CMS Coverage Options

Indian Health Service Partnership Conference

August 2024

TRIBAL AFFAIRS

Discussion Points

I. Medicaid

II. Marketplace

III. Medicare

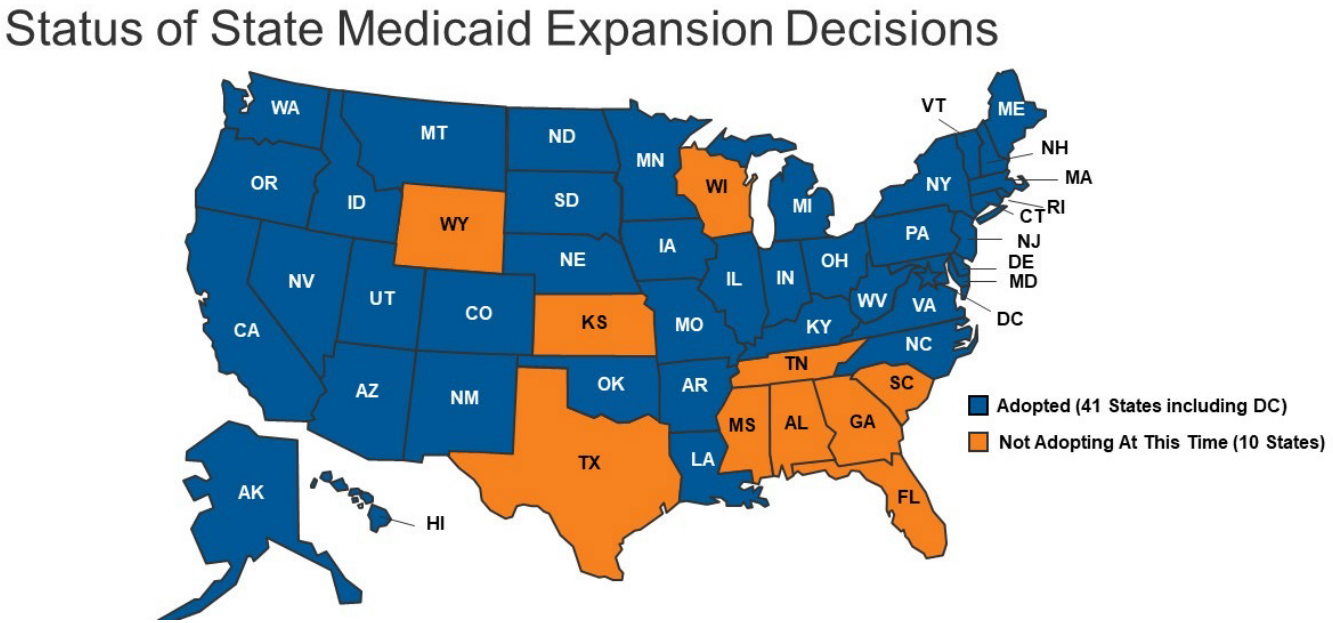
I. Medicaid

- Medicaid established in 1965 as a jointly funded State-Federal partnership
- Each State administers its own program of mandatory and optional services
- Provides coverage for low-income populations.
- Generally, Medicaid eligibility covers the following groups:
  - Children
  - Pregnant Women
  - Families
  - Individuals with Disabilities
  - Elderly needing long term support services
  - Medicaid Expansion population: Childless Adults ages 19-64

What is Medicaid Expansion?

- Prior to ACA, Medicaid was generally not available to non-disabled adults under age 65 unless they had dependent minor children.
- States now have the option to extend Medicaid coverage to low-income adults (ages 19 to 64) with incomes up to 138% of the FPL
- States decide when to expand and there is no deadline for state decision

Medicaid Expansion in 2024:
41 States Including the District of Columbia



NOTES: Current status for each state is based on KFF tracking and analysis of state activity. See link below for additional state-specific notes.
SOURCE: "Status of State Medicaid Expansion Decisions," https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

Medicaid Expansion – Data

- Nearly 5 million nonelderly individuals self-identify as American Indian or Alaska Native (AIAN) alone or in combination with some other race.
- Medicaid provides coverage to more than one in four (27%) nonelderly AIAN adults and half of AIAN children.
- The uninsured rate for nonelderly AIANs in states that implemented the Medicaid expansion fell by almost 4X as much (from 31% in 2013 to 20% in 2017) as the rate in non-expansion states (from 29% to 26%).

