Accessibility to Care

4 of 33 Family of five hugging and smiling

The health care law makes care accessible to everyone by:

Creating the Health Insurance Marketplaces, through which individuals who do not have access to government-sponsored coverage or affordable employer-sponsored coverage may compare and purchase plans (Some individuals are eligible for financial assistance through the advance payments of the premium tax credit and/or cost-sharing reductions)

Expanding Medicaid to cover individuals under age 65 whose household incomes are at or below 138% of the federal poverty level (FPL)

Requiring individuals to maintain minimum essential coverage, qualify for an exemption from coverage, or make a payment when filing their federal income tax returns

Minimum Essential Coverage

5 of 33 Young adult patient in hospital

As of January 1, 2014, individuals not eligible for an exemption are required to demonstrate that they maintain minimum essential coverage or make a payment, called the “individual shared responsibility payment,” when filing their federal income tax returns. Minimum essential coverage is the type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. The following types of health insurance coverage meet the individual responsibility requirement:

Coverage purchased in the individual market including the Federally-facilitated Marketplace;

Government sponsored coverage, such as Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and TRICARE (the Department of Defense heath care program); and

Coverage under an employer-sponsored plan.

Individuals who are ineligible for an exemption and do not have coverage (or the applicable taxpayers who claim such individuals as tax dependents) are required to make an individual shared responsibility payment.

2015: The annual individual shared responsibility payment is the greater of

2% of the taxpayer’s household income that is above the tax return filing threshold for the taxpayer’s filing status, or

The taxpayer’s flat dollar amount, which is $325 per adult and $162.50 per child, limited to a family maximum of $975.

However the total payment amount is capped at the cost of the national average annual premium for a Bronze level health plan available through the Marketplace in 2015.

2016: The annual individual shared responsibility payment is the greater of

2.5% of the taxpayer’s household income that is above the tax return filing threshold for the taxpayer’s filing status, or

The taxpayer’s flat dollar amount, which is $695 per adult and $347.50 per child, limited to a family maximum of $2,085.

However the total payment amount is capped at the cost of the national average annual premium for a Bronze level health plan available through the Marketplace in 2016.

How to Make an Individual Shared Responsibility Payment

7 of 33 Screenshot of “Shared Responsibility Payment Worksheet” from Form 8965 Instructions page 5. There is a footnote to the graphic that reads: Note that the 2015 Form 8965 has not been released as of the date of publication of this training, but will be available in January 2016 on the IRS website.

If you have a client that has to make an individual shared responsibility payment with his or her federal income tax return, your client can use the worksheets located in the instructions to Form 8965, Health Coverage Exemptions, to calculate the amount due.

Your client should then report the amount due on the appropriate line in the Other Taxes section of Form 1040 for the applicable tax year, or on the corresponding lines on Form 1040A or 1040EZ.

Remember, consumers must make a payment only for the month(s) they (or their spouse or dependents) did not have health insurance coverage or qualify for a coverage exemption.

Agents and brokers should refrain from providing tax advice unless they have the requisite expertise and/or are authorized to provide tax advice by a relevant government authority.

Note: The 2015 Form 8965 has not been released as of the date of publication of this training, but will be available in January 2016 on the IRS website.

Young Adult Coverage

11 of 33 Group of young adults. Icons from the AOI earlier in the module are in a row above the image. The 1st icon from the left of a plus sign is highlighted while the others are grayed out.

Under the Affordable Care Act, health plans that cover children as dependents must make dependent coverage available to children up to age 26. These young adults can join or remain on a parent’s plan even if they are:

Married (coverage does not extend to married child’s spouse)

Not living with a parent

Not attending school

Not financially dependent on a parent

Eligible to enroll in their own employer’s plan

Guaranteed Issue and Guaranteed Renewability

12 of 33 Top image is a row of icons with the clipboard icon highlighted and the rest grayed out; bottom image is the phrase Guaranteed Issue around a green check mark

The Affordable Care Act generally requires health insurance issuers to offer all of their individual market and group market plans to any applicant in the state. It also requires health insurance issuers to accept any employer and individual who applies for those policies. This provision is called “guaranteed issue.”

Coverage offered through and outside the Marketplace may restrict guaranteed issue coverage to certain enrollment periods.

