit Program
- Refugee Medical Assistance supported by the Administration for Children and Families
- Coverage through a Basic Health Program standard health plan
- Coverage under an expatriate health plan
- Self-funded health coverage offered to students by universities for plan or policy years that begin on or before December 31, 2014 (for later plan or policy years, sponsors of these programs may apply to U.S. Department of Health and Human Services (HHS) to be recognized as MEC)
- State high risk pools for plan or policy years that begin on or before December 31, 2014 (for later plan or policy years, sponsors of these programs may apply to HHS to be recognized as MEC)
- Other coverage recognized by the Secretary of HHS as MEC

2.2.1.4 Exceptions to Eligibility Criteria

Georgia Access allows two exceptions to the previously outlined eligibility criteria in *Section 2.2.1.3 Minimum Essential Coverage Criteria*:

- A consumer may qualify for a special rule that allows certain victims of domestic abuse and spousal abandonment to claim PTC using the Married Filing Separately filing status when they file their federal income tax returns. These consumers should attest they are single when filling out an application.
    - If a consumer is legally married but lives separately from their spouse for at least six months of the year of coverage, and for more than half of that year, lives with a tax dependent in a home that the consumer pays more than half of the cost of, the consumer may be eligible to file as "Head of Household" and won't have to file Married Filing Separately for the purposes of eligibility for APTC and PTC.
- If a consumer is a lawfully present immigrant and is determined ineligible for Medicaid due to immigration status, they may be eligible for Georgia Access coverage with financial assistance, even though their household income may be below 100% of the FPL.

2.2.2 Cost Sharing Reductions (CSRs)

To be eligible for CSRs that reduce the out-of-pocket expenses (co-pays, co-insurance, and deductibles), a consumer must:

- Meet the same requirements as listed above for PTC

[3] *Certain Medicaid policies are not considered MEC. These include Medicaid providing only family planning services or coverage limited to treatment of emergency medical conditions and medically needy spend-down coverage.*

- Purchase a silver[4] QHP through Georgia Access
- Have a household MAGI less than or equal to 250% FPL

2.2.2.1 Cost Sharing Reductions for American Indian/Alaska Natives

Additional CSRs are available to consumers who are American Indian/Alaska Native (AI/AN) as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d)). AI/AN consumers enrolled in a QHP through Georgia Access are not responsible for any cost sharing requirement(s) for an item or service furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contracted health services.

If an AI/AN consumer would prefer to enroll in a Georgia Access plan, the CSRs available to them include zero cost sharing plans and limited cost sharing plans.

- **Zero cost sharing plan:** AI/AN consumers eligible for a QHP with a tax credit through the IRS, with a household MAGI up to 300% FPL, can choose a "zero cost sharing plan." This means the consumer does not have any out-of-pocket costs – like deductibles, co-pays, or coinsurance – when accessing and receiving care. With a zero-cost sharing plan, the consumer does not need a referral from an Indian Health Service provider.
- **Limited cost sharing plan:** AI/AN consumers eligible for a QHP with a tax credit through the IRS, with a household MAGI below 100% FPL or above 300% FPL, can choose a "limited cost sharing plan." This means the consumer does not have any out-of-pocket costs—like deductibles, co-pays, or coinsurance—when accessing and receiving care from a non-Indian Health Service provider, provided the consumer has a referral from an Indian Health Service provider. Consumers utilizing a limited cost sharing plan may not qualify for APTCs due to their household MAGI level.

Both zero and limited cost sharing plans are free from metal tier restrictions, meaning AI/AN consumers may choose any metal tier plan from bronze to platinum.[5]

2.2.3 Eligibility Verification Standards for Financial Assistance

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.320 (C)

Georgia Access uses electronic interfaces to verify a consumer's self-attestation of income. If the data returned is not reasonably compatible with information provided in the application, further documentation is required from the consumer to verify income. The reasonably compatible range for Georgia Access aligns with federal standards and is defined as either a discrepancy greater than 50% in the consumer's underreported income, or greater than $12,000 of the consumer's underreported income. Further documentation is required from the consumer to verify income if the two values provided are not reasonably compatible.

2.2.4 Determining Tax Credit Amount

ASSOCIATED FEDERAL REGULATION: 26 CFR 1.36 B-1

Georgia Access aligns with federal standards to determine tax credit (APTC/PTC) amounts. Georgia Access uses the following factors to determine tax credit amounts:

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[4] Silver refers to the Metal Tiers which are levels indicating how much medical cost a health insurance plan will cover. The different metal tiers are bronze, silver, gold, and platinum. Bronze tier plans have the lowest monthly premium but highest costs for care while platinum plans have the highest monthly premiums but lowest costs for care.

[5] See CMS Zero to Limited Cost Sharing Fact Sheet for more information.

- Household's projected income (anticipated MAGI)
- Household size

Household size and projected income as a percentage of the FPL are factors in determining tax credit amounts. The HHS poverty guidelines for 2026[7] can be found in the table below.

Persons in Family/Household	Poverty Guideline
1	$15,960
2	$21,640
3	$27,320
4	$33,000
5	$38,680
6	$44,360
7	$50,040
8	$55,720

2.2.4.1 Calculating Income

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.320 (c)(ii); 45 CFR 155.320 (e)(ii)(iii)

Eligibility to receive financial assistance is based on household income. The consumer first reports their projected household income for the upcoming year. Georgia Access then validates the reported number against the previous year's tax record for accuracy and tax credit purposes. Tax credits are calculated on taxable income using the following types of income:

- Wages/salaries
- Social Security retirement and Social Security disability

[7] *See Poverty Guidelines | aspe.hhs.gov for more information.*

- Unemployment
- Self-employment
- Tips and gratuities
- Compensation for personal services
- Farm income
- Net rental/royalty income
- Retirement accounts
- Capital gains and investment income
- Excluded (untaxed) foreign income

Non-taxable income is not factored into financial assistance calculations. Non-taxable income includes the following:

- Supplemental Security Income (SSI)
- Child support
- Workers' compensation
- Temporary Assistance for Needy Families (TANF)
- Veteran's benefits
- Federal income tax refunds
- Insurance proceeds (accident, health, and life)

2.2.4.2 Calculating Age for Household Members

Georgia Access uses the age of each household member that is included in the application as of the date of the Georgia Access application submission. If application changes are reported that cause a change in financial assistance mid-year—such as a household member turning 26 or aging into Medicare—financial assistance will be recalculated at the time the change is reported. A consumer and their dependent(s) must report any changes that impact eligibility for coverage and/or financial assistance within 30 days of the event.

2.2.4.3 Household Composition

Georgia Access allows the following household relationships to be considered as part of financial assistance calculations:

- Spouse
- Child
- Adopted child
- Stepson/stepdaughter
- Ward
- Anyone who is in the consumer's legal custody

2.2.4.4 Household Financial Calculations

Plan selection does not impact financial assistance calculations; household members may enroll in different plans and still receive financial assistance.

2.2.4.5 24-Year-Old Dependents and APTC Eligibility

Georgia Access has specific policies that pertain to individuals in their mid-twenties and tax credit qualification criteria due to the "Qualified Child" tax status.

Under 24-Years-Old and Tax Dependent: When a household has a child below the age of 24, that child can be claimed as a "Qualified Child" on a federal tax form.

24-Year-Olds and Over and Tax Dependent: In APTC households, as soon as the child turns 24, their dependent status automatically drops at the end of their birthday month. When a child turns 24, that child can no longer be claimed as a "Qualified Child" on a tax form, so they are no longer eligible for APTC under a parent's application; however, the child will remain covered on the plan until the age of 26 and the consumer is responsible for the full unsubsidized premium.

Options for 24-Year-Olds and Over who are Tax Dependents: If the parents/guardians do want to claim the 24-year-old as a child, the child may be claimed as a "Qualified Dependent," assuming other IRS-defined qualification criteria are met. If a consumer believes their child is a "Qualified Dependent," they should contact the Georgia Access contact center to let them know that the child should be added back into the tax filing household. The full household will have their eligibility redetermined by Georgia Access to confirm the updated APTC amount.

If the parents/guardians do not want to claim the 24-year-old as a Qualified Dependent, or the child is not eligible to be claimed as a Qualified Dependent, they have two options:

- The parents/guardians can keep the non-tax-qualified child on their plan until age 26, since insurance rules state that the 24-year-old may still be kept on the plan until they turn 26 years old. However, the 24-year-old's APTC is automatically discontinued.
  OR
- The parents/guardians can keep the plan they have for the rest of the household (with APTC) but exclude the 24-year-old. If the 24-year-old would like to apply for coverage and financial assistance on their own, they would need to reapply through Georgia Access separately. The 24-year-old's loss of coverage would qualify them for a Special Enrollment Period (SEP). See *Section 2.7 Special Enrollment Periods*.

2.2.5 Additional APTC Eligibility Scenarios and Associated Guidance

2.2.5.1 Employer-Sponsored Coverage and APTC

ASSOCIATED FEDERAL REGULATION: 26 CFR 1.36 (B- 2)(C)(3); 26 CFR 1.36 (B-1)(E)(2); 26 CFR 1.36(B)(3); 26 CFR 601.105; 36 CFR 1.36B-2(C)(3)(V)(C); 45 CFR 155.320(B); 36B(C)(2)(C)(I)(II)

Employees (as well as their spouse and dependents) who are offered employer-sponsored coverage that is affordable and provides minimum value are not eligible for a premium tax credit. If a consumer thinks their employer-sponsored coverage does not meet the MEC threshold, the minimum value standard, or the affordability requirements, they may apply for financial assistance to have their APTC eligibility reviewed.

A plan is considered "affordable" for an employee if the plan's self-only premiums does not exceed the Affordability Percentage determined annually by the IRS. If a consumer has an offer of employer-sponsored coverage that extends to their household members as well, the affordability of employer-sponsored coverage for those household members will be based on the household premium amount, not the self-only employee premium[9].

2.2.5.2 Retirement Coverage and APTC

ASSOCIATED FEDERAL REGULATION: 26 CFR 1.36 B-2(C)(3)(V); 45 CFR 156.145

[9] *See RP-2022-34 | irs.gov for more information.*

If someone is enrolled in retirement health insurance coverage, they can only apply for a PTC and purchase coverage through Georgia Access if their current coverage does not meet the MEC threshold and it is during OE. If retirement coverage ends outside of OE and they choose not to re-enroll, they would be eligible for coverage in Georgia Access through a SEP.