Medicaid Expansion – Enhancements

- Medicaid expansion will provide increased Medicaid revenues for IHS and tribal-run facilities.
- Purchased/Referred Care (PRC) programs have historically been limited to ONLY emergency services.

Medicaid and CHIP: AI/AN Cost Sharing Protections

AI/ANs have the following Medicaid and CHIP protections:

- Do not have to pay premiums or enrollment fees
- No cost sharing for AI/ANs enrolled in CHIP.
- No cost sharing in Medicaid if the beneficiary has ever used an Indian health care provider, or received services through Purchased/Referred Care.

Medicaid and CHIP: Indian Trust Income and Resource Protections

Certain types of Indian income and resources are not counted when determining Medicaid or CHIP eligibility:

- Per capita payments from a Tribe that come from natural resources, usage rights, leases, or royalties.
- Payments from natural resources, farming, ranching, fishing, leases, or profits from Indian trust land (including reservations and former reservations).
- Money from selling things that have Tribal cultural significance, such as Indian jewelry or beadwork.

Medicaid: AI/AN Estate Recovery Protections

Types of property exempt from Medicaid estate recovery action:

- Property located on a reservation or within the most recent boundaries of a reservation including:
  - Real property and improvements
  - Ownership interest in:
    - Rents
    - Leases
    - Royalties
    - Usage rights
- For use of:
  - Natural resources
  - Fish/shellfish
  - Harvesting animals
  - Harvesting plants or timber

Medicaid: AI/AN Estate Recovery Protections

- Items with religious, spiritual, traditional or cultural significance or used to support subsistence or a traditional lifestyle according to tribal law or custom.

- Ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights in listed properties, as long as they can be clearly identified as such.

Resuming Normal Eligibility and Enrollment Operations

- **Beginning April 2023, states began normal operations,** including **restarting** full Medicaid and CHIP eligibility renewals and **ending coverage for individuals no longer eligible for Medicaid/CHIP –** a process known as "unwinding."

- States will need to **address a significant volume of pending renewals** and other actions. This is likely to **place a heavy burden** on the state workforce and existing processes and **increase the risk** that individuals lose health coverage.

- According to some estimates, **over 15 million people could lose their current Medicaid or CHIP coverage** during the renewal process.[1] Many people will then be **eligible for coverage through the Marketplace® or other health coverage** and need to transition.

- The Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) are **working closely with states now** to ensure that they are ready when unwinding begins; **eligible enrollees retain coverage** by renewing their Medicaid or CHIP; and **enrollees eligible for other sources of coverage,** including through the Marketplace, smoothly transition.

[1]Available at: https://www.urban.org/research/publication/what-will-happen-medicaid-enrollees-health-coverage-after-public-health-emergency

Reminder: Steps to Take if You Get a Renewal Form From Your State

1. **Read the entire letter!**

2. **Complete your renewal form and send it back**– Fill out the form and return it to your state Medicaid or CHIP program right away to avoid a gap in your Medicaid or CHIP coverage. Include all requested information and supporting documents.

   If you're a parent who is no longer eligible for Medicaid, your child may still be eligible for Medicaid or CHIP. It's important to **always** return the renewal form so your state can determine if you or anyone in your family qualifies for coverage.

3. **Look for follow-up information from your state about your coverage** – State Medicaid and CHIP offices will review information and tell you if your coverage has been renewed. If you're no longer eligible, they'll tell you the date coverage will end.

Steps to Take if You've Lost Medicaid or CHIP Coverage

1. **Review the notice from your state to see why you lost Medicaid or CHIP coverage**
   - If the state ended your coverage because they didn't have the necessary information to complete your renewal, you can contact your state to provide the missing information. Find your state's contact information at Medicaid.gov/renewals.
   - If the state ended your coverage because they determined you're no longer eligible, you'll need to find another option for health coverage.
2. **Appeal the decision or re-apply for Medicaid or CHIP**
   - If you think you're still eligible for Medicaid or CHIP and the state wrongly ended your coverage, you can ask the state for a second review and appeal the decision.
   - If there is a change in your situation (like a change in income), you can reapply for Medicaid or CHIP at any time. Visit Medicaid.gov to find out how you can contact your state to re-apply.

