NAVIGATOR RESOURCE GUIDE

ON PRIVATE HEALTH INSURANCE COVERAGE & THE HEALTH INSURANCE MARKETPLACE

Robert Wood Johnson Foundation

The Center on Health Insurance Reforms
Georgetown University Health Policy Institute

Acknowledgements

This guide was produced by the Georgetown University Center on Health Insurance Reforms (CHIR) with support from the Robert Wood Johnson Foundation. It includes questions and answers developed in collaboration with the staff at the Kaiser Family Foundation and the Center on Budget and Policy Priorities. For more information on CHIR's health insurance experts and publications, see http://chir.georgetown.edu/.

Note: The American Association on Health and Disability (AAHD), with funding from the Robert Wood Johnson Foundation, has developed a resource that focuses on key elements of the Affordable Care Act as they affect coverage for persons with disabilities. The project has disability content materials, including the "Guide to Disability for Healthcare Insurance Marketplace Navigators" and fact sheets with more information regarding specific disability related issues. A dedicated website includes all the materials as well as state-specific information, resources, and experiences, and can be found at: http://www.nationaldisabilitynavigator.org

For more information on this project, contact Karl Cooper, AAHD Project Associate, at kcooper@aahd.us and 301-545-6140, extension 204. You can also learn more from the project website at http://www.aahd.us/initiatives/initiativesrwj_ndnrc/

How to Use this Guide

This guide is focused solely on the private insurance reforms of the Affordable Care Act, including the health insurance marketplaces, rating, benefit and cost standards, and premium tax credits. It is intended to supplement the Navigator training available from the U.S. Department of Health and Human Services. It is not intended to be a comprehensive, stand-alone resource for all the reforms of the Affordable Care Act.

This resource is organized into sections that address how individuals may present themselves to Navigators, based on their insurance status and coverage options.

- ► Section 1 covers enrollment issues for individuals, beginning with those who do not have coverage or an offer of group coverage, i.e., from an employer.

- ► Section 2 covers enrollment issues for individuals who have coverage or an offer of coverage—whether through an employer-sponsored plan, individual plan, high-risk pool, retiree plan, or student health plan—and want to understand their options, including eligibility for premium tax credits through the health insurance marketplace.

- ► Section 3 covers enrollment issues for small employers who want to understand and compare their coverage options for their employees.

- ► Section 4 covers post-enrollment issues, including questions that may arise as individuals use their coverage.

Information in this guide is current as of February 21, 2014. Future supplements will incorporate changes to federal rules. While we have made every effort to provide accurate information in this resource guide, navigators should contact their state's marketplace, Department of Insurance, or Medicaid agency for guidance on specific circumstances.

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SECTION 1: INDIVIDUALS WITH NO COVERAGE

Section 1 covers enrollment issues for individuals, beginning with those who do not have coverage or an offer of group coverage, i.e., from an employer.

Chapter 1: Individual Responsibility Requirement (Individual Mandate)

Background

The individual responsibility requirement, also known as the individual mandate, is a provision of the Affordable Care Act requiring that all citizens obtain a minimum standard of health insurance coverage starting in 2014, obtain an exemption, or pay an extra fee (a tax) when filing their federal income tax return. People can obtain the necessary coverage through their job, through a government program such as Medicaid or Medicare, through the health insurance marketplace in their state, or directly from an insurance company. Some people may be able to obtain an exemption from paying the tax penalty, either from the health insurance marketplace or through the tax filing process.

Frequently Asked Questions

1. **I'm uninsured. Am I required to get coverage in 2014?**

   Everyone is required to have health insurance coverage — or more precisely, "minimum essential coverage" — or else pay a tax penalty, unless they qualify for an exemption. This requirement is called the individual responsibility requirement, or sometimes called the individual mandate.

2. **How do I prove that I had coverage and satisfied the mandate?**

   When you file your 2014 tax return (most people will do this by April 15, 2015) you will have to enter information about your coverage (or your exemption) on the return. You may get a notice from your insurance provider by January 31, 2015, describing your coverage status during the previous year. If you do not, check with your insurance company or employer's human resources department.

3. **What's the penalty if I don't have coverage?**

   In 2014, the penalty is the greater of

   - $95 for each adult and $47.50 for each child, up to $285 per family, or
   - 1 percent of family income minus the federal tax filing threshold, which is $10,000 for a person who files singly, $20,000 for somebody who files jointly

   In 2015, the penalty is the greater of

   - $325 for each adult and $162.50 for each child, up to $975 per family, or
   - 2 percent of family income above the federal tax filing threshold

In 2016, the penalty is the greater of

- $695 for each adult and $347.50 for each child, up to $2,085 per family, or
- 2.5 percent of family income above the federal tax filing threshold

In later years, the flat penalty amounts for 2016 will be indexed based on the cost of living.