2.2.5.3 Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and APTC

ASSOCIATED FEDERAL REGULATION: 26 CFR 1.36 B-2(C); 45 CFR 155.420 (B)

Consumers who are offered COBRA coverage can choose to apply for a QHP and APTC through Georgia Access, instead of enrolling in COBRA. If a consumer is enrolled in COBRA coverage, they must wait until that coverage expires, until employer contribution to the COBRA enrollment ceases, or until OE before applying for health coverage through Georgia Access. A consumer is not eligible to receive APTC until their COBRA coverage expires, the employer stops contributing to COBRA, and/or OE allows them to voluntarily leave their COBRA policy and begin a new policy on Georgia Access. If COBRA coverage ends or expires, or the employer stops contributing to COBRA outside of OE, a consumer could apply for Georgia Access coverage through the Loss of MEC SEP.

2.2.5.4 Medicare and APTC

ASSOCIATED FEDERAL REGULATION: 45 CFR 156.440, 26 CFR 1.36B-2; 26 CFR 1.5000A-2

The following applies to consumers eligible for Medicare:

- Consumers who receive Medicare are not eligible to receive financial assistance.
- Consumers who receive Medicare Part A at a cost may drop Part A and Part B coverage, or they can choose not to enroll in Medicare at the time they become eligible (these consumers may be subject to tax penalties or Medicare penalties if they defer Medicare enrollment outside of the qualifying time). Consumers who drop Medicare or Medicare Part A at a cost can enroll in health insurance coverage through Georgia Access with financial assistance.
- Consumers who receive free Medicare Part A cannot drop it without also dropping their retiree benefits (i.e., Social Security) and paying back all received retirement benefits and costs incurred by the Medicare program.
- Consumers over 65 years old who elect not to receive retirement benefits may be eligible for health insurance coverage and financial assistance through Georgia Access.
    - Medicare Part B alone is not considered MEC. However, if a consumer is eligible for Medicare Part B, it is assumed they are also eligible for Medicare Part A and not eligible for financial assistance.

2.2.5.4.1 Age in Medicare

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.305; SECTION 1882 (D)(3) OF SOCIAL SECURITY ACT; 26 CFR 1.36B-2

Consumers enrolled in coverage and financial assistance through Georgia Access will be notified that they have become eligible for Medicare when they turn 65. The notice is sent after Georgia Access conducts its twice-a-year periodic data match.

When a consumer receives the notice that they are eligible for Medicare, they are informed that they will be terminated from their Georgia Access coverage and financial assistance, due to attestations on their Georgia Access application. The consumer is encouraged to terminate their plan once they receive the notice, but if they do not, Georgia Access will do so automatically.

After termination, the consumer may decide they want to forgo Medicare coverage, or purchase Georgia Access coverage in addition to Medicare. The consumer is allowed to purchase Georgia Access coverage, however, due to their Medicare eligibility status, they are not eligible for financial assistance through Georgia Access. If they purchase a plan, it will be at full cost.

2.3 Data Verification

Georgia Access follows the verification standards approved by CMS to verify consumer eligibility information. This section includes acceptable documentation for different types of statuses.

2.3.1 Eligibility Verification Standards for QHPs and SADPs

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.315 (A-J); 45 CFR 155.320 (A-E); 45 CFR 155.330 (A-G); 45 CFR 155.335

The following sections go into detail on the types of acceptable documentation Georgia Access uses to verify eligibility for QHPs and SADPs.

2.3.1.1 US Citizenship or Legal Status

Any of the below documents can be used to verify U.S. citizenship or legal status:

- U.S. passport or passport card
- Certificate of Naturalization (N-550/N-570)
- Certificate of U.S. Citizenship (N-560/N-561)
- State-enhanced driver's license (available in, Michigan, New York, Vermont, and Washington; state issued Real ID)
- Documented evidence issued by a federally recognized Indian tribe that includes the consumer's name and the name of the federally recognized Indian tribe that issued the document, and shows the consumer's membership, enrollment, or affiliation with the tribe. Documents that can be provided include:
    - A tribal enrollment card
    - A Certificate of Degree of Indian Blood
    - A tribal census document
    - Documents on tribal letterhead signed by a tribal official
- Copy of the front and back of a resident alien card
- Copy of another form of documentation showing legal status

If a consumer does not have any of the document types above, they can submit two documents—one from each list below.

One of these documents:

- U.S. birth certificate
- Consular Report of Birth Abroad (FS-240, CRBA)
- Certification of Report of Birth (DS-1350)
- Certification of Birth Abroad (FS-545)
- U.S. Citizen Identification Card (I-197 or the prior version I-179)
- Northern Mariana Card (I-873)
- Final adoption decree showing the person's name and U.S. place of birth
- U.S. Civil Service Employment Record showing employment before June 1, 1976
- Military record showing a U.S. place of birth
- U.S. medical record from a clinic, hospital, physician, midwife, or institution showing a U.S. place of birth
- U.S. life, health, or other insurance record showing U.S. place of birth
- Religious record showing U.S. place of birth recorded in the U.S.
- School record showing the child's name and U.S. place of birth
- Federal or state census record showing U.S. citizenship or U.S. place of birth

- Documentation of a foreign-born adopted child who received automatic U.S. citizenship (IR3 or IH3)

With one of these documents (that has a photograph or other information such as name, age, race, height, weight, eye color, or address):

- Driver's license issued by a state or territory, or ID card issued by the federal, state, or local government
- School identification card
- U.S. military card or draft record or military dependent's identification card
- U.S. Coast Guard Merchant Mariner card
- Voter Registration Card
- A clinic, doctor, hospital, or school record, including preschool or day care records (for children under 19 years old)

Or

- Two documents containing consistent information that verify identity, including but not limited to employer IDs, high school or college diplomas, marriage certificates, divorce decrees, property deeds or titles, or other similar proof of identity.

Consumers must include copies of supporting documentation when submitting an application to Georgia Access or after receiving a DMI notice.

2.3.1.2 Immigration Status

Forms of documentation commonly used to verify immigration status—including Lawfully Present status:

- Permanent Resident Card (I-551, also known as Green Card)
- Temporary I-551 Stamp (on passport or I-94, I-94A)
- Immigrant Visa (with temporary I-551 language)
- Employment Authorization Card (EAD or I-766)
- Arrival/Departure Record (I-94 or I-94A)
- Arrival/Departure Record in foreign passport (I-94)
- Foreign passport
- Country of issuance Reentry Permit (I-327)
- Refugee travel document (I-571)
- Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
- Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
- Notice of Action (I-797)
- Alien registration number or an I-94 number
- One of these documents or statuses:
    - Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
    - Document indicating withholding of removal
    - Administrative order staying removal issued by the Department of Homeland Security
    - Certification from HHS ORR
    - Documentation of status as a Cuban/Haitian entrant
    - Documentation of status as a Resident of American Samoa
    - Compacts of Free Association (COFA) migrants

2.3.1.3 Incarceration Status

Forms of documentation commonly used to verify incarceration status:

- Official release papers from the institution or Department of Corrections
- Parole papers
- Unexpired state ID, driver's license, work ID, or passport
- Pay stubs
- Federal, state, or local benefit letter
- Clinic, doctor, or hospital records for services provided
- Medical claim explanation of benefits provided
  School record/schedule showing enrollment (like for college students)

2.3.1.4 Social Security Status

Forms of documentation commonly used to verify Social Security status:

- Social Security Card
- 1040 Tax Return (Federal or state versions acceptable)
- W2 and/or 1099s (Includes 1099 MISC, 1099G, 1099R, 1099SSA, 1099DIV, 1099S, 1099INT)
- W4 Withholding Allowance Certificate (Federal or state versions acceptable)
- 1095 (includes 1095A, 1095B, 1095C)
- Pay stub documentation
- Social Security Administration documentation (includes 4029)
- Military record
- U.S. Military ID card
- Military dependent's ID card
- Unemployment Benefits (Unemployment Benefits Letter)
- Court Order Granting a Name Change that must have original first and last name, new first and last name, and SSN
- Divorce decree

2.3.1.5 Minimum Essential Coverage Status

Forms of documentation commonly used to verify MEC status:

- A letter from an insurance company on official letterhead or stationery, including:
  - A letter or premium bill from former insurance company that shows an individual or their dependent's cancellation/termination from health coverage.
  - A decertification letter from insurance company stating when coverage will no longer be offered.
- A letter from an employer on official letterhead or stationery that confirms one of these about the consumer or consumer's spouse or dependent family member:
  - That the employer dropped or will drop coverage or benefits.
  - That the employer stopped or will stop contributing to cost of coverage.
  - That the employer changed or will change coverage or benefits, and coverage will no longer be considered qualifying health coverage.
- A letter about COBRA coverage from an employer or health insurance company that confirms the following:
  - The employer's offer of COBRA coverage along with the date this coverage would start.
  - COBRA coverage ended or will end, or employer stopped or will stop contributing to the cost of coverage and applicable dates.
- A letter on official letterhead or stationery stating the consumer lost student health coverage, which shows when the coverage ended or will end.

- Pay stubs, if the consumer lost employer-sponsored coverage:
    - The consumer can submit two pay stubs from the past 1-3 months (one that shows a deduction for health coverage and another that shows that the deduction ended in the past 60 days).
    - If a reduction in work hours caused loss of coverage, the consumer can submit one previous pay stub that shows 30 or more hours of work and a deduction for health coverage, and a pay stub from the past 60 days that shows less than 30 hours of work and no deduction for health coverage.
- Document showing lost coverage because of divorce, legal separation, custody agreements, or annulment within 60 days of application submission, including:
    - Divorce or annulment papers that show the date responsibility ends for providing health coverage or proof that consumer stopped getting health coverage because of relationship to former spouse.
    - Legal separation papers that show the date responsibility ends for providing health coverage.
    - Other confirmation that consumer lost or will lose coverage because of divorce, legal separation, or annulment that shows the date that health coverage ends.
- Document showing lost coverage due to death of a family member, including:
    - A death certificate or public notice of death and proof that consumer received health coverage because of relationship to the deceased person, including a letter from an insurance company or employer showing the names of those covered by the health plan.
    - Other confirmation that shows consumer lost or will lose coverage because of the death of a spouse or other family member.
- For Medicaid
    - A letter from Medicaid or PeachCare for Kids® showing that eligibility for Medicaid or PeachCare for Kids® was terminated and when it was terminated or ended or will end.
- For TRICARE
    - Letter or statement from TRICARE that shows the expiration or un-enrollment date of previous health coverage.
    - Letter or statement from TRICARE that confirms ineligibility for health coverage.
    - Letter, statement, or other document indicating a life change event (like divorce) that would make consumer or a family member ineligible for TRICARE coverage.
    - TRICARE coverage limited to space-available care in a facility of the uniformed services for individuals excluded from TRICARE coverage for care from private sector providers.
    - Letter or statement from TRICARE or other government agency showing that consumer or a family member are enrolled in a TRICARE program that is not considered qualifying health coverage.
    - If consumer sends document(s) verifying enrollment in one of these programs, they may be able to continue health insurance coverage through Georgia Access with help paying for coverage:
        - TRICARE Plus
        - Direct care
        - Line-of-duty care
        - Transitional care for service-related conditions
- For Medicare

    - Letter or statement from Medicare or the Social Security Administration stating that a consumer or their family members are:
        - Not eligible for or enrolled in premium-free Medicare Part A.
        - Eligible for (but not enrolled in) Part A coverage that requires premium payments. Important: A Social Security document that shows consumer does not pay a premium for "Medical Insurance" refers to Part B. It is not acceptable for verifying eligibility for Part A.
        - No longer eligible for Social Security Disability Insurance benefits, and their coverage has ended or will end in the next 90 days.
- For Peace Corps
    - Letter from the Peace Corps with the expiration date for any previous health coverage or a letter showing that consumer never had this type of coverage.
- For Veterans Health
    - Letter from the VA that shows the expiration date of previous health coverage.