Steps to Take if You've Lost Medicaid or CHIP Coverage (continued)

3. **Look at other health coverage options and find the one that is best for you**
   - **The Health Insurance Marketplace** – HealthCare.gov
     - Most people can find a plan for $10 or less per month with financial help.
     - People can qualify for savings on a health plan that lowers the monthly cost.
     - All plans cover doctor visits, prescription drugs, emergency care, and more.
     - You may qualify for a Special Enrollment Period (SEP)
   - **Medicare** – Medicare.gov
     - You may qualify for an SEP to enroll in Medicare without paying a penalty if you missed your initial enrollment period.
   - **Employer-sponsored coverage** – check with your employer
     - You can enroll in an employer plan outside of open enrollment if you recently lost Medicaid or CHIP.

II. Marketplace

- The Health Insurance Marketplace® provides health plan shopping and enrollment services for individuals and families (the individual market), as well as employees of small businesses [the Small Business Health Operations Program (SHOP)] through websites, call centers, and in-person assistance.

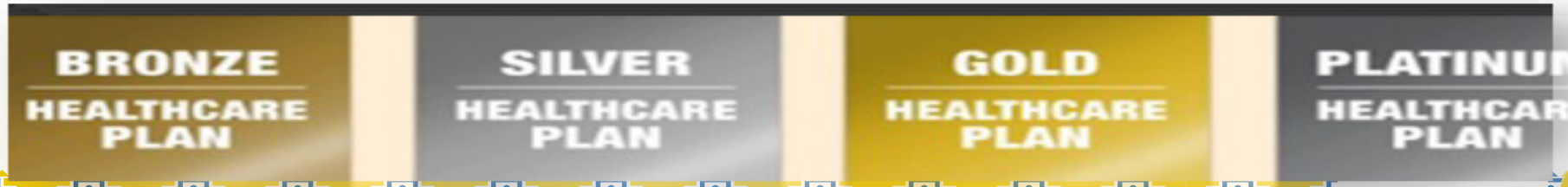
- The Marketplace will determine eligibility for:
  - Coverage in Marketplace plans
  - Advance payments of the premium tax credit (APTC) toward monthly premiums
  - Cost-sharing reductions (CSRs) to lower what consumers pay for out-of-pocket costs, like deductibles, copayments, and coinsurance
  - Medicaid and the Children's Health Insurance Program (CHIP)

Operation of the Marketplaces

- A marketplace can be operated by a state or the Federal Government.
- There are key differences between Marketplace types including:
  1. State-based Marketplace (SBM)
  2. Federally-facilitated Marketplace (FFM)

Health Plan Categories

- Bronze level – a health plan that has an Actuarial Value (AV) of 60 percent (Consumers pay 40 percent of costs on average)
- Silver level – a health plan that has an AV of 70 percent (Consumers pay 30 percent on average)
- Gold level – a health plan that has an AV of 80 percent (Consumers pay 20 percent on average)
- Platinum level – a health plan that has an AV of 90 percent (Consumers pay 10 percent on average)



Who's Eligible for Coverage through the Marketplace

To be eligible for coverage through a Marketplace, individuals and households must:

1. Live in the United States (U.S.) in a state served by the Marketplace where they're applying;
2. Be U.S. citizens, U.S. nationals, or lawfully present immigrants for the entire time they plan to have coverage; and
3. Not be incarcerated (unless pending disposition of charges).

Affordability Program: Premium Tax Credits

- Consumers with certain household incomes who aren't eligible for other qualifying coverage, like through a job, Medicare, most Medicaid coverage, or CHIP, may be eligible for savings through the Marketplace.
- If consumers projected annual household income for the coverage year falls between 100 % and 400 % of the Federal Poverty Level (FPL), they may qualify for a premium tax credit (PTC). Per the Inflation Reduction Act, Congress waived the 400% FPL cap through 2025.

Note:

- PTCs are only available to consumers who enroll in an individual market Marketplace plan through the Marketplace.
- Eligible consumers can use all, some, or none of their PTCs in advance to lower their monthly premiums—these are called advance payments of the premium tax credit (APTC).

Cost-Sharing Reductions: Special Benefits for AI/AN Consumers

AI/AN consumers with income between 100 percent to 300 percent of the FPL can enroll in a “zero cost-sharing plan” through the Marketplace and have no out-of-pocket costs – like deductibles, copayments, and coinsurance – when they get care.