Additionally, the Affordable Care Act generally requires health insurance issuers to offer to renew or continue in force coverage at the option of the policyholder. This is called “guaranteed renewability.”

Coverage of Pre-existing Health Conditions Regardless of Health Status

15 of 33

Effective for plan years beginning on or after January 1, 2014, the Affordable Care Act generally prohibits group health plans and health insurance issuers from limiting or excluding coverage related to pre-existing health conditions, regardless of the age of the covered individual.

Generally, a pre-existing condition is any health condition or illness that was present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended.

Nondiscrimination Regarding Clinical Trial Participation

16 of 33 Top image is a row of icons with the test tube icon highlighted and the rest grayed out; Bottom image is a person working in a medical lab with test tubes

The Affordable Care Act prohibits group health plans and health insurance issuers from:

Precluding participation of qualified individuals in an approved clinical trial

Denying, limiting, or placing additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in an approved clinical trial

Discriminating against qualified individuals on the basis of their participation in an approved clinical trial

Medical Loss Ratio

17 of 33 Top image is a row of icons with the medical bag icon highlighted and the rest grayed out; Bottom image is a chart titled, Health Insurance Issuer Spending of Premiums for Small Group and Individual Policies. Three dimensional pie chart with two parts (labeled 80% and 20%). Text associated with 80% piece is: Minimum Spent on Health Care and Quality Improvement. Text associated with 20% piece is: Maximum Spent on Administrative Costs.

The Affordable Care Act helps keep costs down by limiting the proportion of premiums that a health insurance issuer can spend on things other than providing health insurance coverage and improving the quality of the health care of its enrollees.

MLR is a basic financial measurement that shows how much of the premium dollars a health insurance issuer spends on health care expenses, as opposed to profits or administrative costs. A health insurance issuer that does not spend enough of its premium dollars on health care services or quality improvement activities must provide rebates to insured individuals or policyholders.

In general, if a health insurance issuer uses an average of 80 cents out of every premium dollar to pay customers’ medical claims and to conduct activities that improve the quality of care, the company has an MLR of 80 percent. MLR is not calculated at the individual policy level but at the state level for each issuer and separately for the small group, large group, and individual markets.

An MLR of 80 percent indicates that the health insurance issuer is using the remaining 20 cents of each premium dollar for profits and administrative costs, including salaries and other expenses. A health insurance issuer is generally required to spend at least 80 percent of premium dollars on medical care.

The Affordable Care Act sets minimum MLR standards for different markets, as do some state laws (which can only require a higher MLR standard).

Catastrophic Plans

23 of 33 Icons from the AOI earlier in the module are in a row above the image. The 6th icon from the left of a heart is highlighted and the rest grayed out. A red caduceus symbol appears within a black circle

In addition to the level of coverage plans, issuers in the individual market can offer catastrophic plans. Eligibility for catastrophic plans is limited to:

Individuals under age 30 before the plan year begins

Individuals who have a certification from the Marketplace that they are exempt from the individual responsibility requirement because they do not have an affordable coverage option, or because they qualify for a hardship exemption

Catastrophic plans count as minimum essential coverage.

There is no specific AV for catastrophic plans. Catastrophic plans have specific cost-sharing requirements related to the deductible limit that do not apply to level of coverage plans. Nevertheless, catastrophic plans have several benefits:

Offer lower premiums on average than Bronze, Silver, Gold, or Platinum plans

Cover at least three primary care visits before reaching the deductible

Cover recommended preventative services without cost-sharing

Protect enrollees with a deductible and maximum out-of-pocket cost limit (the limit changes annually; for 2016, the maximum out-of-pocket cost limit is $6,850 for an individual and $13,700 for a family)

Out-of-Pocket Cost Limits

27 of 33 Top image is a row of icons with the vector heart beat icon highlighted and the rest grayed out; Bottom image is a compiled image consisting of six images laid out in a block format; two columns and three rows. The top two images are of an emergency vehicle and a male patient lying on a therapist's couch. The middle two images are of an emergency room sign and prescription drug bottles. The bottom two images are of a hospital building and a child being examined by a doctor with a stethoscope.