2.3.1.6 Self-Attestation for Other Health Coverage

Georgia Access allows consumers to provide self-attestation on their access to government-sponsored health insurance coverage. If a consumer cannot produce government-provided documents stating that they do not have government-sponsored coverage, the consumer may submit the form titled "Georgia Access Letter of Explanation." The form is found on the Georgia Access website. This form may only be submitted if a consumer has been sent a DMI notice requesting additional information, and the consumer has either first submitted an insufficient response to the DMI, or the consumer does not have access to any of the documents outlined as acceptable on their DMI notice. If the consumer does not have access to the documents outlined on their DMI, they should contact the Georgia Access contact center or their Georgia Access enrollment channel to discuss next steps prior to submitting this form.

2.3.1.7 Income Information Status

Forms of documentation that can be used to verify income:

- Wages and tax statement (W-2 and/ or 1099, including 1099 MISC, 1099G, 1099R, 1099SSA, 1099DIV, 1099SS, 1099INT)
- Pay stubs
- Federal or State tax returns (1040)
- Unemployment benefit statements/letter
- Self-employment ledger documentation (schedule C or E for self-employment earnings)
- Bank statements showing regular deposits
- Social Security Administration statements (Social Security Benefits Letter)
- Accountant statements, bookkeeping records, or statement from a knowledgeable source

In addition to the above forms of documentation, Georgia Access solicits additional information about income using the following data sources:

- Verify Current Income Service (accessed through the Federal Data Services Hub (FDSH))
- Previous year IRS tax data (accessed through the FDSH)
- Georgia Department of Labor (GDOL)

2.3.1.8 Self-Attestation for Annual Income

Georgia Access allows consumers to self-attest to the annual income reported on their Georgia Access application. If a consumer cannot provide income verification documents confirming their annual

income, the consumer may submit the form *Georgia Access Letter of Explanation*. The form is on the Georgia Access website. The form may only be submitted if a consumer has been sent a DMI notice requesting more information, and the consumer has either first submitted an insufficient response to the DMI, or the consumer does not have access to any of the documents outlined as acceptable on their DMI notice. If the consumer does not have access to the documents outlined on their DMI, they should contact the Georgia Access contact center or their Georgia Access enrollment channel to discuss next steps prior to submitting this form.

2.3.2 Reasonable Opportunity Periods (ROPs)

When a consumer applies for coverage, consumer-attested information is compared electronically to determine accuracy and consumer eligibility. If there is a data mismatch a DMI is sent to the consumer to request additional document verification. Consumers are provided a ROP of 90 days from the date of notice to provide the requested verification documentation. Consumers who do not provide documentation within the 90-day ROP may have their QHP enrollment and/or financial assistance eligibility revoked or redetermined based on available data sources after a five-day processing grace period. The five-day processing grace period, which starts after the expiration of the ROP, enables time for receipt and manual processing of paper documentation submissions sent to Georgia Access.

2.3.3 Periodic Data Matching (PDM)

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.330 (D)

Georgia Access is required by federal law to periodically check the accuracy of data of consumers receiving financial assistance. If Georgia Access identifies different information through PDM, Georgia Access notifies the consumer via a PDM DMI notice. The consumer has 30 days to submit verification for a PDM DMI.

- If the consumer verifies the updated information in the notice, their information is confirmed, and eligibility is updated in accordance with the effective dates outlined in *Section 2.7.3 Effective Dates for SEPs*.
- If the consumer provides different information than what was identified via PDM, Georgia Access verifies the information provided by the consumer and updates eligibility in accordance with the effective dates outlined in *Section 2.7.3 Effective Dates for SEPs*.
- If the consumer does not respond to the notice, Georgia Access updates the eligibility using the information collected via PDM at the end of the month in which the 30-day ROP expires.

2.4 Enrollment

2.4.1 Open Enrollment Dates

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.410

Georgia Access OE dates are determined by State leadership.

Plan Year	Open Enrollment
2027	November 1, 2026 – January 15, 2027

2.4.1.1 QHPs Not Accepting New Consumers

2.4.1.2 QHP Certification Outside of Standard Timeframe

QHPs are reviewed and certified by Georgia Access annually prior to OE during the designated certification period. Insurance companies cannot add plans for QHP certification consideration outside of the designated application submission and plan certification period.

2.4.1.3 Active Application Timeframe

A consumer's completed application remains active throughout OE. Consumers can make changes to their application and enrollment without an SEP until their plan is effectuated with the first premium payment.

2.4.1.4 Changing Plans during Open Enrollment

During OE, a household may enroll, disenroll, or change their health insurance plan. After the end of OE, a consumer needs an SEP to change their plan or enroll in a plan.

2.4.1.5 Adding a Dependent during Open Enrollment

If a household has effectuated their QHP coverage during OE by paying their initial premium payment, the household may not retroactively add another dependent to their plan, remove a dependent from their plan, or change their plan unless they have a QLE that would provide them with an SEP, such as an adoption or birth of a child.

2.4.2 Coverage Start Dates

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.420(B)(3); 45 CFR 155.410

Consumers who enroll during OE between November 1 and December 15 receive coverage starting January 1 of the upcoming plan year. Consumers who enroll in coverage between December 16 and January 15 receive coverage starting February 1.

Georgia Access follows a first-of-the-following-month coverage start date policy for most SEPs. First-of-the-following month coverage means that when a consumer enrolls in coverage via an SEP, their coverage begins on the first of the month following their plan selection. Some SEPs allow coverage to start earlier than first-of-the-following month. For more information on these scenarios and SEP effective dates, see *Section 2.7 Special Enrollment Periods*.

2.4.2.1 QHP Premium Calculation

ASSOCIATED FEDERAL REGULATION: 45 CFR 147.102(C)(3)(III)(B)

Georgia Access calculates premium rates per the effective date of the covered member. The per member premium rates are not recalculated if there are:

- Only a change in CSR
- If the primary tax filer (subscriber) leaves the plan and there is no other plan change

For households with dependents, there is no limit to the number of dependents allowed in a household. The household premiums are calculated based on the enrollment date using the three oldest dependents under the age of 21. Any additional dependents under the age of 21 are covered under the plan at no additional charge. Premiums for dependents age 21 to 26 are calculated separately and added to the total household premium.

Minors who are married and have children are considered adults under this calculation formula. For child-only plans, the first three oldest children are used to calculate the premium price and the rest are covered under the plan at no additional charge.

2.4.3 Maximum Age of Dependents

ASSOCIATED STATE REGULATION: GA CODE 33-24-28

Dependents on a QHP are eligible to remain dependents until they turn 26 years old. Georgia Access allows 26-year-olds to stay on the household plan until December 31 of the year they turn 26. However, if an individual turns 26 before being enrolled, they are not eligible to join the household plan as a dependent. After December 31, they are removed from the household plan and can choose to apply for and enroll in their own plan. If a dependent who is 26 years old or older is unable to apply for and enroll in their own plan due to a physical or develop mental disability, they may remain on the household plan.

2.4.4 Primary Contact

The primary tax filer for a household is the primary contact for the QHP application. The primary tax filer cannot be changed except in an extenuating circumstance. Consumers must contact their Georgia Access enrollment channel or the Georgia Access contact center if they believe they have an extenuating circumstance.

2.4.5 Enrolling Households with Mixed CSR Status

Mixed CSR status households include households whose members include people with different citizenship or immigration statuses (e.g., a household with an undocumented parent, and children who are U.S.-born citizens). Each member of a mixed CSR status household may be eligible for a different healthcare program.

If a household has mixed CSR status, the family is enrolled using the lowest common denominator CSR status, unless they request multiple health insurance plans.

2.4.6 Children of Undocumented Immigrants

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.300, 305

Georgia Access allows children of undocumented immigrants to apply for health insurance coverage through Georgia Access. If undocumented immigrants have a tax filer ID, the household files taxes, and the children are citizens, the children may be eligible for health insurance coverage and financial assistance even though the parents are not eligible for coverage through Georgia Access[10].

2.4.7 Plan Eligibility

Plan eligibility is determined based on each member of the household's eligibility results (including the consumer's zip code/service area), not the whole household's application.

For example, if a household of four applies for health insurance coverage through Georgia Access and only one person is ineligible, the other three members of the household can still enroll in health insurance coverage through Georgia Access.

2.4.8 Tobacco Status

ASSOCIATED FEDERAL REGULATION: 45 CFR 147.102 (A)(IV)

If a consumer attests to using tobacco products four times or more per week within the last six months of the date of their application, then they are considered a tobacco user.

Georgia Access only allows smoking status to be reported during OE for the entire plan year, unless a subsequent enrollment is made during an SEP or later during OE. If a consumer would like to make a change to their tobacco usage before the next OE and without an SEP, they may file an appeal with Georgia Access.

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[10] While the parents may not be eligible to purchase insurance through Georgia Access, there are other available options they may pursue for coverage. See More information for immigrant households | HealthCare.gov for more information.

2.4.9 Insurance Company Changes

Insurance companies may disenroll a consumer by canceling, terminating, or rescinding a consumer's plan in certain circumstances outlined below.

2.4.9.1 Cancellation by Insurance Company

Insurance companies may cancel a consumer's plan if the consumer's binder payment is not received by the deadline, which is no earlier than the coverage effective date and no later than 30 calendar days after the coverage effective date. Insurance companies must notify consumers of the cancellation. Insurance company-initiated plan cancellations must be transmitted to the Georgia Access Eligibility System within 48 hours of updating the plan status in the insurance company system.