AI/AN consumers at any income level can enroll in a “limited cost-sharing plan” through the Marketplace. Under this plan, a referral **will be** required from an Indian health care provider to avoid out-of-pocket costs when they receive essential health benefits from a qualified health plan (QHP).

Limited and zero cost-sharing plans are available to AI/AN consumers in any plan (e.g. bronze, silver, etc.) category.

When to Enroll

- Eligible consumers can enroll in or change Marketplace plans during the annual Open Enrollment Period (OEP) or during a Special Enrollment Period (SEP).
  - Exception: Members of federally recognized Tribes can enroll in the Marketplace or change plans throughout the year, not just during the yearly OEP or during a SEP.
- In the FFM for individuals and families, the OEP starts on November 1 and ends on January 15 the following year.
- In the SHOP Marketplaces, eligible small employers determine their group's annual OEP (for themselves and their eligible employees/dependents).
  - Small employers can generally complete a group enrollment at any point throughout the year.

How to Apply

- **Consumers can apply for Marketplace coverage through**:
  1. HealthCare.gov (English) and CuidadoDeSalud.gov (Spanish)
  2. Directly through some Marketplace plan issuers
  3. The Marketplace Call Center
  4. Marketplace enrollment assisters
  5. Marketplace-registered agents and brokers, or web-broker sites
  6. Paper Application
- Language assistance is available through interpreters, Call Center support, print, and web resources:
  - Help is available to complete an application.
  - Job aids in 33 languages can be found at: Marketplace.CMS.gov/applications-and-forms/individuals-and-families-forms.html.

Marketplace Call Center

Marketplace Call Center:

- Assists consumers in FFMs and SPMs:
  - 1-800-318-2596 (TTY: 1-855-889-4325)
- Customer service representatives are available 24/7
- Help with eligibility, enrollment, and referrals
- Assistance in English and Spanish
- Oral interpretations in 240+ additional languages
- State Based Marketplaces have their own call centers

In-Person Assistance

- In-person assisters may provide face-to-face, one-on-one assistance to applicants and enrollees submitting Marketplace eligibility applications in their FFM service area.
- Marketplace-approved in-person help is available through several programs to help consumers with the process of applying for enrolling in health insurance coverage, including:
    1. Navigators
    2. Certified Application Counselors
    3. Agents and Brokers
- Consumers can use the Find Local Help tool (LocalHelp.HealthCare.gov) to search for a list of local people and organizations who can help them apply, pick a plan, and enroll in Marketplace coverage.

III. Medicare

Medicare provided health insurance for people:

- 65 and older
- Under 65 with certain disabilities, like ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease) without a waiting period
- Any age with End-Stage Renal Disease (ESRD)

NOTE: To get Medicare you must be a U.S. citizen or lawfully present in the U.S. Must reside in the U.S. for 5 continuous years.

Your Medicare Options

Original Medicare

☑ Part A

☑ Part B

You can add:

☐ Part D

You can also add:

☐ Supplemental coverage

This includes Medicare Supplement Insurance (Medigap). Or, you can use coverage from a former employer or union, or Medicaid.

Medicare Advantage (also known as Part C)

☑ Part A

☑ Part B

Most plans include:

☑ Part D

☑ Some extra benefits

Some plans also include:

☐ Lower out-of-pocket costs

Automatic Enrollment: Medicare Part A & Part B

Enrollment is automatic for people who get:

- Social Security Benefits
- RRB Benefits

Look for your "Get Ready for Medicare Package"

- Mailed 3 months before:
  - You turn 65
  - 25th month of disability benefits
- Includes your Medicare card

Some People Must Take Action to Enroll in Medicare

To apply for Medicare 3 months before you turn 65, contact Social Security at ssa.gov or 1-800-772-1213; TTY: 1-800-325-0778

If you retired from a railroad, contact your local Railroad Retirement Board at 1-877-772-5772; TTY: 1-312-751-4701

NOTE: The age for full Social Security retirement benefits is increasing. Medicare eligibility age is still 65.