In all years, the penalty is also capped at an amount equal to the national average premium for the lowest cost bronze health plan available through the marketplace.

4. If I owe a penalty, when and how do I have to pay it?

If you do not maintain minimum essential coverage in 2014 and you don't qualify for an exemption, you will need to pay a "shared responsibility payment" to the IRS on your 2014 tax return. If you are like most people, you will need to submit your return by April 15, 2015.

5. Are there exemptions to the penalty? What are they?

Yes. You may be eligible for an exemption if any of the following apply to you:

- Cannot afford coverage (defined as those who would pay more than 8 percent of their household income for the lowest cost bronze plan available to them through the marketplace)
- Are not a U.S. citizen, a U.S. national, or a resident alien lawfully present in the U.S.
- Had a gap in coverage for less than three consecutive months during the year
- Won't file a tax return because your income is below the tax filing threshold (in 2013, the tax filing threshold is $10,000 for individuals and $20,000 for a couple)
- Are unable to qualify for Medicaid because your state has chosen not to expand the program
- Participate in a health care sharing ministry or are a member of a recognized religious sect with objections to health insurance
- Are a member of a federally recognized Indian tribe
- Are incarcerated

Others who do not qualify through these categories but have experienced a hardship that makes it difficult to purchase insurance may apply through the health insurance marketplace for an exemption to the individual responsibility requirement.

6. How do I apply for an exemption?

For some types of exemptions, you must apply through the health insurance marketplace; for other types, you must apply when you file your taxes; some types of exemptions can be claimed either way. The religious conscience exemption and most hardship exemptions are available only by going to a health insurance marketplace and applying for an exemption certificate.

The exemptions for members of Indian tribes, members of health care sharing ministries, and individuals who are incarcerated are available either by going to a marketplace and applying for an exemption certificate or by claiming the exemption as part of filing a federal income tax return.

The exemptions for unaffordable coverage, short coverage gaps, certain hardships, and individuals who are not lawfully present in the United States can be claimed only as part of filing a federal income tax return. The exemption for those under the federal income tax return filing threshold is available automatically. No special action is needed.

7. On what grounds can I apply for a hardship exemption to the individual mandate?

People may apply for a hardship exemption if they have experienced difficult financial or domestic circumstances that prevent them from obtaining coverage — such as homelessness, death of a close family member, bankruptcy, substantial recent medical debt, or disasters that substantially damage a person's property. People may also apply for a hardship exemption if obtaining coverage would be so burdensome as to cause the applicant to experience other serious deprivation of food, shelter, or other necessities. Consult your marketplace for more information about hardship exemptions.

8. Do I have to buy a plan by February 15 to avoid a tax penalty?

No. As long as you buy a plan by March 31, 2014, you will avoid paying a penalty. If you are uninsured and you wait until March 31 (or anytime after March 15) to buy a plan, your coverage won't start until May 1. Ordinarily, if you have more than a three month gap in coverage, you would be required to pay a tax penalty. However, for 2014, as long as you buy a plan by March 31 you will automatically qualify for a "hardship" exemption from the individual mandate. You can claim that exemption on your 2014 tax return.

9. If I change health coverage during the year and end up with a gap when I am not covered, will I owe a payment?

Possibly — it depends on how long you were without coverage. Individuals are treated as having minimum essential coverage for a calendar month if they have coverage for at least one day during that month. Additionally, as long as the gap in coverage is less than three consecutive months, you may qualify for an exemption and not owe a payment.

10. **I lost coverage March 15 and didn't get new coverage until April 1. Am I considered uninsured for the month of March because I lacked coverage for part of the month?**

    No, if you are covered even one day during a month, you are considered to be insured for that month. Similarly, a person who is considered exempt from the individual responsibility requirement for even one day during a month is considered exempt for that month.

11. **I live overseas. Do I still have to comply?**

    Probably not. If you are a resident of a foreign country for the full calendar year, you will not have to pay a tax penalty, even if you don't have minimum essential coverage.

12. **Apparently my family isn't eligible for subsidies in the marketplace because I am eligible for self-only coverage at work that is considered affordable. But we can't afford to buy marketplace coverage on our own. Will I have to pay a penalty because my family members are uninsured?**

    No. If the amount you would have had to pay to actually cover your spouse and kids was more than 8 percent of your family income, they won't be penalized for not having health coverage.

