



**Indiana Navigator Pre-Certification Course
Content Outline**

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I. Consumer Assistance Basics (20 Total Questions)

A. Federally-Designated Consumer Assistants (3 Questions)

1. Governing Bodies/Law
 - a. Department of Health and Human Services (HHS)
 - i. Centers for Medicare and Medicaid Services (CMS)
 - ii. HealthCare.gov
 - b. Affordable Care Act (ACA)
2. Types of Federally-Designated Consumer Assistants
 - a. Federal Navigators
 - i. Federal vs. State Requirements for Navigators
 - b. Certified Application Counselors (CACs)
 - c. Non-Navigator Assistance Personnel
 - d. Producers (Agents and Brokers)
3. Definition, Purpose, Roles and Responsibilities, and How to Become Each Type of Federally-Designated Consumer Assistant
4. Federally-Designated Consumer Assistants Serving Hoosiers – State Requirements
 - a. Application of Indiana Navigator Law (IC 27-19)

B. Indiana Navigators and Application Organizations (12 Questions)

1. Who needs to be certified as an Indiana Navigator or Application Organization
2. Application Organizations (1 Question)
 - a. Definition, Roles and Responsibilities
 - b. Becoming an Application Organization
 - i. Online Application
 - ii. Conflict of Interest Disclosure Form
 - iii. Privacy and Security Agreement
 - iv. List of All Locations (for Multi-Location AOs)
 - c. Annual Renewal Requirements
3. Indiana Navigators (2 Questions)
 - a. Definition, Roles and Responsibilities
 - b. Becoming an Indiana Navigator
 - i. Online Application
 - ii. Background Check
 - iii. Conflict of Interest Disclosure Form

***Additional non-scored trial questions may be added to exam**

****Extra time will be allotted for any additional non-scored trial questions**

- iv. Privacy and Security Agreement
- v. Precertification Education
- vi. Certification Examination
- c. Annual Renewal Requirements; Continuing Education
- 4. Limitations for Indiana Navigators and Application Organizations (6 Questions)
 - a. Conflicts of Interest
 - i. Conflict of Interest Policy
 - a. Financial Conflict of Interest
 - b. Conflict of Loyalty
 - c. Changes in Actual or Potential Conflict of Interest
 - d. Conflict of Interest Disclosure Form
 - b. Privacy and Security; confidentiality
 - i. Privacy and Security Agreement
 - a. Personal Information
 - b. Reporting a Breach of Privacy/Security
 - c. Ethical Standards
 - i. Commitment to Clients
 - ii. Self-Determination
 - iii. Informed Consent and Authorization
 - iv. Competence
 - v. Cultural Competence
 - a. Serving Different Cultures and Languages – the National CLAS Standards
 - b. Serving Persons with Disabilities
 - vi. Conflicts of Interest
 - vii. Privacy and Confidentiality
 - viii. Access to Records
 - ix. Professional Conduct
 - d. Advising on plan selection
 - e. Receiving Compensation
 - f. Using unique certification/registration number
 - g. Reporting Requirements
 - i. Change of name or contact information
 - ii. Administrative, criminal, or legal action
 - iii. Change in Conflict of Interest status
 - iv. Security Breach or improper disclosure of consumer's Personal Information
- 5 . Information Resources (3 Questions)
 - a. How and when to access (e.g., websites, resources, agency contacts)

C. State of Indiana – Roles and Responsibilities (5 Questions)

1. State Role in Certification/Registration and Re-certification/Re-registration of Indiana Navigators and Application Organizations
 - a. State Monitoring and Oversight (1 Question)
 - i. Indiana Department of Insurance (IDOI)
 - ii. Family and Social Services Administration (FSSA)
 - b. State Administrative Actions (2 Questions)
 - i. Consequences for Violation of Navigator/Application Organization laws and regulations
 - c. Issuing a Consumer Complaint (2 Questions)
 - i. Who to contact
 - ii. What to expect
 - d. Legal Authority
 - i. Indiana Code (IC 27-19)
 - ii. Indiana Administrative Code (760 IAC 4)