When to Sign Up or Make Changes to Your Medicare Coverage

If you don't already have Medicare:

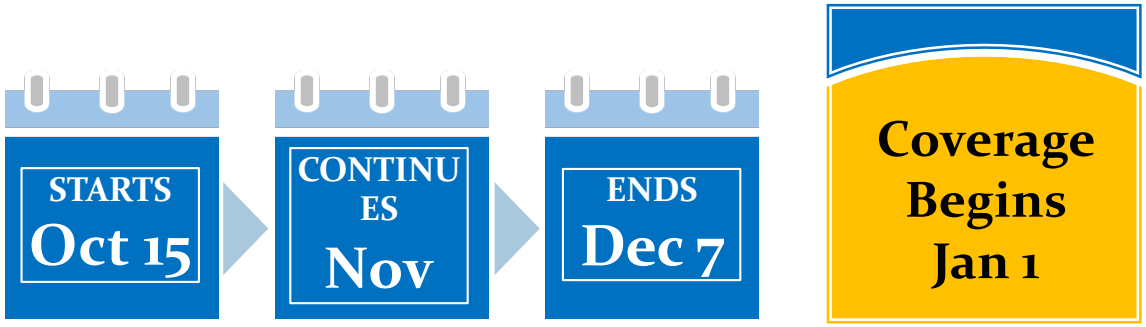
- Initial Enrollment Period (IEP)
- Special Enrollment Period (SEP) (in certain circumstances)
- General Enrollment Period (GEP)

If you already have Medicare and want to change how you get your coverage:

- Open Enrollment Period (OEP)
- Medicare Advantage OEP
- 5-Star Enrollment Period
- Special Enrollment Period (SEP) (in certain circumstances)

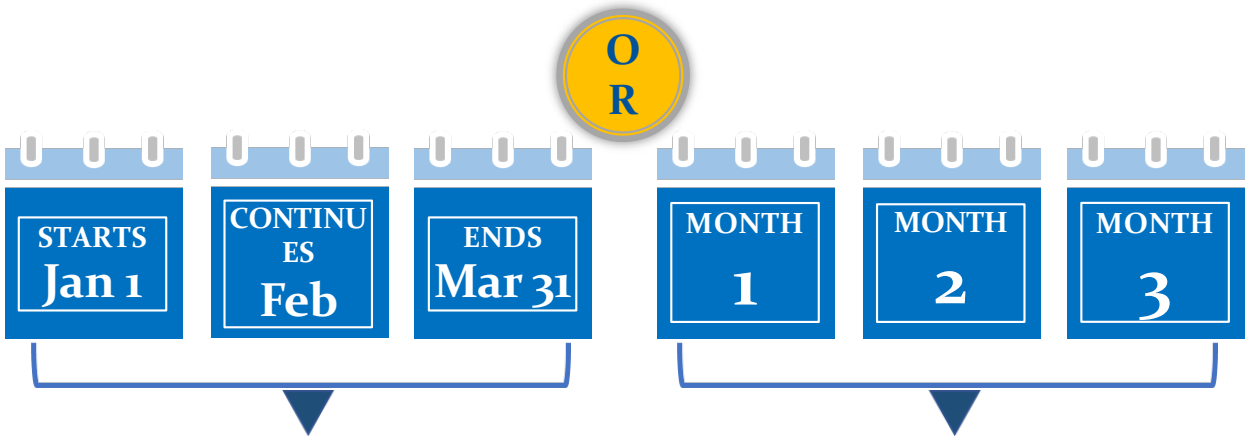
Yearly Open Enrollment Period (OEP) for People with Medicare

7-Week Period



- 7-week period each year where you can enroll in, disenroll, or switch Medicare Advantage Plans or Medicare drug plans
- This is a time to review health and drug plan choices

Medicare Advantage Open Enrollment Period



Annual
Medicare Advantage OEP
January 1—March 31

Newly Eligible
Medicare Advantage OEP
1st 3 months of entitlement to Medicare Part A and Part B

You can:

- Switch to another Medicare Advantage Plan, with or without drug coverage
- Drop your Medicare Advantage Plan and return to Original Medicare. If you do:
  - You can enroll in a Medicare drug plan
  - Coverage begins the 1st of the month after you enroll in the plan

NOTE: You need to be in a Medicare Advantage Plan to use this enrollment period.