Minimum Essential Coverage

13. **How do I know if my coverage counts so I can avoid paying the tax penalty?**

    To meet the coverage requirement, individuals must have "minimum essential coverage." Most people that have health coverage today have a plan that will count as minimum essential coverage, and will not need to do anything more than continue the coverage that they have. If you have any of the following types of coverage, you likely have minimum essential coverage:

    - Employer-sponsored coverage, including COBRA continuation coverage and retiree coverage
    - Coverage purchased in the individual market, including a plan purchased in a health insurance marketplace
    - Medicare Part A coverage and Medicare Advantage plans
    - Most Medicaid coverage
    - Children's Health Insurance Program coverage
    - Certain types of Veterans health coverage administered by the Veterans Administration
    - TRICARE (coverage for members of the military)
    - Self-funded student health coverage (for 2014; may change in 2015)
    - High-risk pool coverage (for 2014; may change in 2015)

- Coverage for Peace Corps volunteers
- Refugee Medical Assistance from the federal Administration for Children and Families
- Department of Defense health benefit program for civilian employees known as “Non Appropriated Fund” personnel

All health insurers must provide individuals with a Summary of Benefits and Coverage, which uses a standard format to outline the benefits, cost-sharing and coverage limits of plans. The Summary of Benefits and Coverage must also state whether the plan meets minimum value and counts as minimum essential coverage, although in 2014, that information may be provided separately in a cover letter.

If you don’t currently have coverage, will soon lose coverage, or are thinking of changing coverage, you can obtain minimum essential coverage by purchasing a plan on your state’s health insurance marketplace.

Some types of coverage sold outside a health insurance marketplace do not qualify as minimum essential coverage, such as discount plans, short-term policies, or policies that cover only cancer. These kinds of products are sometimes referred to as “excepted benefits.” They do not count as minimum essential coverage.

If you are uncertain whether your plan qualifies as minimum essential coverage, contact your employer’s human resources department or your health insurer.

14. Do private insurance policies have to be labeled to show whether they are minimum essential coverage?

All health insurers and employer-sponsored group health plans must provide people with a Summary of Benefits and Coverage, which uses a standard format to outline the benefits, cost-sharing and coverage limits of plans. The Summary of Benefits and Coverage must also say whether the plan meets minimum value and counts as minimum essential coverage, although in 2014, that information may be provided separately in a cover letter.

15. I’m in a grandfathered plan that doesn’t cover prescription drugs, does that count as minimum essential coverage?

Yes, grandfathered plans count as minimum essential coverage.

16. **Does the individual mandate require me to purchase dental coverage for me or my child?**

Individuals who enroll in minimum essential coverage that does not include pediatric benefits will not owe a tax penalty for lacking dental coverage. This might happen for a number of reasons. Pediatric dental benefits are included in essential health benefits and must be offered through marketplaces. Some marketplace plans offer dental benefits together in the same policy with other health benefits. In other cases, dental benefits are offered through stand-alone plans. Where stand-alone plans are offered, affordability of pediatric dental benefits may be a problem for some families. In addition, the essential health benefit rules do not apply to large employer plans or to self-insured employer plans, and so people enrolled in such plans may or may not have pediatric dental benefits.

17. **I notice short-term policies are for sale outside of the marketplace and they are much cheaper than many other policies. What is a short-term policy? If I buy a short-term policy, does that satisfy the requirement to have minimum essential coverage?**

As the name implies, a short-term health insurance policy offers coverage for a period of less than 12 months (e.g., many offer coverage for just six months) and are renewable at the option of the insurance company. Though you may be given an opportunity to request to renew the policy, if you've made claims since you bought it, the insurer can refuse to renew it. This is also called a non-guaranteed-renewable policy. Short-term policies are not considered minimum essential coverage. Insurance companies that sell such policies are required to notify you that they do not constitute minimum essential coverage.

18. **I have Medicaid coverage just for the care I need while I'm pregnant. Does that count for the individual responsibility requirement?**

No, certain types of Medicaid coverage do not count as minimum essential coverage, including pregnancy-related Medicaid and other limited Medicaid coverage. However, you will not have to pay a penalty. You can get an exemption from the penalty if you have pregnancy-related Medicaid coverage in 2014.

Chapter 2: Health Insurance Marketplace: Navigating New Coverage Options

Eligibility For The Health Insurance Marketplace

Background

Health insurance marketplaces (also known as Exchanges) are new organizations that will be set up to create more organized and competitive markets for buying health insurance. They will offer a choice of different health plans, certifying plans that participate and providing information to help consumers better understand their options. Through the marketplace, individuals and families will be able to shop for coverage if they

need to buy health insurance on their own. Premium and cost-sharing subsidies will be available through the marketplace to reduce the cost of coverage for individuals and families, based on their income. Individuals and families with very low incomes will also be able to find out at the marketplace if they are eligible for coverage through Medicaid and CHIP. Finally, small businesses can also buy coverage for their employees through the Small Business Health Options Program (SHOP) marketplace.

There will be a health insurance marketplace in every state for individuals and families and for small businesses. Some marketplaces will be operated by the state and have a special state name (such as Covered California or The Maryland Health Connection.) In other states where the federal government runs the marketplace, it will be called The Health Insurance Marketplace of [state name.]