2.4.9.2 Termination by Insurance Company

ASSOCIATED FEDERAL REGULATION: 45 CFR 156.270 (D)

Insurance Companies may terminate a plan if a consumer's premium was not received during the applicable grace period. Insurance companies are required to provide grace periods according to *Section 2.5.3 Grace Period Window*. Insurance company-initiated plan terminations must be transmitted to the Georgia Access Eligibility System within 48 hours of updating the plan status in the Insurance company system.

2.4.9.3 Rescission by Insurance Company

Insurance companies may rescind a plan if the consumer or certified agent falsified consumer information to gain coverage. All cases of suspected fraud are investigated by OCI's Criminal Investigations Division (CID). Upon completion of an investigation, insurance companies submit rescission requests to Georgia Access for review and approval. If approved, Georgia Access processes the rescission and the responsible insurance company notifies the consumer.

2.4.10 Disenrollment

ASSOCIATED FEDERAL REGULATION: 45 CFR 162.1501; 45 CFR 155.430

An insurance company can disenroll a consumer or a consumer can voluntarily disenroll and set the date for the end of the current month, next month, or the following month. The disenrollment date is always the last day of the month unless it is due to death (in which case, disenrollment is one day after the date of death).

A consumer who fails to provide required verifications by a specified deadline may be disenrolled on the last day of the month following the deadline. For any other scenario, the insurance company should submit a ticket to the Georgia Access contact center.

Updated termination dates on enrollments are only applied through insurance company or consumer requests and then escalated to the Georgia Access contact center.

2.4.10.1 Retroactive Disenrollment

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.430

In limited circumstances, consumers may apply for a retroactive termination date due to either dual, accidental, or unauthorized enrollment/plan switch. Retroactive terminations are at the discretion of Georgia Access and are in accordance with federal regulations.

Retroactive disenrollment of coverage follows the circumstances outlined below:

- Georgia Access allows a consumer to request a retroactive cancel if:
    - They have not claimed their Georgia Access account.

    - There is no contact with the Georgia Access contact center/issuer outside of the complaint/request to cancel.
    - They are affiliated with a certified agent/assister, and multiple agent changes/updates are noted within the consumer's account.
    - They are affiliated with an EDE, and multiple changes/updates are noted within the consumer's account.
    - Paper notices have been returned for an invalid address, or they attest that the address on file does not belong to them.
    - Attest to have ESI or other MEC coverage (including Medicaid).
  - Georgia Access allows retroactive disenrollments/cancellations for Unauthorized Enrollment (UE) and/or Unauthorized Plan Switch UPS) provided the consumer meets the previously mentioned criteria, including the following if:
    - The consumer can authenticate their name, DOB, and SSN but cannot confirm a portion of the mailing address, the consumer will be allowed to retroactively cancel the policy
    - The issuer confirms existing medical or pharmacy claims, but the consumer denies enrolling, authorizing enrollment, or needing the coverage.

- The maximum timeframe for a retroactive disenrollment for Medicare-based enrollment will be six months from the date of the request OR the day prior to the Medicare start date, whichever is earlier.
- Retroactive dual coverage disenrollment for enrollment in Medicaid/PeachCare for Kids® may occur up to 60 days prior to the reporting date.
- Retroactive disenrollment related to other MEC coverage or general consumer error may be allowed if it is within 14 days of the requested termination date

When a consumer or certified agent reports dual coverage of MEC and requests a disenrollment for the consumer's QHP coverage, Georgia Access requires documentation of group coverage as needed and disenrolls within the above timeframes. Georgia Access also:

- Disenrolls coverage on the last day of the month that the consumer reported; or
- Retroactively disenrolls without dual coverage proof if notified within 14 days of the requested termination date.

2.4.10.2 Disenrollment Due to a Move Out-of-State

Consumers are required to disenroll from coverage through Georgia Access if they move out of state. Disenrolling for a move can be pre-set by the consumer based on general disenrollment procedures.

When a consumer or certified agent reports a move out of state and requests a retroactive disenrollment for the consumer's coverage, Georgia Access ends the coverage on the last day of the month in which the consumer reported the move.

2.4.11 Reinstatement

Consumers requesting reinstatement must submit the request to their insurance company. Insurance companies may reinstate consumers for cases of non-payment or insurance company error. If a consumer's reinstatement request results in the insurance company determining that there was no error on the insurance company's part, then the issuer must submit a request through the Georgia Access contact center to have the consumer reinstated.

Insurance companies are allowed to reinstate coverage if the coverage termination date falls within the last 90 days. If the date is more than 90 days in the past, insurance companies are required to submit the consumer reinstatement request via a ticketing system to the Georgia Access contact center for

review and approval prior to reinstatement.

When the insurance company is allowed to reinstate coverage, they may activate coverage but must submit a ticket immediately to the Georgia Access contact center to ensure the consumer's eligibility is updated in the Georgia Access eligibility system. The ticket must be submitted within two business days of processing the reinstatement.

Georgia Access will not reinstate coverage without a documented error or exceptional circumstance such as consumer error, system or agency error, natural disaster, or domestic abuse. Due to redetermination processes, consumers may also experience a temporary loss of financial eligibility, which may result in an enrollment termination. If the consumer contacts their insurance company within the same month the loss of financial eligibility occurs, the insurance company may reinstate coverage without a gap in coverage.

2.4.12 Re-Enrollment Following Termination for Non-Payment

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.400 (1)(IV); 45 CFR 156.270; 45 CFR 147.104-5

A consumer with a plan or plans previously terminated by the insurance company for non-payment of premium, who then re-enrolls on Georgia Access, may be required by the insurance company to arrange repayment of unpaid delinquent premiums due up to 12 months prior to effectuation of the new policy. The insurance company may extend the binder payment deadline while the consumer makes payments on the delinquency. Insurance companies may terminate coverage for a consumer's failure to complete the repayment option with the insurance company.

2.5 Consumer Premium Payments

2.5.1 Initial Payment (aka "binder payment" or "binder")

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.400; 45 CFR 155.410; 45 CFR 155.420

Consumers must make their binder payment (first month's premium payment) to complete their enrollment and for prospective coverage to be effectuated. The binder payment must consist of the first month's full premium or be within an insurance company's payment threshold if the insurance company has implemented such a policy as outlined in *Section 2.5.2 Premium Payment Threshold*. If the consumer has paid the initial premium within the payment threshold, the coverage can be effectuated.

Insurance companies may set the deadline for consumers to pay their binder payment no earlier than the coverage effective date, and no later than 30 calendar days after the coverage effective date. During OE, coverage begins as stated in *Section 2.4.2 Coverage Start Dates*. Ongoing payments after the initial binder payment are due by the last day of the month prior to the month of coverage.

For an approved SEP, insurance companies may set the deadline for consumers to pay their binder payment no earlier than the coverage effective date, and no later than 30 calendar days after the date the insurance company receives the enrollment transition or the coverage effective date, whichever is later. If the binder payment is not paid by the deadline, the policy may be cancelled by the insurance company.

For retroactive effective dates, the binder payment must consist of the premiums for all the months of retroactive coverage and the premium for the first month of prospective coverage. The deadline for making this binder payment must be no earlier than 30 calendar days from the date the insurance company receives the enrollment transaction or the date the retroactive coverage date is set in the Eligibility System.

If the consumer pays only the premium for one month of coverage by the deadline, only prospective coverage should be effectuated, in accordance with regular effective dates. The insurance company must receive payment in full (or payment within the premium payment threshold) from the consumer for any applicable binder payment by the applicable binder payment deadline. Insurance companies may not grant grace periods for payment of the binder payment.

If a consumer adds a retroactive enrollment to an already effectuated enrollment, the consumer must pay all outstanding retroactive premiums by the next monthly billing cycle due date. Failure to pay the outstanding premium by the due date triggers a grace period.

If an insurance company is experiencing billing or enrollment issues due to high volume or technical errors, the insurance company can implement a reasonable extension of binder and monthly premium payments. This ensures that an enrollee's coverage is not canceled due to non-payment. Insurance companies should notify plan management at planmanagement@georgiaaccess.ga.gov should this situation occur.

2.5.2 Premium Payment Threshold

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.400(G)

Georgia Access insurance companies may implement a premium payment threshold policy for plans offered through Georgia Access that is applied to the net premium owed by the consumer. Insurance companies that implement such a policy typically consider a payment to be made in full once the consumer has paid the threshold amount established by the insurance company. The typical threshold amount is a percentage equal to or greater than 95% of the net premium owed by the consumer. An insurance company must maintain the premium payment threshold for the entirety of the plan year and must apply the threshold policy consistently across all Georgia Access plans and consumers.

When a consumer has paid within the premium threshold but has not paid the full portion of the premium, the consumer still owes the balance. If the consumer has paid the initial premium within the threshold's tolerance percentage but has not paid the full amount, the insurance company can still effectuate the enrollment. If the consumer makes subsequent premium payments within the threshold's tolerance, but has not paid the full amount due, the insurance company may consider the consumer to be current on all payments due for the purpose of determining whether to place the enrollee into an applicable non-payment grace period. If the consumer continues paying an amount less than the owed amount including past premiums, the owed amount will accumulate and may increase beyond the threshold amount. If that is the case, the consumer's account has become past-due, and the consumer will be subject to a grace period for failure to pay premiums.

2.5.3 Grace Period Window

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.430; 45 CFR 156.270(D) AND (G)

Consumers with effectuated coverage are granted a grace period before their coverage can be terminated for non-payment. If the premium payment has not been received by the insurance company on or before the 30th day of the coverage month, a grace period is triggered. The grace period is different for consumers who receive APTCs:

- For consumers with APTCs, the grace period is three consecutive months, beginning with the month of non-payment.
- For consumers without APTCs, the grace period is 30 days for individual market plans and 31 days for small group plans, per O.C.G.A. 33-30-4.

Partial payments do not adjust a grace period. If a consumer is eligible for APTCs but elects not to receive the credit in advance, they do not qualify for the three-month grace period. The three-month grace period only applies to consumers who are receiving APTCs.

If a consumer with a grace period expiring on or before December 31 actively reselects coverage offered by the same insurance company during OE with a January 1 effective date, the insurance company will generally need to treat the active reenrollment under guaranteed availability rules, effectuating the new coverage, subject to a binder payment.

2.5.4 Payment of Medical Claims Incurred During the Grace Period

For consumers receiving APTCs, insurance companies must pay all appropriate claims for services rendered to the consumer during the first month of the grace period and may pend claims for services rendered to the consumer in the second and third months of the grace period. Insurance companies must notify providers of the possibility for denied claims when a consumer is in the second and third months of the grace period.

If the consumer's coverage is terminated for non-payment of premiums retroactively to the last day of the first month of the grace period, the insurance company may deny any claims that were pended for services received during the second and third months of the grace period. However, the insurance company cannot retroactively deny claims from the first month of the grace period. Any premium payments received by an insurance company for coverage beyond the retroactive termination date are refunded to the consumer.

