

2026 Federally-facilitated Marketplace (FFM) Agent/Broker Certification Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

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SAMPLE

Questions

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- 1. What financial assistance can clients expect when using the Marketplace?**
 - A. Only subsidies for those with specific conditions**
 - B. Potential discounts based on income and household size**
 - C. Full insurance coverage without the need for premiums**
 - D. Assistance is primarily aimed at those under 65**
- 2. If an agent's advertisement is misleading, what could CMS do?**
 - A. Thank the agent for their creativity**
 - B. Encourage the agent to continue posting ads**
 - C. Consider the ad as compliant with guidelines**
 - D. Consider the ad as misleading**
- 3. What does the "Bronze" tier in health insurance indicate?**
 - A. Highest level of coverage**
 - B. Plan with the highest out-of-pocket costs**
 - C. Intermediate level of coverage**
 - D. Lowest level of coverage**
- 4. What factors affect the coverage decisions made by Marketplace plans?**
 - A. Personal preferences and cultural background**
 - B. Plan type and policy limits set by insurers**
 - C. Only the health conditions of the clients**
 - D. Regulations imposed by the state**
- 5. Who can become a Federally-facilitated Marketplace agent or broker?**
 - A. Anyone with a high school diploma**
 - B. Non-licensed individuals interested in health insurance**
 - C. Licensed insurance agents or brokers who meet training requirements**
 - D. Anyone over the age of 21**

- 6. What role does an agent or broker play in Marketplace applications?**
- A. They create the application without any consumer input**
 - B. They assist and guide consumers through the enrollment process**
 - C. They are solely responsible for the premium amounts**
 - D. They decide the eligibility of the consumers**
- 7. How long do consumers have to select a health plan after a birth or adoption through a Special Enrollment Period?**
- A. 30 days**
 - B. 60 days**
 - C. 90 days**
 - D. 120 days**
- 8. What could happen if the Marketplace Appeals Center finds that a consumer's eligibility determination was incorrect?**
- A. The consumer will lose all previous coverage**
 - B. The consumer may owe money to their Marketplace plan**
 - C. The consumer may receive a refund for prior premiums paid**
 - D. Both B and C**
- 9. What program provides financial assistance to eligible individuals purchasing health insurance through the FFM?**
- A. Medicare Benefits**
 - B. Supplemental Health Program**
 - C. Premium Tax Credits**
 - D. Health Savings Accounts**
- 10. What is the role of the Navigator program in the Marketplace?**
- A. Navigators assist consumers in understanding their options and help them enroll in coverage**
 - B. Navigators manage the financial operations of the Marketplace**
 - C. Navigators set insurance premium rates for various plans**
 - D. Navigators handle complaints about insurance providers**

Answers

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1. B
2. D
3. D
4. B
5. C
6. B
7. B
8. D
9. C
10. A

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Explanations

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1. What financial assistance can clients expect when using the Marketplace?

- A. Only subsidies for those with specific conditions**
- B. Potential discounts based on income and household size**
- C. Full insurance coverage without the need for premiums**
- D. Assistance is primarily aimed at those under 65**

Clients using the Marketplace can expect potential discounts based on their income and household size, which reflects the purpose of the Affordable Care Act (ACA). The ACA provides financial assistance to individuals and families who qualify, primarily through premium tax credits and cost-sharing reductions. These forms of assistance help make health insurance more affordable by lowering monthly premium costs and out-of-pocket expenses when accessing care. Eligibility for these discounts is determined by comparing household income to the federal poverty level, and the amount of assistance available can vary depending on both income and the size of the household. Therefore, this option accurately captures the essence of how financial assistance is structured within the Marketplace. While financial assistance is more prevalent for those with lower incomes, it is not exclusively aimed at clients under 65, nor does it involve guarantees of full insurance coverage without premiums. Additionally, the assistance is not limited only to those with specific conditions, which reinforces the broader eligibility criteria that encompass a range of households based on income levels.