Links to all state marketplaces can be found at www.HealthCare.gov.

Frequently Asked Questions

19. Who can buy coverage in the marketplace?

Most people can shop for coverage in the marketplace. To be eligible you must live in the state where your marketplace is, you must be a citizen of the U.S. or be lawfully present in the U.S., and you must not currently be incarcerated.

Not everybody who is eligible to purchase coverage in the marketplace will be eligible for subsidies, however. To qualify for subsidies people will have to meet additional requirements having to do with their income and their eligibility for other coverage.

20. I live in one state, but drive across the border every day to work in a different state. What marketplace should I use to buy coverage?

Generally, you should buy coverage in the marketplace in the state where you live.

21. I'm eligible for health benefits at work, but I want to see if I can get a better deal in the marketplace. Can I do that?

You can always shop for coverage on the marketplace, assuming you meet other eligibility requirements, but if you have access to job-based coverage, you might not qualify for premium tax credits.

22. I have Medicare. Can I drop it and go to the health insurance marketplace?

If you have Medicare, you cannot buy a plan in the marketplace. In fact, companies that sell marketplace plans are prohibited from selling these plans to you if they know you are covered by Medicare. However, a small number of individuals are enrolled in Medicare Part A and paying premiums (typically

those who have not paid Medicare taxes for 10 years or more). These individuals may be eligible for a premium tax credit, and coverage through a health insurance marketplace may be the best option for them.

23. Can I buy a plan in the marketplace if I don't have a green card?

If you are not a U.S. citizen, a U.S. national, or an alien lawfully present in the U.S., you are not eligible to buy a plan on the health insurance marketplace. However, you can shop for health insurance outside of the marketplace in the non-group market. Insurers outside of the marketplace are prohibited from turning you down based on your health status or your immigration status and must generally follow the same rules as plans in the marketplace. To obtain coverage, contact a state-licensed health insurance company or a licensed agent or broker. Your state Department of Insurance can help you find one. See Appendix C for a list of state Departments of Insurance websites.

24. My son goes to college in another state but we want him on our family plan in the health insurance marketplace. Can we do that?

Yes. If your son or daughter is a member of your tax household, they can join your family plan on the health insurance marketplace, even if they live out of state. However, your child may need to return home in order to access care within your plan's network. If he or she gets health care services in another state, the providers may be outside your plan's network and you may have to pay high co-payments or coinsurance. Your son or daughter is also likely eligible to buy coverage in the state where they attend school. If they do so, they would have a greater choice of in-network providers.

25. My husband is covered under my plan at work. If I retire and sign up for my retiree plan, will my husband be eligible to buy a plan on the marketplace?

Probably. Most people are eligible to buy a plan on the health insurance marketplace. However, depending on your household income and his access to other coverage options, he may not be eligible for premium tax credits to lower the cost of a marketplace plan. For example, if he is eligible for Medicare and doesn't sign up for your retiree plan, he would not be eligible for premium tax credits. However, if he's not eligible for Medicare and doesn't enroll in your retiree health plan, he could be eligible for premium tax credits, assuming your household income is less than 400 percent of the federal poverty level ($62,040 for a couple in 2013). See Appendix A for more information on the federal poverty level for individuals and families.

26. I own my own business and have no employees, what are my options?

While you are not eligible to purchase small group health insurance through the SHOP marketplace, you can purchase individual market coverage and may be able to qualify for premium tax credits and/or cost-sharing reductions through the health insurance marketplace for individuals.

Multi-State Plans

27. What is a Multi-State Plan?

The Multi-State Plan program was established under the Affordable Care Act to provide people with additional coverage options in the health insurance marketplace. A Multi-State Plan is one that has been approved to participate on the health insurance marketplace by a federal government agency, the U.S. Office of Personnel Management. This is the same agency that administers the health plan for federal government employees.

28. Are Multi-State Plans available in every state?

In 2014, there are Multi-State Plans in 30 states and the District of Columbia, but by 2017 the law requires that all 50 states have Multi-State Plans.

29. Are Multi-State Plans available in and out of the Marketplace?

No. Multi-State Plans may only be sold through the health insurance marketplace.

30. If I sign up for a Multi-State Plan and then need to get care while I'm in a different state, can I count on being able to find in-network providers in another state?

Not necessarily. In 2014, Multi-State Plans are offered through the Blue Cross Blue Shield Association. Some Multi-State Plans will reimburse as "in-network" care rendered by providers in other state Blue Cross Blue Shield plan networks, but others may not. This information should be provided in the description of the Multi-State Plan's features on your state's health insurance marketplace.

Marketplace Verification and Appeals

31. The marketplace said I must submit additional information to document my eligibility (to buy coverage or to qualify for premium tax credits). They gave me 90 days. I won't be able to gather the information that quickly. Can I request an extension?