2.6 Renewals

2.6.1 Automatically Renewing Coverage

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.335; 45 CFR 156.290 (5); 45 CFR 155.430

Georgia Access automatically re-enrolls, or renews, consumer QHP coverage for the next plan year if consumers are deemed eligible and agreed on the application to be auto renewed for the next plan year. Upon initial application and ongoing, consumers can opt out of auto-reenrollment.

If a consumer is deemed conditionally eligible for the next plan year, they are renewed. The consumer may need to supply additional information, if requested, to prove eligibility. During the conditional eligibility period, consumers keep their APTC until the deadline for submitting the documentation needed to resolve any data matching inconsistencies.[12] Georgia Access automatically renews consumer QHP/SADP coverage even if the consumer loses eligibility for APTC or CSR by renewing them into the same or a corresponding plan without APTC or CSR. Consumers who are no longer eligible to enroll in QHP/SADP coverage on Georgia Access are not renewed.

When an insurance company does not renew its plans or when existing plans are not re-certified, Georgia Access does not automatically enroll or crosswalk these consumers into a new plan with another insurance company. Instead, affected consumers are encouraged to return during Open Enrollment to shop for and select a new plan that best meets their needs.

2.6.2 Changes to CSR or APTC

If there are changes to a consumer's CSR level or APTC due to changes in the consumer's eligibility (such as income change, household size change, etc.), Georgia Access automatically renews their coverage unless they have turned 26 and aged out of their household's QHP, or they have specifically requested their health insurance coverage end with the plan year.

2.6.3 Changing Subscriber for Child-Only Policy

If a household has a child-only health insurance policy, the original child subscriber remains the subscriber on the policy until they age out of the coverage, even if the household has a younger

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[12] *After 1/1/2025, Georgia Access will not renew a 26-year-old dependent at the end of the plan year. The consumer may apply and enroll in their own plan during Open Enrollment, or with a valid QLE.*

dependent join the policy. In a scenario where the child ages out the next child would become the subscriber.

2.6.4 Insurance Company Use of Payment

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.400; 45 CFR 156.270

New enrollments completed during OE, or an SEP require payment of the first month's premium (a binder payment) in full or within the premium payment threshold set by the insurance company to be made by the initial payment due date for coverage to become effective. Binder payments are not required for renewals, as the renewal is a continuation of effectuated coverage.

The three-month grace period for payment carries over for renewed enrollments if APTC is used to lower monthly premiums. If a delinquency exists on the account, insurance companies may apply any payments received to the delinquency.

2.6.5 Dental Renewals

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.335 (J); 77 FR 18309, 18315

Dental insurance plans are renewed for consumers during OE.

Georgia Access consumers determined eligible for Medicaid programs are not auto renewed in either medical or dental enrollments during the redetermination process. Georgia Access doesn't prohibit consumers from re-enrolling without a tax credit.

2.6.6 APTC Renewals

2.6.6.1 APTC Amount

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.340 (F)

When Georgia Access re-enrolls consumers, the APTC amount is automatically set so that 100% of the APTC is applied to the monthly premium. If a consumer prefers a different percentage applied to their monthly premium, they can adjust it at any time in their Georgia Access application. The change becomes effective the first of the month following the change.

2.6.6.2 Cutoff Date for APTC Redetermination

Information submitted for the redetermination of APTC and CSR must be completed by December 15 for a January 1 coverage start date. Completion after December 16 has an effective start date of February 1. If a consumer is eligible for an SEP, the household APTC can be calculated or re-calculated during this time.

2.6.6.3 APTC and CSR Effective Date

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.310; 45 CFR 155.340; 45 CFR 155.330

Consumers who are enrolled in a QHP/SADP with financial assistance that experience a change in APTC have their updated APTC amount applied to their enrollment starting the first of the month following the date of their new eligibility.

Consumers who are enrolled in a QHP/SADP without financial assistance and gain eligibility for APTC have their new APTC amount applied to their premiums effective the date of their new eligibility.

Consumers who enroll in Georgia Access via an SEP and receive a new APTC eligibility determination, or who are enrolled and have a change in CSR, have their new APTC and/or CSR level amount applied to their enrollment following the enrollment rule, or per any guidelines due to SEPs, complex cases, or appeals resolution.

2.6.6.4 Splitting APTC between QHP and SADPs

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.340; 26 CFR 1.36B-3(E)

Applicants enrolled in a QHP and receiving APTC must first apply the APTC to the QHP premium. Any remaining APTC may be applied to the premium of a pediatric dental plan or the pediatric portion of an SADP.

2.6.6.5 Reporting Changes and Redeterminations

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.335; 45 CFR 155.335(E)

Georgia Access is required to redetermine eligibility for QHPs and SADPs, as well as any federal financial assistance (if applicable), for a consumer and their dependent(s) based upon a change to any eligibility criteria.

The change in eligibility can be reported by the consumer or obtained by Georgia Access through PDM during the plan year. A change reported by the consumer may need to be verified before it is finalized. This includes ensuring the information provided is consistent with the verification sources used by Georgia Access, or that the consumer has provided documentation to support the change. If a change cannot be verified, Georgia Access must redetermine eligibility based on other available information. See *Section 2.3.3 Periodic Data Matching (PDM)* for more information on PDM.

A consumer and their dependent(s) must report any changes that impact eligibility for coverage and/or financial assistance within 30 days of the event.

2.6.6.5.1 Changes Consumers are Required to Report – QHP/SADP

Consumers must report changes related to:

- Household size or composition due to changes related to birth, adoption, placement for adoption, marriage, divorce, death, or similar changes
    - In cases of death, Georgia Access conducts PDM twice a year to account for consumers with no other household members to report the death
- Residency, including a change to a residential and/or mailing address
- Citizenship, nationality, or lawful presence status
- American Indian/Alaska Native status (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d))
- Incarceration status

2.6.6.5.2 Changes Consumers are Required to Report - Financial Assistance

Consumers receiving financial assistance are required to report changes related to:

- Eligibility determination for or enrollment in other health insurance, including Medicare, Medicaid/PeachCare for Kids®, other government-sponsored health insurance, or employer-sponsored coverage
- Income
- Employment status, including any change in eligibility for employer-sponsored insurance

2.7 Special Enrollment Periods (SEPs)

2.7.1 Qualifying Life Events (QLEs) for SEPs

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.420

A QLE is a change in a consumer's situation that makes the consumer eligible for an SEP. SEPs allow consumers to enroll in health insurance outside of the yearly OE Period. Georgia Access allows unenrolled individuals and current consumers and their dependent(s) to enroll in or make changes to their plan selection during a plan year if any of the below qualifying events are reported within 60 days of occurring.

- Loss of MEC
- Change in Household Size
- Change in Residency (with Limitations)
- Change in Financial Eligibility
- Exceptions/Other
- Change in Eligibility Status

Additional information on QLEs that may trigger SEPs can be found in the following subsections.

2.7.1.1 Addition of a New Dependent

A consumer is entitled to an SEP if their household has a baby, adopts a child, or is appointed by a court as the ward for a child, even if the child gains alternative health insurance coverage such as PeachCare for Kids®. The new APTC eligibility calculation is effective the first of the month of the reported event.

Adult dependents can only be added to a health insurance plan through Georgia Access if they have their own QLE.

2.7.1.2 Loss of Off-Exchange Health Insurance Coverage Outside of Open Enrollment

A consumer is entitled to an SEP if while enrolled in health insurance plans sold outside of Georgia Access (off-Exchange)—such as short-term health insurance plans—the plan ends outside of OE—even if they are given the option to renew their coverage. If a consumer ages out of their pediatric dental plan, they do not qualify for an SEP. All coverage lost must meet MEC thresholds.

2.7.1.3 Student Losing Student Health Coverage

A consumer is entitled to an SEP if they are a college or university student who loses their student health insurance coverage. To receive the SEP, students need to have a Certificate of Creditable Coverage, the previous year's school transcripts, and a letter from the university informing them of the loss of coverage. This is a one-time SEP for the academic year.

2.7.1.4 Domestic Violence

A consumer is entitled to an SEP due to domestic violence situations. Georgia Access does not require proof and accepts consumer self-attestation in these situations.

2.7.1.5 Individual Coverage Health Reimbursement Arrangement (ICHRA) and Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)

A consumer is entitled to an SEP if they become eligible for either an ICHRA or a newly provided QSEHRA from their employer. An ICHRA and a QSEHRA are employer funded health reimbursement arrangements that are alternatives to group health plans. These HRAs enable employers to reimburse employees for some or all premium and health expenses. To qualify for a SEP, the employer must meet specific eligibility criteria set forth by the HRA regulations.

2.7.1.6 Loss of Medicaid/PeachCare for Kids®

A consumer qualifies for an SEP if they lose their Medicaid/PeachCare for Kids® coverage. Georgia Access is extending the federal SEP to grant consumers a 90-day SEP for loss of Medicaid/PeachCare for Kids® coverage; a 60-day SEP will be implemented for instances where a consumer was referred for Medicaid determination during OE but is denied Medicaid after the OE period is done.

Additional Medicaid Denial exception that allows an SEP

- The consumer applied for coverage through Georgia Access due to a qualifying event (ex: birth) and was assessed as potentially eligible for Medicaid/PeachCare for Kids ®, and the Medicaid agency issued an ineligibility determination more than 60 days after the qualifying event. The consumer is allowed to enroll in coverage back to the original application date.

2.7.1.7 Guaranteed Availability of Coverage

ASSOCIATED FEDERAL REGULATION: 45 CFR 157.104 AND 105

A consumer is entitled to an SEP if their plan availability ends prior to the end of the plan year. In such a situation, Georgia Access terminates the consumer's enrollment when the plan availability ends. The consumer is granted an SEP due to loss of MEC, unless otherwise directed.

2.7.1.8 Plan Display Error

ASSOCIATED FEDERAL REGULATION: 45 CFR 156.1256

A consumer is entitled to an SEP if their insurance company or Georgia Access identifies incorrect plan data displayed to consumers and the resulting correction is determined to negatively impact consumers. Georgia Access and insurance companies will both communicate this change in eligibility to the impacted consumers, who are able to use the SEP to enroll in new coverage. Consumers must be informed within 30 days of the data change request approval.

2.7.1.9 Loss of a Dependent

A consumer is not entitled to an SEP if they lose a dependent from their household (including death). A loss of a dependent (i.e., change in household size) automatically updates a consumer's existing enrollment.