II. Indiana Health Coverage Programs (20 Questions Total)

A. Overview of Indiana Health Coverage Programs (14 Questions)

1. Types of Indiana Health Coverage Programs – Benefit Packages/Available Services
 - a. Hoosier Healthwise
 - b. Children’s Health Insurance Program (CHIP)
 - c. Healthy Indiana Plan (HIP)
 - i. Types of Coverage
 1. HIP Plus
 2. HIP Basic
 3. HIP State Plan
 4. HIP Maternity
 - ii. Gateway to Work
 - iii. POWER Account Contributions and Preventive Care
 - iv. Tobacco Surcharge
 - d. Managed Care Entities
 - e. Hoosier Care Connect
 - f. Traditional Medicaid (Fee-for-Service)
 - g. M.E.D. Works
 - h. Home & Community Based Services (HCBS) Waivers
 - i. Behavioral and Primary Healthcare Coordination Program
 - i. Medicare Savings Program
 - j. Family Planning Eligibility Program
 - k. Breast and Cervical Cancer Program

- I. Right Choices Program
- m. End Stage Renal Disease Program
- n. Presumptive Eligibility (PE)
- 2. General Factors of Eligibility
 - a. Residency
 - b. Citizenship/Immigration Status
 - c. Income Standards
 - d. Requirement to Provide a Social Security Number
 - e. Requirement to File for Other Benefits
 - f. Medicaid Modified Adjusted Gross Income (MAGI) Methodologies
 - i. MAGI vs. non-MAGI Populations
 - g. Medicaid Eligibility Based on Blindness or Disability

B. Indiana Application for Health Coverage / Post-Enrollment (6 Questions)

- 1. Preparing to Help Consumers Apply for Health Coverage
 - a. Step One: Inform the Consumer of Any Actual or Potential Conflicts of Interest and of the Indiana Navigator's Roles and Responsibilities
 - b. Step Two : Complete Preliminary Eligibility Screening
- 2. Application Process
 - a. How to Help Consumers Apply for Indiana Health Coverage Programs
 - b. Methods (i.e., online, paper, phone, in-person)
 - c. Checking Application Status
 - d. Home and Community-Based Services Waiver Programs
 - e. Presumptive Eligibility application process
- 3. Authorized Representatives
- 4. Appeals
- 5. What an Individual Can Expect After Being Determined Eligible for an Indiana Health Coverage Program
 - a. Effective Date of Eligibility
 - b. Notices and Insurance Card
 - c. CHIP Premiums
 - d. HIP POWER Account Contributions
 - e. M.E.D. Works Premiums
- 6. Using Coverage
 - a. Prior Authorization
 - b. Copayments
 - c. Reporting Changes
 - d. Who to Contact for Assistance or Grievances
 - e. Eligibility Redeterminations

III. Health Insurance Basics and the Federally Marketplace (20 Questions Total)

A. Basics of the Federal Health Insurance Marketplace (4 Questions)

1. Functions of the Marketplace
 - a. Insurance Affordability Options under the ACA
 - i. Insurance Affordability Programs
 - a. Cost-Sharing Reductions (CSRs)
 - b. Premium Tax Credits (PTCs)
 - c. Eligibility
 - d. Requirement to File and Report Changes
 - ii. Federal Poverty Level (FPL)
 - iii. Modified Adjusted Gross Income (MAGI)
 - b. Small Business Health Insurance Options Program (SHOP) Marketplace
 - i. Small Employers Definition
 - ii. SHOP Enrollment Period
 - c. Application Process
 - i. Household Eligibility
 - ii. Payment of the Premium Tax Credits (PTCs)
 - iii. APTC Reconciliation
 - iv. Cost-Sharing Reductions (CSRs)
 - v. Open Enrollment Periods/Re-enrollment
 - vi. Special Enrollment Periods
 - vii. Open Enrollment Period and the Outside Market
2. Qualified Health Plans (QHPs)
 - a. Metal Tiers
 - b. Actuarial Value
3. Stand-Alone Dental Plan