Yes. You must request any extension before the 90-day deadline runs out. You can request the extension in writing or through the marketplace call center. In your request you should include your name, a description of the supporting documents requested, the reason you need an extension, and the amount of additional time you need. You may want to ask a Navigator for help requesting an extension.

32. The marketplace said I must submit additional information to document my eligibility (to buy coverage or to qualify for premium tax credits or to receive an exemption). They gave me 90 days, but I missed the deadline. Can I request an extension?

If the marketplace hasn't received the requested information within 90 days and you didn't already ask for an extension, the marketplace will make a determination based on the information it has. If you disagree with that decision you can appeal.

33. How do I appeal a marketplace decision?

You can request an appeal of any marketplace decision, including decisions about:

- Your eligibility to buy coverage in the marketplace
- Your eligibility to buy coverage outside the open enrollment period
- Your eligibility for Medicaid or CHIP
- Your eligibility for, or the amount of, premium tax credits or cost-sharing reductions
- Your eligibility for an exemption from the penalty for not having health insurance
- Untimely (late) notice from the marketplace about a decision

After you have applied for coverage in the marketplace, you will get an eligibility notice (called a Determination Notice) either in the mail or online (depending on how you applied for coverage) that explains what you qualify for. If you don't agree with that notice, you can file an appeal. To make your appeal, start by reviewing the marketplace's decision. The notice will explain the reasons for the decision and the process you should follow if you want to appeal.

There are four ways to file a marketplace appeal:

1. Log into your "My Account" at www.HealthCare.gov/marketplace/individual
2. Call 1-800-318-2596. (TTY: 1-855-889-4325)
3. Mail in an appeal request form. These forms will be available soon.
4. Write a letter to:

   Health Insurance Marketplace
   465 Industrial Blvd.
   London, KY 40750-0061

To request an appeal, you'll have to provide your name and contact information and an explanation of what you are appealing and why. You can make your appeal online, in writing, or over the phone by calling the marketplace call center.

You can submit documents to the marketplace that support your case. You can submit documents along with your initial appeal request or at any time during the appeal process, up until a hearing.

The marketplace may offer you the option of receiving temporary benefits while your appeal is pending. You can accept the temporary benefits or waive them. If you accept temporary benefits during the appeals process and then lose your appeal, you might have to pay back the benefits you were ultimately determined to be ineligible for.

After you file an appeal, you will get the following from the marketplace:

- A letter that states that your appeal was received
- A letter asking for more information or documentation if needed
- A decision, which the marketplace must mail to you within 90 days of receiving your appeal request

The marketplace will review your completed appeal once it is submitted. Then the marketplace will let you know its decision. If you still disagree with the decision, you can request a hearing. While you are waiting for the hearing to take place, the marketplace may contact you to try to resolve the dispute informally.
If you need help with your appeal:

- You can call the health insurance marketplace call center at 1-800-318-2596 (TTY: 1-855-889-4325), or visit www.HealthCare.gov to get more information about appeals.
- You can contact either your state's Consumer Assistance Program (CAP), your state's Department of Insurance (See Appendix C for a list of state Departments of Insurance), or a local Navigator. Visit https://localhelp.healthcare.gov to find help in your area.
- You can get help from an interpreter by calling 1-800-318-2596.
- You may want to ask a Navigator for help requesting an appeal. You can also appoint an authorized representative to help you.

34. How long will the appeal take?

This will depend on the reason for your appeal and the documentation needed to decide your appeal. Contact the marketplace for more information about your appeal.

Open and Special Enrollment Periods

Background

Under the Affordable Care Act, health insurers selling individual coverage are required to sell a plan to all applicants, with certain limited exceptions. One of the most important exceptions allows insurers to limit the amount of time during the year that policies are available, a period of time called an open enrollment period. Under federal rules, for 2014, the open enrollment period is October 1, 2013 to March 31, 2014. For coverage that will begin in 2015, the open enrollment period will be November 15, 2014 to February 15, 2015. However, states may establish longer or more frequent open enrollment periods.

Individuals who experience life changes, such as marriage, divorce, or the birth of a child may also qualify for a special enrollment period, which gives them a right to sign up for a plan outside of the open enrollment period.

Frequently Asked Questions

35. When can I buy a health plan through the marketplace?

In general, you can only enroll in non-group health plan coverage during the open enrollment period. This year the open enrollment period began October 1, 2013 and extends through March 31, 2014. After that, the marketplace open enrollment period will last from November 15 through February 15. Once the open enrollment period is over, individuals and families will not be able to enroll in marketplace health plans until the next open enrollment period. However, if you experience certain changes in circumstances during the year, you will have a special 60-day opportunity to enroll in marketplace health plans, outside of the open enrollment period. In addition, if you have an individual insurance policy that is cancelled outside the open enrollment period, you will have a special 30-day opportunity to enroll.