2.7.2 Timeline for Reporting a QLE and Obtaining Coverage

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.305-320; 45 CFR 155.420

In most cases, consumers have 60 days to report a QLE, validate the event, and enroll in a plan through Georgia Access. If an individual reports multiple QLEs at one time, the effective date of their health insurance plan is dated to the earliest effective date of all QLEs. Once an individual enrolls in a new health insurance plan, their SEP closes, and they cannot change their plan until the next OE or new QLE occurs.

Additional QLE reporting scenarios:

- If a consumer knows they are losing MEC, they can report the loss of that coverage up to 60 days in advance.
    - If the consumer is losing Medicaid or PeachCare for Kids®, they can report the loss of that coverage up to 90 days before or after the loss.
- If an existing Georgia Access consumer's address is updated after 60 days of the event (either through reconciliation or consumer/certified agent request) or a death is reported outside of the required 60-day timeframe, and the consumer made all payments with the insurance company, Georgia Access either maintains the consumer's enrollment if they are eligible for the plan's service area, offers to crosswalk the consumer into a different plan with the same insurance company in the new service area, or offers to crosswalk the consumer into a different plan with a different insurance company within the same plan level and new service area if there is not a similar plan with the same insurance company.
- If a consumer reports a QLE, their current plan may no longer be available to them. If the consumer does not select a new plan during their SEP, Georgia Access disenrolls the consumer from their current plan when their SEP ends. Alternatively, the consumer whose plan is no longer available due to the reported change can choose to enroll in a different plan (with the same or a different insurance company) during their SEP.

2.7.3 Effective Dates for SEPs

Coverage effective dates for SEPs differ based on the QLE. Effective dates are determined as follows:

- Date of the event:

    - In cases including—but not limited to— birth, or adoption, the effective date of the newly selected coverage will be the date of the life event.
- First of the following month:
    - In cases including—but not limited to—residency changes, immigration status changes, or loss of certain types of MEC, the effective date of the newly selected coverage will be the first day of the month following the date the life event occurred.
    - For life events involving marriage or divorce, the effective date of the selected coverage shall be the first day of the month following the date the life event is reported.
    - Consumers seeking a first-of-the-month effective date who are in a pending verification status may request an earlier effective date to be considered upon approval of the QLE. Those who do not complete verification in a timely manner may appeal to request an earlier effective date.
- Future date:
    - In cases including—but not limited to—reporting a future loss of MEC, the effective date of the newly selected coverage will be the first of the month following the new enrollment, even if the old coverage has not yet been terminated.
- Other scenarios:
    - In the case of exceptional circumstances during which an SEP is given—such as plan display errors and natural disasters, the effective date of the newly selected coverage will be assigned on a case-by-case basis after the approval of the SEP.

2.7.4 Life Events That Do Not Trigger an SEP

Life events that do not trigger an SEP include:

- Voluntarily dropping coverage
- Loss of eligibility for coverage when the consumer was not enrolled in coverage (e.g., loses job, but was not enrolled in the employer's health plan)
- Income change that does not trigger a change in eligibility
- Termination from other coverage for not paying premiums or for fraud
- Death of a family member without a resulting loss of coverage
- Becoming pregnant
- Loss of a dependent (can trigger an SEP for dependent if eligible)
- Loss of financial assistance due to not responding to a DMI request within the required timeframe
- Loss of QHP coverage for failure to respond to a DMI request within the required timeframe

2.7.5 New SEPs

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.420

Georgia Access has the authority to create new SEPs for the benefit of Georgia Access consumers.

Georgia Access may identify the need for a new SEP. In such an example, affected consumers receive a notice with information on how to apply for the new SEP.

2.7.6 SEP Exceptions and Over-Ride Requests

ASSOCIATED FEDERAL REGULATION: 45 CFR 147.104

Consumers may request enrollment updates outside of an SEP in certain scenarios via the Georgia Access contact center.

2.8 Eligibility Appeals

Georgia Access has a consumer appeal process in accordance with the federal requirements. Georgia Access consumers have the right to appeal any Georgia Access eligibility determinations – including but not limited to QHP, financial assistance, or timelines that they believe were made in error.

2.8.1 Timeline to Request an Appeal

Consumers have 90 days from the date of their Eligibility Determination Notice (EDN) to file an appeal with Georgia Access. For citizenship and immigration issues, consumers have 95 days from the date of the EDN to file an appeal with Georgia Access.

If the consumer misses the deadline, they can still request an appeal and be granted a "good cause" extension by explaining the reason for missing the deadline and providing verification.

The *Georgia Access Consumer Appeal Request Form* and associated *Information Sheet* are posted to the Georgia Access website. Consumers may file a consumer appeal directly with Georgia Access by submitting a completed *Georgia Access Consumer Appeal Request Form* via:

- Their Georgia Access EDE partner account
- Their certified agent
    - Note: Certified agents submitting an appeal on behalf of their consumer should upload a completed *Consumer Appeals Request Form* through the Georgia Access agent portal.
- Their certified Navigator or CAC
    - Note: Certified Navigators and CACs submitting an appeal on behalf of their consumer should upload a completed *Consumer Appeals Request Form* through the Georgia Access entity portal.
- The Georgia Access consumer portal
- Mailing the Georgia Access contact center

2.8.2 Expedited Appeal Requests

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.540

If the consumer has a medical emergency or believes that waiting for a standard appeal decision may seriously jeopardize their life, health, or ability to attain, maintain, or regain maximum function, they can ask for an expedited appeal. For example, consumers may request an expedited appeal if they are currently hospitalized or urgently need medication.

The consumer may indicate the request for an expedited appeal along with an explanation on the *Georgia Access Consumer Appeal Request Form*.

2.8.3 Decisions Consumers May Appeal

Consumers can appeal Georgia Access eligibility determinations related to the initial determination or redetermination of the following:

- Not eligible for APTCs or CSRs
- Eligible for APTC, but the amount seems incorrect
- Not eligible for a SEP
- Not eligible for a QHP or SADP
- Cancellation or termination of a plan by Georgia Access
- To change the enrollment coverage effective date

- Denial of coverage reinstatement request 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)
- 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)
- Eligibility determination and noticing was not timely
- Another Georgia Access eligibility result not listed above

2.8.4 Decisions Consumers May Not Appeal

Consumers cannot appeal Georgia Access eligibility determinations related to the following:

- Consumer disagrees with the coverage end date (however, they can appeal to have terminated /canceled coverage reinstated).
- Consumer's QHP insurance company did not apply premium tax credits correctly
- Consumer wants to change information on their Georgia Access application
- Consumer believes their QHP insurance company owes them a refund
- Consumer wants to end their QHP coverage on an earlier date
- Consumer's QHP insurance company refuses to pay a claim the consumer thinks should be covered[13]
- Consumer owed back some or all of the premium tax credits applied during the year to lower their monthly premiums when they filed their federal income tax return
- Consumer wants to contest payment sent to and/or received by an insurance company

2.8.5 Representation

Consumers may represent themselves or appoint an authorized representative to assist with their appeal request. The representative may be a friend, relative, attorney, certified agent, certified Navigator, certified CAC, or another trusted person. Consumers must sign and submit documentation (within their *Georgia Access Consumer Appeal Request Form* or *Georgia Access Consumer Paper Application Form: Appendix C*) through a Georgia Access enrollment channel or the Georgia Access contact center.

2.8.6 Continuation of Benefits During Appeal Process

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.525

Consumers can continue to receive health insurance coverage, APTC, and CSR benefits as determined by the Georgia Access Eligibility System while their appeal is in progress. However, consumers may be responsible for the cost of their coverage if the appeal decision finds that they are not eligible for the full premium tax credit amount received during the appeal.

2.8.7 Finding of Ineligibility

ASSOCIATED FEDERAL REGULATION: 26 CFR 1.36B-4

If the State or federal appeal decision results in a finding that the consumer is ineligible for APTCs/PTCs, they will be required to pay back some (or all) of their tax credit when filing their federal tax return, in accordance with the IRS CFR 1.36B-1.

[13] *Consumers would need to follow a different appeal process through their insurance company.*

If the Georgia Access or Federal appeal decision results in a finding that the consumer is ineligible for CSRs, they will be disenrolled from this benefit ongoing.

2.8.8 Medicaid and PeachCare for Kids® Appeals

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.510

If a consumer requests an appeal for a Medicaid or PeachCare for Kids® eligibility determination, the Georgia Access contact center must transmit the eligibility determination and all relevant consumer application and appeal information to the Department of Human Services (DHS), the Medicaid or PeachCare for Kids® agency, through a secure electronic interface.

2.8.9 Dismissal of Appeals

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.530

Consumer appeals may be dismissed by Georgia Access in the following situations:

- The consumer withdraws the appeal request by informing the Georgia Access contact center through written documentation or telephonically.
- The consumer fails to appear at an OCI Administrative Procedures Division (APD)- or CMS-scheduled hearing without good cause.
- The consumer dies while the appeal is pending.[14]

2.8.9.1 Notice of dismissal to the consumer

If an appeal is dismissed in response to one of the situations above, Georgia Access must provide written documentation to the consumer. The documentation will include the following:

- The reason for dismissal
- An explanation of the dismissal's effect on the consumer's eligibility
- An explanation of how the consumer may request the vacation of the dismissal by demonstrating good cause