B. The Marketplace Application (5 Questions)

1. Preparing to Help Consumers Apply for Health Coverage
 - a. Step One: Inform the Consumer of Any Actual or Potential Conflicts of Interest and of the Indiana Navigator's Roles and Responsibilities
 - b. Step Two: Complete Preliminary Eligibility Screening
2. Application Process
 - a. Methods (i.e., paper, online, phone)
 - b. Beginning the Marketplace Application
 - c. Disability Question on the Marketplace Application
 - d. Employer Coverage Questions on the Marketplace Application
 - e. Sources of Information Needed for the Marketplace Application
3. Verifying Eligibility
4. Interaction with the Marketplace
 - a. After Completing an Application
 - b. Notices

- c. Plan Selection
- d. Appeals - Challenging a Decision
- e. Reporting Changes
- f. Eligibility Redeterminations
- g. Re-enrollment

C. Health Insurance Basics (6 Questions)

- 1. Basics of Health Insurance Markets
- 2. Basics of Health Insurance Coverage
 - a. Health Plan Cost
- 3. Types of Health Insurance Coverage
 - a. Catastrophic Plans
 - b. Grandfathered Plans
 - c. Qualified Health Plans
 - d. Multi-State Plans
- 4. Other Commercial (off-Marketplace) Coverage Types
 - a. Stand-Alone Plans
 - b. Other Excepted Benefit Plans
- 5. Basics of the Affordable Care Act
 - a. Individual Impacts
 - i. Requirement to have health insurance (the “Individual Mandate”)
 - ii. Guaranteed Availability and Guaranteed Renewability
 - iii. Essential Health Benefits
 - iv. Help Paying for Health Insurance and Cost-Sharing
 - v. Enrollment Periods
 - b. Insurer Impacts
 - i. Rating Requirements
 - ii. Medical Loss Ratio
 - c. Individual Shared-Responsibility Requirement
 - i. Minimum Essential Coverage
 - ii. Penalty
 - iii. Exemptions
 - d. Elimination of Lifetime and Annual Maximums
 - e. Rating Factors (i.e., age, tobacco, location)

D. Indiana Insurance Law and Terminology (5 Questions)

- 1. Indiana Code 27-19 – Health Benefit Exchange
- 2. Indiana Administrative Code (760 IAC 4) – Indiana Navigators and Application Organization
- 3. Glossary of Commonly Used Terms

Key Terms and Concepts

- Actuarial Value (AV)
- Administrative Action
- Affordable Care Act (ACA) (also referred to as Patient Protection and Affordable Care Act (PPACA))
- Application Organization (AO)
- Authorized Representative (AR)
- Auto Assignment
- Behavioral and Primary Healthcare Coordination Program (BPHC)
- Benefits Portal
- Bronze Plan
- Catastrophic Plan
- Centers for Medicare & Medicaid Services (CMS)
- Certificate of Coverage
- Certified Application Counselor (CAC)
- Children's Health Insurance Program (CHIP)
- COBRA Insurance (also known as Consolidated Omnibus Budget Reconciliation Act)
- Coinsurance
- Compensation
- Complaint
- Conflict of Interest
- Conflict of Interest Disclosure Form
- Conflict of Interest Policy
- Conflict of Loyalty
- Consumer Assistant
- Consumer Directed Health Plan (CDHP) (also known as High Deductible Health Plan (HDHP))
- Copayment (also referred to as Copay)
- Cost-sharing
- Cost-sharing Reduction (CSR)
- Deductible
- Department of Health and Human Services (HHS)
- Dependent
- Division of Family Resources (DFR)
- Enrollment Period
- Essential Health Benefit (EHB)
- Ethics
- Explanation of Benefits (EOB)
- Family and Social Services Administration (FSSA)
- Family Planning Eligibility Program
- Fast Track
- Federal Navigator