Individuals and families buying non-group coverage on their own, outside of the marketplace, can also only enroll in coverage during open enrollment periods and special enrollment opportunities.

American Indians and Alaska Natives, however, can enroll in coverage throughout the year, not just during open enrollment periods or special enrollment opportunities.

36. When can I enroll in Medicaid through the marketplace?

You can enroll in Medicaid or CHIP at any time during the year, not just during open enrollment.

37. Why can't I buy a plan when I need it? Why do I have to wait for the open enrollment period?

If everyone were allowed to wait until they were sick to buy coverage, premiums would be very expensive. An open enrollment period encourages healthy people to buy a plan to protect themselves from unanticipated events during the year. Health insurers need a mix of healthy and sick people to make premiums fair for everyone.

38. Can I buy or change private health plan coverage outside of open enrollment?

In general, you can only buy or change your private, non-group health plan coverage outside of the open enrollment period if you have a qualifying life event that entitles you to a special enrollment opportunity. Events that trigger a special enrollment opportunity are:

- Loss of eligibility for other coverage (for example, if you lose your employer-sponsored coverage because you quit your job, were laid off, or if your hours were reduced, or if you lose student health coverage when you graduate). Note that loss of eligibility for other coverage because you didn't pay premiums does not trigger a special enrollment opportunity.
- Gaining a dependent (for example, if you get married or give birth to or adopt a child). Note that pregnancy does NOT trigger a special enrollment opportunity.
- Divorce or legal separation that results in a loss of coverage
- Loss of dependent status (for example, "aging off" a parent's plan when you turn 26)
- Moving to another state or within a state if you move outside of your health plan service area
- Exhaustion of COBRA coverage
- Losing eligibility for Medicaid or the Children's Health Insurance Program
- For people enrolled in a marketplace plan, income increases or decreases enough to change your eligibility for premium tax credits and/or cost-sharing reductions
- Change in immigration status
- Enrollment or eligibility error made by the marketplace or another government agency or somebody, such as an assister, acting on their behalf

In addition, if you are enrolled in an individual insurance policy and it is cancelled during 2014, you will be given a special 30-day opportunity to enroll in a new plan.

Note that some triggering events will only qualify you for a special enrollment opportunity in the health insurance marketplace; they do not apply in the outside market. For example, if you gain citizenship or lawfully present status, the marketplace must provide you with a special enrollment opportunity.

When you experience a qualifying event, your special enrollment opportunity will last 60 days from the date of that triggering event.

States have flexibility to expand special enrollment opportunities for consumers. Check with your State marketplace for more information.

39. If I buy a plan, when does my coverage start?

If you buy a plan between October 1 and December 15, 2013, and make your first premium payment by the due date specified by your plan, your new coverage will start on January 1, 2014. After December 15, 2013, if you buy a plan between the 1st and 15th of the month and pay your premium by the plan's due date, your coverage becomes effective on the first day of the following month. If you enroll between the 16th and the last day of any month between December 2013 and March 31, 2014 and pay your premium by the plan's due date, your coverage will become effective the first day of the second following month. In other words, if you buy your coverage on December 16th, 2013, your coverage will be effective February 1, 2014. Likewise, if you buy a plan on January 16th, 2014, your coverage becomes effective on March 1, 2014.

40. Does pregnancy trigger a special enrollment opportunity to buy or change coverage?

No it does not. However, when the baby is born you will be eligible for a special enrollment opportunity. You can enroll your baby in coverage at that point. You (and your spouse) can also change health plans during this special enrollment opportunity.

41. My hours at work were cut and I no longer qualify for my employer's plan. Do I have to wait until the open enrollment period to sign up for an individual plan?

No. You qualify for a "special enrollment period" and can purchase individual coverage, so long as you do so within 60 days of losing your employer plan.

42. My income has gone down and I think I may now qualify for premium tax credits in the health insurance marketplace. Do I have to wait for an open enrollment period before I can enroll?

It depends. If you are currently enrolled in a marketplace health plan and are newly eligible for a premium tax credit, or if you've had a change in eligibility for premium tax credits or cost-sharing reductions, you may enroll in a new plan on the health insurance marketplace at any time during the year, so long as you do so within 60 days of your change in status. However, if you are not currently in a marketplace plan, you do not qualify for a special enrollment period.

NOTE: Check the rules of your State's marketplace. States have the flexibility to expand special enrollment opportunities for consumers.

43. I just got a promotion and no longer qualify for premium tax credits. Can I drop my current plan and buy a new one even though it's outside the open enrollment period? Can I buy a plan outside the health insurance marketplace?

If you are currently enrolled in a plan on the health insurance marketplace, you may buy a new plan if you lost eligibility for premium tax credits, so long as you do so within 60 days of your change in status. However, if you want to buy health insurance outside the health insurance marketplace, you may need to wait until the open enrollment period.