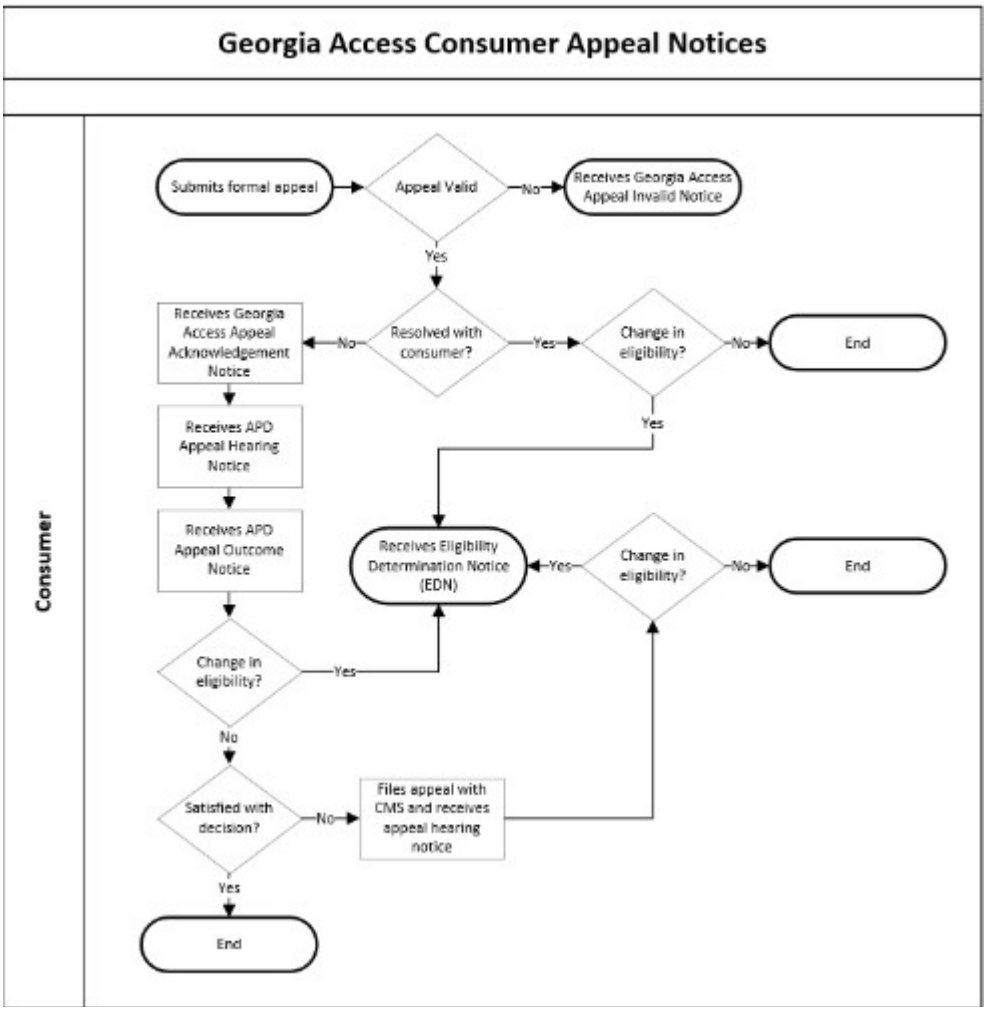
2.8.9.2 Vacating a dismissal

Georgia Access may vacate the appeal dismissal if, within 30 days of being notified of an appeal dismissal, the consumer makes a written request with good cause to rescind the appeal dismissal. If the consumer's request is denied, Georgia Access must provide a written notice to the consumer, noting that the request to vacate the dismissal was denied.

2.8.10 Appeals Notices

Throughout the appeals process, consumers will receive notices from Georgia Access and OCI APD. Escalated consumer appeal notices from OCI APD will inform consumers on the date and time of the hearing, the outcome and decision of the escalated appeal, and information on how to request a federal appeal through CMS. The visual below outlines the different notices a consumer will receive throughout Georgia Access's appeal process.

[14] *The appeal process may proceed if the authorized representative of the consumer's estate requests to continue the appeal process.*



2.9 Exemptions

CMS will process exemptions on behalf of Georgia Access. Consumers can access the health coverage exemption applications through HealthCare.gov. To shop for catastrophic plans on Georgia Access, the consumer will need to enter the Exemption Certificate Number (ECN) received from Healthcare.gov on their Georgia Access eligibility application. Once the consumer enters the ECN, they will be able to view catastrophic plan options.

2.9.1 Hardship Exemption

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.605(D)(1); 155.305(H); 26 U.S. CODE 5000A(E)(5)

Consumers of any age aged 30 and older may qualify for a hardship exemption and enroll in Catastrophic coverage, if they experienced a financial hardship or circumstance that prevented them from getting health insurance. Hardship exemptions usually cover the month before, the month or months during the hardship, and the month following a specific life situation. In some cases, Healthcare.gov may provide the exemption for additional months, up to a full calendar year.

The following types of hardships are permitted:

- Homelessness
- Eviction/Foreclosure
- Shut-off Notice

- Domestic Violence
- Death of a Family Member
- Disaster (i.e., flood, fire)
- Bankruptcy
- Medical Expenses
- Increase in Expenses to Care for Family Member
- Medical Support for Child
- Eligibility Appeals Decision
- Ineligible for Medicaid due to Non-Expanded State
- Other Hardship

There are no exemptions based on employment status. However, consumers may qualify for any of the other hardships listed above.

2.9.1.1 Internal Revenue Service Hardship Exemption

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.605(E)

A consumer has the option to file for a hardship exemption directly through the IRS when filing their federal taxes. Hardship exemptions granted by the IRS do not require an exemption certificate number from Georgia Access.

The IRS may allow an individual to claim a hardship exemption in the below circumstances[15]:

- Filing threshold
- Self-only coverage in an eligible employer-sponsored plan
- Eligible for services through an Indian health care provider
- Ineligible for Medicaid based on a State's decision not to expand
- General hardship[16]

2.9.2 Affordability Exemption

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.605(D)(1); 155.305(H); 26 U.S. CODE 5000A(E)(1)

Consumers aged 30 and over may qualify for an affordability exemption and enroll in Catastrophic coverage if they do not have access to an affordable coverage option. An affordability exemption usually covers the month or months during which a consumer, or a member of their household, experience a lack of affordable coverage options. In some cases, Healthcare.gov may provide the exemption for additional months, up to a full calendar year.

Consumers can meet the affordability exemption in two ways: Marketplace and Job-based.

2.9.2.1 Marketplace Affordability

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.605(D)

The marketplace affordability exemption is based on whether the lowest-price Bronze-level plan available costs more than 9.96% of the consumer's projected household income. If a consumer is seeking a Marketplace affordability exemption, they must apply for the exemption with Healthcare.gov first. The application process determines the monthly premiums and financial assistance for which the

[15] *See IRS Notice 2014-76 for more information.*

[16] *See Authority to Grant HS Exemptions 2018 | cms.gov for more information.*

consumer is eligible. The consumer then qualifies for the exemption if the lowest-price Bronze-level plan available would cost more than 9.96% of the consumer's projected household income.

2.9.2.2 Job-based affordability

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.605(D); 26 CFR 13.36B-1(D)

The job-based affordability exemption is based on whether the consumer's job-based health insurance is considered unaffordable. There are two ways to determine job-based health affordability depending on how the coverage is offered:

- **For an employee:** If the annual premium for the lowest-price self-only plan offered by their employer is more than 9.96% of their annual household income.
- **For the employee's spouse and dependents:** If the annual premium for the lowest-price family plan offered by their employer is more than 9.96% of their annual household income.

Additional considerations include:

- **Premium Tax Credit:** If the lowest-price self-only plan an employer offers costs more than 9.96% of an employee's total household income, the employee may be eligible for a Premium Tax Credit if they buy a Georgia Access plan.
- **Family Coverage:** If the lowest self-only plan an employer offers costs less than 9.96% of an employee's total household income, the employee is not eligible for an affordability exemption. However, other members of the household could be eligible for this exemption if family coverage offered to them is unaffordable.
- **Wellness Incentives:** Wellness incentives that affect premiums offered by an employer-sponsored plans are not included when calculating the employer plan costs.

2.9.3 Appealing an Exemption Decision

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.635

If a consumer does not agree with their exemption decision, they may file a consumer exemption appeal directly with HealthCare.gov.

Filing an appeal does not guarantee that an exemption will be granted, but it does allow the consumer to have their application reviewed again.

3 Consumer Support Policies

3.1 Consumer Support Overview and Entities

This section describes the available consumer support options within Georgia Access. Direct consumer support is provided by Georgia Access EDE partners, insurance companies, certified agents, Georgia Access certified Navigators, certified CACs, and the Georgia Access contact center. Consumers can find additional information on all aspects of Georgia Access on the Georgia Access website.

3.1.1 Insurance Companies

Georgia Access insurance companies provide back-end, post-enrollment support for consumers. Insurance companies integrate with the Georgia Access eligibility system to receive and transfer consumer enrollment files and maintain integrity with CMS to receive APTC payments for eligible consumers. Insurance company member services usually provide consumer support post-enrollment, including:

- Insurance company account questions
- Enrollment questions

- Billing questions

Some insurance companies may serve in a dual role as a Georgia Access EDE partner, and also provide front-end consumer support. Additional information is outlined in *Section 3.1.2 Georgia Access EDE Partners*.

3.1.2 Georgia Access Enhanced Direct Enrollment (EDE) Partners

3.1.2.1 Web brokers

Web brokers are Georgia Access EDE partners that have been certified by Georgia Access to host a technology platform that interfaces with the Georgia Access eligibility system to assist consumers with shopping, plan selection, and enrollment in QHPs. Web brokers display all QHPs and SADPs available to consumers within respective counties in Georgia. Web brokers that own and operate their underlying technology platform are also considered technology providers.

Web brokers are required to provide the following consumer support:

- Application support (online, telephonic)
- Telephonic support (call center)
- Language assistance
- Accessibility assistance

3.1.2.2 Insurance Companies

Insurance companies may also be certified as EDE partners that facilitate consumer direct enrollment in QHPs and/or SADPs via a technology platform. Insurance companies only display their own insurance company QHPs and/or SADPs available to consumers within respective counties in Georgia. Insurance companies are required to provide the following consumer support:

- Application support (online, telephonic)
- Telephonic support (call center)
- Language assistance
- Accessibility assistance

3.1.3 Certified Agents

Certified agents are individuals licensed by the State to sell health insurance products in Georgia and are certified by Georgia Access to sell plans through Georgia Access. Certified agents may provide the following consumer support:

- Application support (online, telephonic, or in-person)
- Telephonic support
- Language assistance
- Accessibility assistance

3.1.4 Georgia Access Navigators

Georgia Access Certified Navigators are individuals who are designated and licensed by Georgia Access to provide education and consumer support regarding Georgia Access. Certified Navigators are typically employed by Navigator Grantee Organizations but can also be volunteers. Navigator Grantee Organizations receive state funds through a grant process. Certified Navigators are licensed to help consumers understand Georgia Access and fill out applications. However, certified Navigators are legally prohibited from conducting certain actions, such as providing plan selection advice or directly enrolling a

consumer into a plan. Certified Navigators are intended to primarily provide in-person support for consumers.

3.1.5 Georgia Access Certified Application Counselors (CACs)

Georgia Access certified CACs are individuals who are designated and certified by the SBE to provide education and consumer support regarding Georgia Access. CACs are usually volunteers managed by CDOs but can also be employees. CDOs are uncompensated by the State for their activities. CACs help consumers understand Georgia Access and fill out applications. However, CACs are legally prohibited from conducting certain actions, such as providing plan selection advice or directly enrolling a consumer into a plan. CACs provide in-person support for consumers.