2. If an agent's advertisement is misleading, what could CMS do?

- A. Thank the agent for their creativity**
- B. Encourage the agent to continue posting ads**
- C. Consider the ad as compliant with guidelines**
- D. Consider the ad as misleading**

If an agent's advertisement is misleading, the Centers for Medicare & Medicaid Services (CMS) would consider the ad as misleading. This response is rooted in CMS's commitment to ensuring that all marketing and advertising materials related to health insurance are accurate and not deceptive. Misleading advertisements can confuse consumers and lead to poor decision-making regarding their health coverage options. CMS has established guidelines to protect consumers and ensure that information provided to them is clear, truthful, and not misleading. When an advertisement fails to meet these standards, CMS has the authority to take appropriate actions, such as requiring revisions to the ad or even imposing penalties on the agent for non-compliance. This action reinforces the importance of accurate and honest advertising, thereby helping to maintain the integrity of the health insurance marketplace. In contrast, the other choices would not align with CMS's objective of protecting consumers. Thanking the agent for creativity or encouraging the posting of misleading ads would undermine the regulatory framework designed to ensure fair business practices. Considering the advertisement compliant with guidelines is also not an appropriate response, as it directly contradicts the agency's role in overseeing truthful marketing.

3. What does the "Bronze" tier in health insurance indicate?

- A. Highest level of coverage
- B. Plan with the highest out-of-pocket costs
- C. Intermediate level of coverage
- D. Lowest level of coverage**

The "Bronze" tier in health insurance indicates the lowest level of coverage among the four tiers defined by the Affordable Care Act (ACA). This tier typically covers approximately 60% of healthcare costs, which means that individuals with a Bronze plan will generally pay a higher share of their medical expenses compared to those with higher-tier plans such as Silver, Gold, or Platinum. Choosing a Bronze plan often results in lower monthly premiums, making it an appealing option for those who may not anticipate needing much care or who prefer to manage costs more directly through higher out-of-pocket expenses when medical services are required. The tiering system serves to help consumers understand the trade-offs between premium costs and potential out-of-pocket expenses they might face when using healthcare services. In contrast, the other options point to plans that would generally involve greater coverage or higher costs, which do not align with what the Bronze tier represents.

4. What factors affect the coverage decisions made by Marketplace plans?

- A. Personal preferences and cultural background
- B. Plan type and policy limits set by insurers**
- C. Only the health conditions of the clients
- D. Regulations imposed by the state

The correct answer highlights that coverage decisions made by Marketplace plans are significantly influenced by the type of plan being offered and the policy limits as defined by insurers. Different plan types, such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), or Exclusive Provider Organizations (EPOs), have unique structures and benefits that determine what services are covered, how much out-of-pocket expense the insured will encounter, and how providers are accessed. Policy limits also play a critical role, as they can cap the amount of coverage for certain services or treatments, thereby impacting the scope of care a member can receive. Insurers design these plans based on a combination of actuarial assessments, regulations, and market dynamics that dictate the standard offerings. By focusing on plan types and insurer-defined policy limits, one can better understand the framework within which coverage decisions are made, as these elements dictate how services are delivered and reimbursed within the Marketplace. Understanding this facilitates a clearer navigation of the insurance landscape for consumers and helps agents and brokers effectively advise clients on their options.

5. Who can become a Federally-facilitated Marketplace agent or broker?

- A. Anyone with a high school diploma**
- B. Non-licensed individuals interested in health insurance**
- C. Licensed insurance agents or brokers who meet training requirements**
- D. Anyone over the age of 21**

Becoming a Federally-facilitated Marketplace agent or broker requires specific qualifications to ensure that individuals are knowledgeable and compliant with relevant health insurance regulations. The correct answer indicates that licensed insurance agents or brokers who meet training requirements are eligible to participate in the Marketplace. To successfully assist individuals and families in understanding and navigating health insurance options, agents and brokers need to have a thorough understanding of the Marketplace, including the various plans, coverage options, and subsidy eligibility. Meeting training requirements is essential, as it ensures that these professionals are well-informed about the rules and standards set forth by the Marketplace. This training helps them provide accurate information and guidance to consumers seeking health coverage. Other choices do not meet the criteria established by the Health Insurance Marketplace. Options that mention non-licensed individuals or those based solely on educational level or age do not satisfy the necessary requirements for participation in the Marketplace. Only licensed agents or brokers, who have undergone the required training, can effectively fulfill the role of assisting consumers in navigating their health insurance choices through the Federally-facilitated Marketplace.

6. What role does an agent or broker play in Marketplace applications?

- A. They create the application without any consumer input**
- B. They assist and guide consumers through the enrollment process**
- C. They are solely responsible for the premium amounts**
- D. They decide the eligibility of the consumers**

An agent or broker plays a crucial role in assisting and guiding consumers through the enrollment process in the Marketplace. This includes helping individuals understand their coverage options, answering questions about the plans available, and offering support in completing the application for health insurance. They serve as intermediaries who ensure that consumers have the information they need to make informed decisions regarding their healthcare coverage. By providing personalized assistance, agents and brokers help consumers navigate the often complex health insurance landscape, making it easier for them to find a plan that suits their needs and budget. Their function is pivotal in fostering a smoother enrollment experience, which can lead to higher enrollment numbers and increased satisfaction among consumers with their chosen health plans.