NOTE: Check the rules of your state's marketplace. States have the flexibility to expand special enrollment opportunities for consumers.

44. I am an American Indian. When can I enroll in a marketplace plan?

If you are an eligible American Indian, you may enroll in or change plans on the health insurance marketplace one time per month.

45. I signed up for a bronze plan with a high deductible during open enrollment. Now, six months later, I need surgery and would rather be in a different plan with a lower deductible. Can I change plans?

No, in general, once you sign up for a plan, you are locked into that coverage for 12 months, or until the next open enrollment period. A change in health status doesn't make you eligible for a special enrollment opportunity.

46. My marketplace plan took effect last month, but I just learned my primary care doctor is not in the plan's network. Can I change plans?

It depends. Under limited circumstances, you may be able to change plans. If you are enrolled in a plan through a federally run marketplace and you meet all four of the following criteria, you may be able to get a special enrollment opportunity to change plans:

- You are changing to a plan with the same insurer;
- You are changing to a plan in the same metal level and with the same cost-sharing reduction, if applicable to you;
- You are changing plans to move to a more inclusive network or for other limited circumstances; and
- It is still open enrollment.

If you meet all four of those conditions, you can contact the marketplace call center at 800-318-2596 and request a special enrollment period. The call center can tell you if your marketplace is state run or federally run; this special enrollment opportunity only applies in federally run marketplaces.

Eligibility For Premium Tax Credits and Cost-Sharing Reductions

Background

Starting in January 2014, individuals may qualify for financial help with premiums and out-of-pocket costs for coverage purchased through a health insurance marketplace. Financial help is available in two forms: a premium tax credit and cost-sharing reductions.

To be eligible for the premium tax credit, the individual must meet all of the following criteria:

- Enrolled in a plan sold through the health insurance marketplace,
- Not eligible for minimum essential coverage, other than coverage offered in the individual market (see below for definitions of minimum essential coverage), and
- Household income between 100 percent and 400 percent of the federal poverty level (See Appendix A for more information on the federal poverty level for individuals and families).

In general, minimum essential coverage includes the following:

- Employer-sponsored coverage, including COBRA continuation coverage and retiree coverage
- Coverage purchased in the individual market, including a plan purchased in a health insurance marketplace
- Medicare Part A coverage and Medicare Advantage plans
- Most Medicaid coverage
- Children's Health Insurance Program coverage
- Certain types of Veterans health coverage administered by the Veterans Administration
- TRICARE (coverage for members of the military)
- Self-funded student health coverage (for 2014; may change in 2015)
- High-risk pool coverage (for 2014; may change in 2015)
- Coverage for Peace Corps volunteers
- Refugee Medical Assistance from the federal Administration for Children and Families
- Department of Defense health benefit program for civilian employees known as "Nonappropriated Fund" personnel

There may be other types of coverage that qualify as minimum essential coverage.

There are exceptions to the list of minimum essential coverage, in which having some forms of minimum essential coverage do not disqualify an individual for the premium tax credit because of special circumstances.

Those exceptions include the following:

- Employer-sponsored coverage: if the coverage is either "unaffordable" or does not meet minimum value standards ("inadequate"), then the individual may still qualify for the premium tax credit.
  - Unaffordable means the cost of self-only coverage in the lowest cost plan is more than 9.5 percent of the individual's household income.
  - To provide minimum value, the plan must have an actuarial value of at least 60 percent.
- Individual market coverage: though it meets the minimum essential coverage standard, having this coverage does not disqualify the enrollee for premium tax credits.
- Children's Health Insurance Program coverage:
  - An individual subject to a waiting period before he or she can enroll in their state's Children's Health Insurance Program is not considered eligible for minimum essential coverage and may therefore be eligible for the premium tax credit during the waiting period.

  NOTE: Not all states have a waiting period for their Children's Health Insurance Program.
  - An individual who is not enrolled in the Children's Health Insurance Program because he or she hasn't paid premiums is considered eligible for minimum essential coverage and therefore not eligible for premium tax credit. Similarly, an individual who is not enrolled in Medicaid because he or she hasn't paid premiums is considered eligible for minimum essential coverage and therefore not eligible for premium tax credits.
- Coverage tied to a certain condition: individuals who may be eligible for Medicare or Medicaid based on disability, blindness or illness are considered eligible for minimum essential coverage only when the agency responsible for eligibility determinations determines the individual eligible for Medicare or Medicaid. Until that time, the individual is eligible for premium tax credit.
- Other coverage, including coverage that may have a substantial premium. In these circumstances, only those who are enrolled in the following coverage are ineligible for the premium tax credits:

- Self-insured student health plan (for 2014; this may change in 2015). See FAQ #213 for information on determining whether you are in a self-insured student plan
- State high-risk pools
- Medicare Part A coverage requiring payment of premiums
- Certain TRICARE programs: Young Adult, Retired Reserve, Reserve Select, and the Continued Health Care Benefit Program

There may be other exceptions to minimum essential coverage that allows individuals to apply to premium tax credits.