Other Medicare Special Enrollment Periods (SEPs)

You may have an SEP if you:

Part A (Hospital Insurance) Covers

- **Inpatient care in a hospital, including:**
  - Semi-private room
  - Meals
  - General nursing
  - Drugs (including methadone to treat an opioid use disorder)
  - Other hospital services and supplies
- **Inpatient care in a skilled nursing facility (SNF)** after a related 3-day inpatient hospital stay

Part A
Hospital Insurance

Part A (Hospital Insurance) Covers (continued)

Part A helps cover:

- Blood (inpatient)
- Hospice care
- Home health care
- Inpatient care in a religious nonmedical health care institution (RNHCI)

Part A
Hospital Insurance

Paying for Part A 2023

Most people don’t pay a premium for Part A, but:

- If you or your spouse paid FICA taxes for at least 10 years, you get Part A without paying a **premium**
- You may have a **penalty** if you don’t enroll when first eligible for Part A (if you have to buy it)
  - Your monthly premium may go up 10%
  - You'll have to pay the higher premium for twice the number of years you could’ve had Part A, but didn’t sign up

Medicare Part B (Medical Insurance) Covers

- Doctors' services
- Outpatient medical and surgical services and supplies
- Clinical lab tests
- Durable medical equipment (DME) (like walkers and wheelchairs)
- Diabetic testing equipment and supplies
- Preventive services (like flu shots and a yearly wellness visit)
- Home health care
- Medically necessary outpatient physical and occupational therapy, and speech-language pathology services
- Outpatient mental health care services

What's Not Covered by Part A & Part B?

Some of the items and services that Part A and Part B don't cover include:

- Most dental care
- Vision (for prescription glasses)
- Dentures
- Cosmetic surgery
- Massage therapy
- Routine physical exams
- Hearing aids and exams for fitting them
- Long-term care
- Concierge care
- Covered items or services you get from an opt out doctor or other provider

They may be covered if you have other coverage, like Medicaid or a Medicare Advantage Plan that covers these services.

What You Pay in 2024: Part B Monthly Premiums

Standard premium is $174.70

Some people who get Social Security benefits pay less due to the statutory hold harmless provision

Your premium may be higher if you didn't choose Part B when you first became eligible or if your income exceeds a certain threshold

What You Pay in Original Medicare in 2024: Part B

Yearly Deductible	$240 in 2024
Coinsurance for Part B Services	▪ 20% for most covered services, like doctor's services and some preventive services, if provider accepts assignment ▪ $0 for most preventive services ▪ 20% for outpatient mental health services, and copayments for hospital outpatient services

NOTE: If you can't afford to pay these costs, there are programs that may help. These programs are discussed later in the presentation.

Decision: Should I Keep/Sign Up for Part B?

Consider:

- Most people pay a monthly premium
  - Usually deducted from Social Security/RRB benefits
  - Amount depends on income
- Part B may supplement employer coverage
  - Contact your benefits administrator to understand the impact to your employer plan
  - If you don't have other coverage, declining Part B will mean you don't have full coverage
- Sometimes, you must have Part B

How Part D Works

- It's optional
  - You can choose a plan and join
  - May pay a lifetime penalty if you join late

- Plans have formularies (lists of covered drugs), which:
  - Must include range of drugs in each category
  - Are subject to change—you'll be notified
- Your out-of-pocket costs may be less if you use a preferred pharmacy
- If you have limited income and resources, you may get Extra Help

Medicare Drug Plan Costs: What You Pay in 2024

Most people will pay:

- A monthly **premium** (varies by plan and income)
- A yearly **deductible** (if applicable)
- **Copayments or coinsurance**
- **Out-of-pocket** costs
  - A **percentage** of the cost while in the coverage gap, which begins at $3300-$3800 for out-of-pocket spending for 2024
  - **Very little** after spending $8,000 out-of-pocket in 2024--will automatically get catastrophic coverage

Insulin Products & Medicare Coverage

If you have **Medicare** and take insulin, we have some great news for you. Now you'll pay $35 per month (or less) for each covered insulin drug you take, and you don't have to pay a deductible.