7. How long do consumers have to select a health plan after a birth or adoption through a Special Enrollment Period?

- A. 30 days
- B. 60 days**
- C. 90 days
- D. 120 days

Consumers have 60 days to select a health plan after a birth or adoption through a Special Enrollment Period. This time frame is designed to allow new parents to enroll their child in health insurance coverage following significant life events such as the birth or adoption of a child. The Special Enrollment Period provides flexibility beyond the standard open enrollment period, recognizing that circumstances change and families need to ensure their health care needs are met promptly. The 60-day window ensures that families can make informed decisions about their health care options without being rushed, contributing to better health outcomes for both the parents and the newly added family member. This aligns with the rules governing Special Enrollment Periods as set forth by the Centers for Medicare & Medicaid Services (CMS).

8. What could happen if the Marketplace Appeals Center finds that a consumer's eligibility determination was incorrect?

- A. The consumer will lose all previous coverage
- B. The consumer may owe money to their Marketplace plan
- C. The consumer may receive a refund for prior premiums paid
- D. Both B and C**

If the Marketplace Appeals Center finds that a consumer's eligibility determination was incorrect, there are several potential outcomes concerning the consumer's health insurance coverage and related financial implications. When a determination is deemed incorrect, it may lead to a situation where the consumer's eligibility for financial assistance or coverage needs to be recalibrated. This can involve the consumer owing money to their Marketplace plan if they were originally granted financial assistance that they were not eligible for, thus creating a liability for the premiums they received. Additionally, if the determination was incorrect to the point that the consumer was entitled to different coverage or assistance than they received, they may also be eligible for a refund of premiums paid during the period in question. This could occur if it's found that they were eligible for a higher level of assistance or certain benefits that were not initially applied. Therefore, both aspects B and C are valid outcomes of the appeals process, making the combined answer the most comprehensive conclusion in relation to the potential consequences for the consumer.

9. What program provides financial assistance to eligible individuals purchasing health insurance through the FFM?

- A. Medicare Benefits**
- B. Supplemental Health Program**
- C. Premium Tax Credits**
- D. Health Savings Accounts**

The program that provides financial assistance to eligible individuals purchasing health insurance through the Federally-facilitated Marketplace (FFM) is the Premium Tax Credits. These tax credits help lower the cost of premiums for consumers who purchase health insurance through the marketplace. They are designed to make health coverage more affordable for people with limited income. These credits are available to individuals and families with household incomes between 100% and 400% of the Federal Poverty Level (FPL). The amount of the credit is calculated based on the individual's or family's expected contribution towards premiums, ensuring that coverage remains accessible. The other options, while related to health care, do not provide direct assistance for purchasing health insurance through the FFM. Medicare Benefits specifically cater to older adults and certain younger individuals with disabilities, not those purchasing marketplace coverage. The Supplemental Health Program is not a defined program in the context of the FFM, and Health Savings Accounts are accounts that allow individuals to save money for medical expenses but do not offer direct financial assistance for premium costs.

10. What is the role of the Navigator program in the Marketplace?

- A. Navigators assist consumers in understanding their options and help them enroll in coverage**
- B. Navigators manage the financial operations of the Marketplace**
- C. Navigators set insurance premium rates for various plans**
- D. Navigators handle complaints about insurance providers**

The Navigator program plays a vital role in the Federally-facilitated Marketplace by providing assistance to consumers as they navigate their health insurance options. Specifically, Navigators are trained and certified individuals or organizations whose primary responsibility is to educate consumers about the health insurance choices available through the Marketplace. They help individuals understand the different plans, including coverage details, costs, and eligibility for financial assistance, ensuring that consumers are empowered to make informed decisions about their health care. In addition to providing information about coverage options, Navigators facilitate the enrollment process, guiding consumers through the application procedure to obtain health insurance. This support is particularly valuable for those who may find the complexity of health insurance challenging or overwhelming. By helping consumers enroll in coverage, Navigators contribute to increased access to healthcare and ensure that individuals are aware of their benefits and rights within the Marketplace framework. This understanding of the Navigator program's role underscores its importance in promoting informed consumer choices and facilitating access to necessary health services. The other options focus on functions that do not align with the primary purpose of Navigators in the Marketplace.