Generally, all non-grandfathered health plans must limit cost sharing for enrolled individuals in the following ways:

Deductibles, coinsurance, and copayments cannot be applied to certain recommended preventive services.

Annual cost-sharing limits cannot exceed the limits for certain high deductible health plans. (For 2016, the limits are $6,850 for an individual and $13,700 for families enrolled in individual market plans.)

No annual or lifetime dollar limits are allowed on EHB.

Module Summary

32 of 33 Standard summary graphic with three overlapping images used throughout this topic

The key points from this module are:

Individuals must maintain minimum essential coverage, qualify for an exemption from coverage, or make an individual shared responsibility payment when filing their federal income tax returns.

Health insurance issuers must:

Offer all of their group and individual market policies to any eligible individual in the state (This reform is called "guaranteed issue”);

Not limit or exclude coverage related to pre-existing health conditions, regardless of the age of the covered individual;

Spend the required percentage of premium dollars on medical care or provide a rebate to the insured individuals or policyholders; and

Offer health insurance plans that cover benefits in at least ten categories (called EHB).

There are four levels of coverage for health plans: Bronze, Silver, Gold, and Platinum. Each of these levels is based on an average measure of plan generosity (AV).

In addition to the level of coverage plans, issuers in the individual market can offer catastrophic plans to individuals under age 30 before the plan year begins and to individuals who have a certification from the Marketplace that they are exempt from the individual responsibility requirement because they do not have an affordable coverage option, or because they qualify for a hardship exemption.

All health plans must limit cost sharing and out-of-pocket costs.

Rates can vary by age, family composition, geographic area, and tobacco use.

----------

The Health Insurance Marketplaces

4 of 24 A young man and woman seated at a desk and pointing to a piece of paper

Each state and the District of Columbia has a Health Insurance Marketplace where individuals and small businesses may compare and purchase health insurance.

There are two types of Marketplaces:

The Individual Marketplace for individual consumers and their families

The Small Business Health Options Program (SHOP) Marketplace for small business owners and their employees

This overview module has been designed to provide agents and brokers who choose to operate in the Federally-facilitated Marketplace with familiarity of the basic topics in both types of Marketplace. This will help you understand and answer questions consumers may have about either type of Marketplace.

Likewise, agents and brokers operating in an Individual Marketplace may get questions from consumers about a SHOP Marketplace and whether it applies to them or their family members. This overview module will help you understand the consumers' questions and better serve consumers.

State-Based and Federally-facilitated Marketplaces

5 of 24 Top image is a family of three shopping for groceries; bottom image is a business owner holding an

A Marketplace can be operated primarily by a state or by the federal government. Some states have established their own Marketplaces, known as State-based Marketplaces. If a state chose not to establish its own Marketplace, the Department of Health & Human Services (HHS) has established a Federally-facilitated Marketplace in that state. Some states with a Federally-facilitated Marketplace perform some of the Marketplace functions in partnership with the federal government. These are called State Partnership Marketplaces. Some states may also choose to operate a State-based SHOP Marketplace with a Federally-facilitated Individual Marketplace. These are referred to as SHOP-only State-based Marketplaces.

Qualified Health Plans

7 of 24 An image of a man's hand drawing the connections between elements of health care plans on a white board. The connections are, from top to bottom: Hospitals, Providers, Uninsured, Social Programs, Insurance, Prescription Drugs, Medical Research, and Healthcare Costs.

The Marketplaces offer only health insurance plans that are certified as qualified health plans, or QHPs. These QHPs must be licensed and meet certain transparency requirements. To become certified, a QHP must meet a minimum set of criteria, including:

Coverage, at a minimum, of a comprehensive package of benefits, known as essential health benefits (EHB)

Benefit design standards, including non-discrimination requirements and limits on cost-sharing

Network adequacy standards

Each issuer seeking to offer a QHP through a Marketplace must offer a Silver level and a Gold level QHP in the Marketplace.

For QHP certification, a plan must have an adequate provider network available to its enrollees. A QHP must:

Offer a network with a sufficient number of providers, including mental health and substance abuse providers, to ensure access to all services without unreasonable delay

Include a sufficient number and geographic distribution of essential community providers to ensure reasonable and timely access to a broad range of such providers for low-income and medically underserved populations in the QHP’s service area

Navigators, Non-Navigator Assistance Personnel, and Certified Application Counselors

14 of 24 An older couple seated across a desk from a business woman who is pointing to a piece of paper

In addition to licensed agents and brokers, there are three types of assisters that operate within the Federally-facilitated Marketplace: Navigators, non-Navigator assistance personnel, and certified application counselors. Select each link below to learn more.