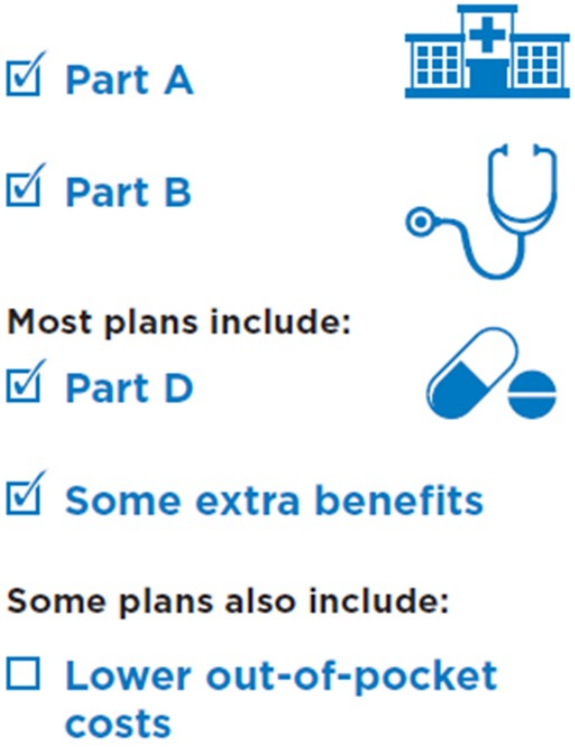
That means for a 90-day supply, no more than $105. This applies to everyone who takes insulin, even if you get Extra Help. Medicare covers insulin in 2 ways: Part D (drug coverage) Part D covers insulin you get from your Medicare drug plan. (Note: If your Part D plan covers disposable insulin patch pumps, the pump is considered an insulin supply, and might cost more than $35.)

Part C (Medicare Advantage) if you use an insulin pump that's covered under Medicare Part B's durable medical equipment benefit, or you get your covered insulin through a Medicare Advantage Plan, your insulin costs will be capped at $35 for a one-month supply.

The Part B deductible won't apply. If you have Medicare Supplement Insurance (Medigap) that pays your Part B coinsurance, plan should cover the $35 (or less) cost for insulin you get under Part B. To learn more: • Visit Medicare.gov/coverage/insulin

Visit Medicare.gov/about-us/inflation-reduction-act or Call 1-800-MEDICARE.

Medicare Advantage Plans (Part C)



- Another way to get your Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) **coverage**
- Offered by Medicare-approved **private companies** that must follow rules set by Medicare
- Most Medicare Advantage Plans include drug coverage (Part D)
- In most cases, you'll need to use health care providers who participate in the **plan's network** (some plans offer out-of-network coverage)

Marketing & Communications Oversight Improvements for Plan Year 2024

MA Organizations can't:

- Advertise benefits that aren't available to beneficiaries in the service area(s) where the marketing appears
- Market any products or plans, benefits, or costs, unless the MA organization or marketing name(s) as listed in HPMS of the entities offering the referenced products or plans, benefits, or costs are identified in the marketing material
- Advertise about savings available that are based on a comparison of typical expenses for uninsured individuals, unpaid costs of dually eligible beneficiaries, or other unrealized costs of person with Medicare

Marketing & Communications Oversight Improvements for Plan Year 2024 (continued)

- Ads will be prohibited if they don't mention a specific plan name
- The TPMO disclaimer must add
  - SHIPs as an option for beneficiaries to get additional help
  - Include the number of organizations/plans represented
- MA organizations can't use
  - Superlatives unless a source of documentation/data support language
  - Data older than the prior contract year (must be specifically identified)
  - Use the Medicare name, CMS logo, and products or information issued by the Federal Government, including the Medicare card, in a misleading way.
    - Use of the Medicare card image is permitted only with authorization from CMS

Help for People with Limited Income & Resources

- Medicare Savings Programs
- Medicaid
- Extra Help
- CHIP

Minimum Federal Eligibility Requirements for Medicare Savings Programs

Medicare Savings Programs	Individual Monthly Income Limits	Married Couple Income Limits	Helps Pay Your
Qualified Medicare Beneficiary (QMB)	$1,275	$1,724	Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments)
Specified Low-Income Medicare Beneficiary (SLMB)	$1,526	$2,064	Part B premiums only
Qualifying Individual (QI)	$1,715	$2,320	Part B premiums only
Qualifying Disabled & Working Individuals (QDWI)	$5,105	$6,899	Part A premiums only

Resource limits for QMB, SLMB, and QI are $9,430 for an individual and $14,130 for a married couple. Resource limits for QDWI are $4,000 for an individual and $6,000 for a married couple.