3.1.6 Georgia Access Website

Georgia Access hosts a website (GeorgiaAccess.gov) that provides a wide range of information, for consumers and all stakeholders. The website includes the following information:

- OE dates
- A list of certified Georgia Access enrollment options (web brokers, agents, and insurance companies) and relevant contact information (website, phone number)
    - A list of available web brokers and insurance companies selling QHPs and SADPs in the market
    - A list of Certified agents with public profiles
- A link to the Georgia Access consumer portal
- Specifics on participating CACs and certified Navigators; includes relevant contact information
- How to submit consumer QHP applications online, by phone, in-person, or paper
- Process to file a Georgia Access eligibility appeal or exemption
- Available consumer support
- Requirements for QLEs and SEPs
- Frequently asked questions
- Content in English and Spanish
- How to obtain language translation services beyond English and Spanish
- How to obtain accessibility services
- Referrals and links to enrollment platforms Medicaid and PeachCare for Kids®
- Behavioral health insurance options
- Disclaimers on subjects like anti-discrimination and privacy and security

3.1.6.1 Federally Required Information

ASSOCIATED FEDERAL REFERENCE: 45 CFR 155.205(B); 45 CFR 158; 45 CFR 155.1040; 45 CFR 156; 42 CFR 50; 45 CFR 155.220

All certified Georgia Access enrollment options and the Georgia Access consumer portal are required to maintain federal and state standards for providing standardized comparative information on available QHPs to consumers. Specific information provided includes, but is not limited to:

- Premium and cost-sharing options
- Summary of benefits and coverage established under Section 2715 of the Public Health Service Act
- Identification of whether the QHP is a bronze, silver, gold, or platinum level plan as defined by Section 1302(d) of the Affordable Care Act, or a Catastrophic plan as defined by Section 1302(e) of the Affordable Care Act

- Results of the enrollee satisfaction survey, as described in Section 1311(c)(4) of the Affordable Care Act
- Quality ratings assigned in accordance with Section 1311(c)(3) of the Affordable Care Act
- Medical loss ratio information, as reported to HHS in accordance with 45 CFR 158
- Transparency of coverage measures reported to the Exchange during certification in accordance with 45 CFR 155.104

All Georgia Access enrollment options and the Georgia Access consumer portal provide consumers with the option to take the following actions:

- Check eligibility status for affordability programs and different plan metal tiers in Georgia Access
- Compare the cost of available QHPs; considers consumer eligibility for tax credits and cost sharing reductions
- Complete a consumer QHP application
- Select a QHP and start the enrollment process

3.1.7 Contact Center

The Georgia Access contact center operates a phone line to support consumers, Georgia Access EDE partners, certified agents, certified Navigators, certified CACs, and insurance companies, as well as a ticketing system to track and manage inquiry resolutions.

3.1.7.1 Georgia Access Contact Center Phone Line

The Georgia Access contact center manages the Georgia Access contact center phone line and associated Interactive Voice Response (IVR) system to route inquires to the appropriate contact center representatives or to transfer a consumer to the appropriate external resource. IVR support is provided in both English and Spanish. There are two phone numbers associated with Georgia Access one serving Georgia Access EDE partners, certified agents, certified Navigators, certified CACs, and insurance companies and the other serving consumers, as follows:

- Certified Georgia Access Enrollment Option Support Number: (888) 312-4237
- Consumer Support Number: (888) 687-1503

3.1.7.2 Georgia Access Contact Center Hours of Operation

The Georgia Access contact center hours of operation are posted publicly on the Georgia Access website.

3.1.7.3 Contact Center Mailing Address

The Georgia Access contact center vendor manages a PO Box for all documentation consumers mail to Georgia Access. Consumers may send paper copies of documentation to the contact center including their paper application, appeals form, exemptions form, and DMI/SVI documentation. The mailing address is as follows:

Georgia Access Contact Center
PO Box 12264
Birmingham, AL 35202

3.2 Notices

3.2.1 Consumer Notices

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.230

Consumer notices are correspondences between Georgia Access and consumers relating to eligibility and enrollment.

3.2.2 Notice Delivery

All consumer notices are generated by the Georgia Access eligibility system, either automatically or manually by the Georgia Access contact center or Georgia Access staff.

Consumers can access notices via multiple methods, including by mail, the Georgia Access consumer portal, or via their EDE partner portal. Consumers select their notice preference for either electronic or paper notices within the consumer application. The default notice preference within the application is electronic and can be updated through the Georgia Access consumer portal or EDE application at any time by the consumer.

3.2.3 Notice Accessibility Options

Consumers may request a different format of their notice by contacting the Georgia Access contact center or their affiliated EDE partner directly. Possible formats upon request include, but are not limited to, the following:

- Large print notices
- Braille notices
- Spanish translations

3.3 Accessibility and Language Services

3.3.1 Language Assistance

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.205(C); 45 CFR 92.101

Language assistance is available to consumers participating in Georgia Access. Information must be provided to applicants with limited English proficiency through the provision of language services at no cost to the individual.

3.3.1.1 Support Provided by Georgia Access EDE Partners and the Georgia Access Consumer Portal

Georgia Access EDE partners (web brokers and insurance companies) and the Georgia Access consumer portal (through the Georgia Access contact center) are required to provide language services for website content and consumer QHP applications in both English and Spanish.

Oral and Written Translations

- Georgia Access EDE partners and the Georgia Access consumer portal (through the Georgia Access contact center) must provide a language translation services line in at least 150 languages at no cost to the consumer.
- Georgia Access EDE partners and the Georgia Access consumer portal (through the Georgia Access contact center) must provide written translations at no cost to consumers who are limited English proficient (LEP).

Tagline Requirement

- Georgia Access EDE partners, the Georgia Access consumer portal (through the Georgia Access contact center), and Georgia Access website must provide taglines on website content and documents critical for obtaining coverage indicating the availability of language access services.
- Georgia Access EDE partners, the Georgia Access consumer portal (through the Georgia Access contact center), and Georgia Access website must provide taglines in at least the top fifteen non-English languages spoken by Georgia's LEP population. The top fifteen non-English

languages are published in the *CMS Regulations and Guidance Language Access Guide for Exchanges, Qualified Health Plan (QHP) Issuers, and Web Brokers*[17].

3.3.1.2 Support Provided by the Georgia Access Contact Center

The Georgia Access contact center provides consumer support services through contact center representatives in both English and Spanish. Consumers who contact the Georgia Access contact center phone line have the option to continue in Spanish for IVR options or to reach a Spanish-speaking contact center representative. All other languages are supported by the Georgia Access contact center through the language translation services line.

If a Georgia Access EDE partner or certified agent cannot support a consumer's language request, they must escalate the request to the Georgia Access contact center for resolution. If a certified Navigator or certified CAC cannot support a consumer's language request, the certified Navigator or certified CAC can submit a ticket to the Georgia Access contact center for resolution.

If a consumer has requested language assistance in the past, the contact center representative updates the consumer's account to make note of the language needs in the future.

3.3.2 Accessibility Assistance

ASSOCIATED FEDERAL REGULATION: 45 CFR 155.205(C)

Georgia Access EDE partners and the Georgia Access contact center provide accessibility services to consumers with accessibility needs. Information must be provided to applicants and enrollees in plain language and in a manner that is accessible and timely to individuals living with disabilities.

3.3.2.1 Support Provided by Georgia Access EDE Partners and the Georgia Access Consumer Portal

Georgia Access EDE partners and the Georgia Access consumer portal (through the Georgia Access contact center) are required to provide accessibility support for consumers. These include:

- Providing a teletypewriter (TTY) line or informing consumers to dial 711
- Providing support to read notices
- Providing large print notices
- Providing additional accessibility support services

If a Georgia Access EDE partner or certified agent is unable to provide the requested support, they must escalate the consumer accessibility request to the Georgia Access contact center for resolution. If a certified Navigator or certified CAC cannot support a consumer's accessibility request, the certified Navigator or certified CAC can submit a ticket to the Georgia Access contact center for resolution.

3.3.2.2 Support Provided by the Georgia Access Contact Center

The Georgia Access contact center reviews and provides accessibility support to escalated cases, provided that the request does not cause undue burden to the State.[18]

If a ticket requires support beyond that of a contact center representative, Georgia Access staff coordinates with the Georgia Access contact center representative and external vendors to ensure accessibility assistance is provided. This escalated assistance may include the following:

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[17] *See –Non-English Languages by State | cms.gov for more information.*

[18] *See Undue Burden General Exception | section508.gov for more information.*

- Providing braille translations as needed
- Providing video relay
- Providing cued speech and tactile interpreters

3.3.3 Complaints

Consumers may file complaints about Georgia Access, Georgia Access EDE partners, certified agents, or insurance companies with the Georgia Access contact center. It is important that consumers are able to file complaints in an accessible way.

3.3.3.1 Georgia Access Complaint

Consumers may file a complaint to Georgia Access for the following reasons:

- Not eligible for APTCs or CSRs
- Eligible for APTC, but the amount is wrong
- Not eligible for a SEP
- Not eligible for a QHP or SADP
- Cancellation or termination of a plan by Georgia Access
- Denial to change the enrollment coverage end date or effective date
- Denial of coverage reinstatement request
- 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)
- Eligibility determination and noticing was not timely
- Georgia Access general complaint

To file a complaint, visit the Georgia Access website or call the Georgia Access contact center during hours of operation. Consumers with a Georgia Access account can login and submit a complaint ticket at any time.

3.3.3.2 OCI Consumer Services Division Complaint

Consumers may file a complaint to the OCI Consumer Services Division for the following reasons:

- Insurance claim processing
- Discrimination
- Suspected law violation

To file a complaint, visit OCI Consumer Services or call the OCI Consumer Services Hotline during hours of operation.

3.3.3.3 OCI Criminal Investigations Division Complaint

Consumers may file a complaint to the OCI Criminal Investigation Division for suspected fraud. Examples of suspected fraud committed by insurance companies or agents can include but are not limited to:

- Using illegal incentives in health insurance marketing
- Lying about the details of a health insurance plan
- Signing up consumers who have not consented

To file a complaint, visit OCI Criminal Investigation Division or call the Fraud Tip Line during hours of operation. Consumers should prepare documentation which supports their insurance fraud allegation.

4 Tax Reporting Policies

4.1 Form 1095 A

Starting Plan Year 2025 Georgia Access will provide annual 1095-A tax statements to all consumers enrolled in QHPs following the year of coverage. 1095-A forms are sent to consumers by Georgia Access via their selected delivery preference. Consumers enrolled in catastrophic or dental-only plans do not receive a 1095-A. If electronic delivery has been selected, consumers can log into the Georgia Access portal and access an electronic copy in their secured inbox. If the consumer selected postal mail, then the consumer will receive the form by January 31st. If the consumer is using one of the EDE platforms, access instructions for your EDE account may differ so you should contact the EDE partner directly to request information on how to obtain Form 1095A.

[19] *See About Form 1095-A, Health Insurance Marketplace Statement | irs.gov for more information.*