Navigators

Non-Navigator assistance personnel

Certified Application Counselors (CACs)

Navigators and non-Navigator assistance personnel in the Federally-facilitated Marketplace are required to disclose to consumers certain relationships they have with health insurance and stop-loss insurance issuers. CACs are required to disclose to consumers any potential conflicts of interest, including any relationships with issuers of QHPs or insurance affordability programs. Further, all of these Federally-facilitated Marketplace assisters are required to provide information in a fair, accurate, and impartial manner. They must also inform consumers about all of the QHPs and insurance affordability programs for which they are eligible. They may not receive compensation directly or indirectly from any health insurance issuer or issuer of stop loss insurance in connection with the enrollment of any individuals or employees in a QHP or non-QHP.

Navigators receive grants from the Federally-facilitated Marketplace to, among other things, assist consumers in applying for eligibility and enrolling in health coverage through the Federally-facilitated Marketplace. Navigators must also conduct public education activities to raise awareness about the Marketplace. Health insurance and stop loss insurance issuers and their subsidiaries are expressly prohibited from being Navigators.

Non-Navigator assistance personnel (also known as in-person assistance personnel) help consumers apply for eligibility and enroll in health coverage through the Marketplace, as well as assist with other issues related to health insurance. In the Federally-facilitated Marketplace, there are some federal contractors doing this work in some metro areas. In State-Partnership Marketplaces, Non-Navigator assistance personnel may be funded though federal grants known as “establishment grants,” targeted at establishing Health Insurance Marketplaces in states.

Certified application counselors are staff members and volunteers of organizations designated by the Federally-facilitated Marketplace, such as community health centers, health care providers and certain social service agencies. In the Federally-facilitated Marketplace, certified application counselors are certified directly by those designated organizations. Like Navigators and non-Navigator assistance personnel, certified application counselors perform Marketplace application and enrollment assistance but, in general, are not required to perform outreach or education or help consumers with other issues related to health insurance, though they may choose to do so. The Certified Application Counselor Program helps each Marketplace build on existing community infrastructure and relationships with target populations by expanding the number of organizations providing assistance to consumers.

Requirements for Navigator, Non-Navigator Assistance Personnel, and CAC ('Assister') Impartiality

15 of 24 A couple seated at desk with a business woman looking at a piece of paper

While assisters in the Federally-facilitated Marketplace cannot make specific plan recommendations to consumers, they may facilitate enrollment in a QHP by providing comprehensive information about the substantive benefits and features of a plan, clarifying the similarities and distinctions among plans, and assisting consumers with making informed decisions in the plan selection process, consistent with the consumer’s expressed interests and needs. If an assister is asked by a consumer to recommend a specific plan, an assister should remind the consumer that he or she is prohibited from making plan recommendations because Federal standards require assisters to remain fair and impartial.

However, in those circumstances where a consumer has requested a plan recommendation, the assister may, consistent with the consumer’s expressed needs and desires, determine that it is appropriate to inform the consumer of the general availability of agents and brokers who are state licensed and registered with the Federally-facilitated Marketplace, who can make specific plan recommendations (provided that agents and brokers are permitted to do so under state law). The assister may direct the consumer to general listings of agents and brokers or more specific listings, if those listings are created using objective sorting criteria, such as by geographic proximity. However, the assister should not make a referral to any specific agent or broker.

Reporting Fraudulent Activity

16 of 24 Dictionary entry of the word fraud, which is in bold print

As you provide assistance to clients seeking health coverage, you play an important role in observing and reporting any potentially fraudulent practices taking place in relation to the Health Insurance Marketplace. For example, a client may share information with you if individuals have contacted him or her seeking personal and financial information, or you may observe others’ behaviors that cause you to suspect a health care scam is taking place.