What's Extra Help?

- Program to help people pay for Medicare drug costs (Part D) (also called the low-income subsidy (LIS))
- If you have the lowest income and resources, you pay no premiums or deductible, and small or no copayments
- If you have slightly higher income and resources, you pay reduced deductible and a little more out of pocket
- No coverage gap or late enrollment penalty if you qualify for Extra Help

NOTE: A Special Enrollment Period (SEP) allows you to change your Medicare drug plan (also known as a PDP) once per quarter in the first 3 quarters of the year

Qualifying for Extra Help

You automatically qualify for Extra Help if you get:

- Full Medicaid coverage
- Supplemental Security Income (SSI)
- Help from Medicaid paying your Medicare premiums (Medicare Savings Programs; sometimes called “partial dual”)

If you don’t automatically qualify you must:

- Apply online at ssa.gov/benefits/medicare/prescriptionhelp.html
- Call Social Security at 1-800-772-1213; TTY: 1-800-325-0778, and ask for the “Application for Help with Medicare Prescription Drug Plan Costs” (SSA-1020)

Temporary Medicare Telehealth Changes

Through December 31, 2024 (Consolidated Appropriations Act, 2023)

- Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) can serve as a distant site provider for non-behavioral/mental telehealth services
- Generally, any provider who can bill Medicare can bill for telehealth through December 31, 2024
- There are no geographic restrictions for originating site for non-behavioral/mental telehealth services
- Some non-behavioral/mental telehealth services can be delivered using phones (audio only)
- You don't need an in-person visit within 6 months of the first behavioral/mental telehealth service, and yearly thereafter
- Telehealth services can be given by a variety of providers (physical therapist, occupational therapist, speech language pathologist, or audiologist)

Permanent Medicare Telehealth Policy Changes

- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) can serve as a distant site provider for behavioral/mental telehealth services
- Medicare patients can get telehealth services for behavioral/mental health care in their home
- There are no geographic restrictions for originating site for behavioral/mental telehealth services
- Behavioral/mental telehealth services can be delivered using phones (audio only)
- Rural hospital emergency departments can be an originating site

Telehealth: Medicaid & CHIP

- For Medicaid and CHIP, telehealth flexibilities aren't tied to the end of the PHE and have been offered by many state Medicaid programs long before the pandemic
- Coverage will ultimately vary by state
- To assist states with the continuation, adoption, or expansion of telehealth coverage, CMS has released the State Medicaid & CHIP Telehealth Toolkit and a supplement that identifies for states the policy topics that should be addressed to facilitate widespread adoption of telehealth:

  Medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf

Helpful Resources

- **Link to AI/AN Trust Income and MAGI Fact Sheet:** https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/AIAN-Trust-Income-and-MAGI.pdf
- **Cost Sharing Protections Brochure:** https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/Understanding-Cost-Sharing-brochure.pdf
- **Medicaid Application (see Appendix B):** https://marketplace.cms.gov/applications-and-forms/marketplace-application-for-family.pdf

Helpful Websites

01	Medicare	Medicare.gov
02	Medicaid	Medicaid.gov
03	Social Security	ssa.gov
04	Health Insurance Marketplace®	HealthCare.gov
05	Children's Health Insurance Program	InsureKidsNow.gov
06	CMS National Training Program	CMSnationaltrainingprogram.cms.gov
07	State Health Insurance Program (SHIP)	shiphelp.org

Helpful Contacts

For questions about Medicaid or CHIP – Contact your state Medicaid or CHIP office directly

- Find the contact information for your state Medicaid office at Medicaid.gov/renewals

For questions about the Health Insurance Marketplace® – Visit HealthCare.gov or contact a local enrollment assister in your area

- Find a list of enrollment assisters in your area at LocalHelp.HealthCare.gov
- Call 1-800-318-2596. TTY users: 1-855-889-4325.

For questions about Medicare – Visit Medicare.gov

- Call 1-800-MEDICARE (1-800-633-4227). TTY users: 1-877-486-2048.
- To get help with the Medicare enrollment form, contact local Social Security office. Find an office near you at ssa.gov/locator or call Social Security at 1-800-772-1213. TTY users: 1-800-325-0778.
- Contact your local State Health Insurance Assistance Program (SHIP) at Shiphelp.org