- Federal Poverty Level (FPL)
- Federally-facilitated Marketplace (FFM) (also referred to as Federal Marketplace, Exchange, or HealthCare.gov)
- Financial Interest
- Flexible Spending Account (FSA)
- Gateway to Work
- Glossary of Commonly Used Terms
- Gold Plan
- Grandfathered Health Plan
- Health Insurance (also referred to as Insurance, Benefits, or Coverage)
- Health Maintenance Organization (HMO)
- Health Savings Account (HSA)
- Healthy Indiana Plan (HIP)
- HIP Basic
- HIP Maternity
- HIP Plus
- HIP State Plan
- Home and Community-Based Services (HCBS) Waivers
- Hoosier Care Connect
- Hoosier Healthwise (HHW)
- Indiana Administrative Code – Title 760, Article 4
- Indiana Application for Health Coverage (IAHC)
- Indiana Code 27-19
- Indiana Department of Insurance (IDOI)
- Indiana Health Coverage Program (IHCP)
- Indiana Navigator
- Indiana Navigator Designation Form for Licensed Insurance Producers and Consultants
- Individual Mandate (also referred to as Individual Shared-Responsibility)
- Individual Market
- In-Network Provider
- Insurance Affordability Programs (also referred to as Cost Sharing Reductions and Premium Tax Credits)
- Insurer (also referred to as health insurance Issuer, Carrier, or Company)
- M.E.D. Works (short for Medicaid for Employees with Disabilities)
- Managed Care Entity (MCE) (also referred to as Managed Care Organization (MCO))
- Marketplace
- Medicaid
- Medical Loss Ratio (MLR)
- Medical Review Team (MRT)
- Medically Frail
- Medicare Savings Program
- Metal Tier (also referred to as Health Plan Category, Metal Level, or Metal Plan)
- Miller Trust (also referred to as Qualified Income Trust (QIT))
- Minimum Essential Coverage (MEC)

- Minimum Value (MV)
- Modified Adjusted Gross Income (MAGI)
- Navigator Continuing Education (CE)
- Navigator Service Request Form
- Non-Modified Adjusted Gross Income (Non-MAGI) Population
- Non-Navigator Assistance Personnel (also known as In-Person Assister or In-Person Counselor)
- Office of Medicaid Policy and Planning (OMPP)
- Open Enrollment Period
- Out-of-network Provider
- Out-of-pocket Maximum (also referred to as Out-of-pocket Limit)
- Partnership Marketplace
- Pediatric
- Personal Identifiable Information (PII)
- Platinum Plan
- Policy Year
- POWER Account (also referred to as Personal Wellness and Responsibility Account)
- Pre-existing Condition
- Preferred Provider Organization (PPO)
- Premium
- Premium Tax Credit (PTC) (also referred to as Advanced Premium Tax Credit or APTC) or Subsidy)
- Presumptive Eligibility (PE) (also referred to as PE for Pregnant Women (PEPW), Hospital PE (HPE), or PE for Inmates)
- Primary Care Provider (PCP)
- Prior Authorization (PA)
- Privacy and Security Agreement
- Producer (also referred to as an Agent or Broker)
- Provider (also referred to as Healthcare Provider)
- Qualified Health Plan (QHP)
- Qualified Provider (QP)(also referred to as Presumptive Eligibility (PE) Qualified Entity)
- Rating Factors
- Redetermination
- Re-Enrollment
- Reporting Requirement
- Right Choices Program
- Security Breach
- SHOP (Small Business Health Options Program) Marketplace
- SHOP Enrollment Period
- Silver Plan
- Siron (also known as Vertafore)
- Small Employer (also referred to as Small Group Employer)
- Social Security Administration (SSA)
- Social Security Disability Insurance (SSDI)

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- Special Enrollment Period (SEP)
- Stand-Alone Dental Plan
- State Health Insurance Assistance Program (SHIP)
- State-based Marketplace
- Summary of Benefits and Coverage
- Supplemental Nutrition Assistance Program (SNAP)
- Supplemental Security Income (SSI)
- Temporary Assistance for Needy Families (TANF)
- Traditional Medicaid (also referred to as Fee-for-Service)
- Transitional Medical Assistance (TMA)
- 1115 (c) Waiver