If you have concerns or specific complaints about potentially fraudulent practices in the Federally-facilitated Marketplace, report them to the HHS Office of Inspector General Hotline at 1-800-HHS-TIPS (1-800-447-8477) or via https://forms.oig.hhs.gov/hotlineoperations/. You may also report them to the Federal Trade Commission, the nation’s consumer protection agency. You should also report your concerns to the Federally-facilitated Marketplace Producer and Assister Help Desk via email at FFMProducer-AssisterHelpDesk@cms.hhs.gov.

Compensation in the Federally-facilitated Marketplace

17 of 24 Stack of money

The Federally-facilitated Marketplace does not directly appoint or compensate agents or brokers. To receive compensation for enrolling consumers in a QHP through the Federally-facilitated Marketplace, an agent or broker needs to be appointed with that QHP issuer in accordance with state law. To become appointed with a particular QHP issuer, we recommend that agents and brokers contact the QHP issuer directly, or contact their state regulators, such as the Department of Insurance (DOI).

Agents and brokers in the Federally-facilitated Marketplace are compensated in accordance with their agreements with QHP issuers and any applicable state-specific requirements. The Marketplace does not set compensation levels. To the extent permitted by a state, appointed agents and brokers receive compensation directly from QHP issuers for assisting qualified individuals in enrolling in QHPs through the Marketplace. An agent or broker’s National Producer Number (NPN) must be entered on a Federally-facilitated Marketplace application in order to receive compensation from QHP issuers with whom the agent or broker has an appointment for assisting a consumer with that application.

A QHP issuer must pay the same compensation for QHPs offered through a Federally-facilitated Marketplace as they do for similar health plans offered in the state but outside the Federally-facilitated Marketplace. In fact, this compensation approach is a required condition of the QHP certification process for QHPs offered in the Federally-facilitated Marketplace.

BasicsMonitoring Roles

20 of 24 Magnifying glass with data

Select each of the following links to learn about the three monitoring roles involved in the Marketplace.

State Role

All agents and brokers — including web-brokers — seeking to enroll individuals through the Federally-facilitated Marketplace must be appropriately licensed by the applicable state and adhere to all applicable state laws. States maintain their current roles overseeing licensing, marketing, and enforcement standards for the agents and brokers in their insurance markets.

QHP Issuer / Web-broker RoleCLOSE

Similar to the private insurance market, QHP issuers and web-brokers operating in the Federally-facilitated Marketplace are responsible for ensuring their affiliated agents and brokers comply with all applicable standards. QHP issuers and web-brokers must verify that their affiliated agents and brokers have a valid state license to sell health insurance products. Agents and brokers are required to provide their affiliated QHP issuers with a copy of their Federally- facilitated Marketplace training curriculum certificates, and QHP issuers may ask agents and brokers for their Federally-facilitated Marketplace user ID. It is very important that you keep your curriculum certificate and remember your Federally-facilitated Marketplace user ID for this reason. Agents and brokers must also comply with any policies of the QHP issuers and web-brokers with which they are affiliated, and must adhere to the federal privacy and security standards (which are discussed in the “Privacy Standards and Definitions” and “Protecting and Handling PII” modules included in this curriculum), and other applicable federal regulatory requirements.

Agents and brokers must enter into the applicable Federally-facilitated Marketplace Agreements. In these Agreements, agents and brokers consent to comply with the Marketplace’s privacy and security standards. CMS works with the state regulators to coordinate oversight activities related to agents and brokers. CMS also provides to each state a list of the agents and brokers who have successfully registered with the Federally-facilitated Marketplace in that state.

Why do Culturally and Linguistically Appropriate Services (CLAS) Matter?

22 of 24

The HHS Office of Minority Health has developed the National Culturally and Linguistically Appropriate Services in Health and Health Care, more commonly referred to as the National CLAS standards. When working with consumers, agents and brokers are encouraged to take CLAS into consideration to make education, enrollment, and outreach efforts more effective. CLAS enables you to communicate better and build the trusting relationships necessary to work successfully with individuals, employers and employees. The following are the CLAS Standards intended to advance health equity, improve quality and help eliminate health care disparities. Select each item to read more.

CLAS Standard 1:

Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Governance, Leadership and WorkforceCLOSE

CLAS Standard 2:

Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.

CLAS Standard 3:

Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.

CLAS Standard 4:

Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

CLAS Standard 5:

Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

CLAS Standard 6:

Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

CLAS Standard 7:

Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

CLAS Standard 8:

Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement and AccountabilityCLOSE

CLAS Standard 9:

Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organizations’ planning and operations.

CLAS Standard 10:

Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.

CLAS Standard 11:

Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

CLAS Standard 12:

Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

CLAS Standard 13:

Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.

CLAS Standard 14:

Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.

CLAS Standard 15:

Communicate the organization’s progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.2

Module Summary

23 of 24 Standard summary graphic with three overlapping images used throughout this topic

The key points from this module are:

Each state and the District of Columbia has a Health Insurance Marketplace where qualified individuals, qualified employers, and qualified employees may purchase insurance.

QHPs must be licensed and meet certain transparency requirements. To become certified, a QHP must meet a minimum set of criteria, including coverage of the EHB, benefit design standards, and network adequacy standards.

Other types of plans may be offered through the Marketplace, including CO-OP plans, Multi-state Plans, and stand-alone dental plans.

People that enroll in federal health care programs outside of the Marketplace generally have minimum essential coverage and do not need to obtain additional coverage through the Marketplace in order to comply with the requirement to maintain minimum essential coverage.

Agents and brokers can assist individuals, employers, and employees with enrollment in QHPs in the Federally-facilitated Marketplace.

Web-brokers can assist consumers in the Individual Marketplace to select and enroll in a QHP through the web-brokers’ own website.

Agents and brokers in the Federally-facilitated Marketplace are compensated in accordance with their agreements with QHP issuers and any state-specific requirements. The Federally-facilitated Marketplace does not set compensation levels.

All agents and brokers — including web-brokers — seeking to enroll individuals through the Federally-facilitated Marketplace must be licensed by the applicable state and adhere to all applicable state laws.

HHS may terminate an agent's, broker's, or web-broker's Federally-facilitated Marketplace Agreement(s) for cause if HHS determines that a specific finding of noncompliance or a pattern of noncompliance is sufficiently severe between the agent, broker, or web-broker and CMS.

---------------------------------------

Introduction

3 of 18 Computer data with the word Confidential superimposed on top

In helping consumers obtain eligibility determinations, compare plans, and enroll in qualified health plans (QHPs) through the Federally-facilitated Marketplace (FFM), agents and brokers who are registered with the FFM may gain access to personally identifiable information (PII).

Consumers are defined to include applicants, qualified individuals, enrollees, qualified employees, qualified employers, or these individuals’ legal representatives or authorized representatives.

Obtaining PII obligates anyone with access to it to ensure that the information remains private and secure. These obligations are defined within both federal and state law.

In this module, you will learn basic information on specific privacy rules for the Federally-facilitated Marketplace and how those rules apply to agents and brokers.

Module Objectives

4 of 18 A padlock with a key inserted

Upon completion of this module, you should be able to:

Describe the difference between privacy, security, and confidentiality

Define PII

Explain the “Agreement Between Agent or Broker and the Centers for Medicare & Medicaid Services (CMS) for the Federally-facilitated Exchange Individual Market” and the “Agreement Between Agents and Brokers and the CMS for the Federally-facilitated Exchange Small Business Health Options Program (SHOP)”

Explain how individuals may access their PII

Describe the requirements regarding the Privacy Notice Statement

Describe the authorized functions for which an agent or broker may create, collect, disclose, access, maintain, store and use PII in the Federally-facilitated Marketplace

Understand the requirement to obtain a consumer's informed consent for any use or disclosure outside of the authorized functions

--

Privacy vs. Security

5 of 18 Business man selecting a security app icon that is floating in the air before him

How are privacy and security defined?

Privacy is an individual’s right to control the use or disclosure of personal information. An example of this is setting the privacy settings on a Facebook account so that only certain people may view, comment, or post on your Facebook page.

Confidentiality is preserving authorized restrictions on information access and disclosure, including means for protecting personal privacy and proprietary information.

Security refers to the mechanisms in place to protect the confidentiality and privacy of personal information. An example of this is the microchip embedded into a charge or debit card.

Both privacy and security are operationally achieved through a blended approach of developing and implementing effective policies and procedures and applying proper controls. Privacy and security go hand-in-hand to protect PII.