Frequently Asked Questions

47. Who is eligible for marketplace premium tax credits?

Premium tax credits will be available to U.S. citizens and lawfully present immigrants who purchase coverage in the marketplace and who have income between 100 percent and 400 percent of the federal poverty level (See Appendix A for more information on the federal poverty level for individuals and families). Premium tax credits are also available to lawfully residing immigrants with incomes below 100 percent of the poverty line who are not eligible for Medicaid because of their immigration status. (Generally, immigrants must lawfully reside in the U.S. for five years before they can become eligible for Medicaid.)

In addition, to be eligible for the premium tax credits, individuals must not be eligible for public coverage—including Medicaid, the Children's Health Insurance Program, Medicare, or military coverage—and must not have access to health insurance through an employer. (There are exceptions to this. For example, there is an exception in cases when the employer plan is unaffordable because the employee's share of the premium exceeds 9.5 percent of the employee's income. There is also an exception in cases where the employer plan doesn't provide a minimum level of coverage. See FAQ #48.)

48. When can I apply for marketplace premium tax credits when other coverage is available?

In general, if you have any of the following types of coverage, you would be ineligible for premium tax credits through the marketplace:

- Employer-sponsored coverage, unless the coverage is unaffordable (your required contribution to the premium for self-only coverage costs more than 9.5 percent of household income) or does not meet minimum value (an actuarial value of less than 60 percent) Special rules apply when the affordability of family coverage is a concern.
- Government-sponsored coverage, including Medicare Part A coverage, Medicare Advantage

plans, Medicaid coverage and the Children's Health Insurance Program coverage, Veterans health coverage and TRICARE (coverage for members of the military)

- Coverage for Peace Corps volunteers

49. I'm married. I work full-time for a large employer that offers me health benefits, but won't cover spouses. Is that allowed? Can my spouse apply for coverage and subsidies in the marketplace?

Beginning in 2015, employers with 100 employees or more will be required to offer health benefits to full-time workers, but not to their dependents. If they do not offer coverage to their workers, they face a penalty if an employee qualifies for premium tax credits in the marketplace. Beginning in 2016, employers with 50 or more employees that don't offer health benefits to their full-time workers may also be liable for a penalty. Employers will also be required in 2016 to offer health benefits to dependent children; however, employers are not required to offer coverage to the spouses of employees.

Meanwhile, because your spouse is not offered health benefits through your job, s/he may be eligible to apply for coverage and premium tax credits through the marketplace.

50. My family and I are offered health benefits through my job, but we can't afford to enroll. My employer pays 100 percent of the premium for workers, but contributes nothing toward the cost of adding my wife and kids. Can we try to find a better deal in the marketplace?

You can always shop for coverage on the marketplace, but your family members won't be eligible for tax credits to help pay the premium. When people are eligible for employer-sponsored coverage, they can only qualify for marketplace premium tax credits if the employer-sponsored coverage is unaffordable. The way this is calculated, coverage is unaffordable only if your cost for coverage for a single person under the employer plan is more than 9.5 percent of your income. So although you may feel your family coverage is unaffordable in practical terms, it is considered technically affordable.

If your family members end up uninsured because family coverage is unaffordable, they will not have to pay a tax penalty under the "individual mandate."

51. I'm offered health benefits at work, but they're not very good. I'm applying for better coverage and subsidies in the marketplace. The application asks whether I'm offered job-based health coverage that meets minimum value. What does that mean?

The term "minimum value" means that your job-based plan would cover at least 60 percent of an average group of people's covered health costs. Most employer plans will meet this test, but some may not. The marketplace application includes a form with questions about job-based coverage. You should take this form to your employer and ask them to fill it out. With that information the marketplace will determine whether the plan meets minimum value. If it doesn't, you may be able to qualify for premium tax credits to help pay for marketplace coverage.

52. My employer's health plan only covers generic drugs. Does that mean it doesn't have minimum value? Can I shop for better coverage and subsidies on the marketplace?

Whether your employer's health plan meets minimum value will depend on a number of factors. The marketplace application includes a form with questions about job-based coverage. You should take this form to your employer and ask them to fill it out. With that information the marketplace will determine whether the plan meets minimum value. If it doesn't, you may be able to qualify for premium tax credits to help pay for marketplace coverage.

53. My employer's plan is grandfathered so it doesn't cover preventive services. Can I shop for better coverage in the marketplace if my job-based plan is grandfathered?

You can always shop for coverage in the marketplace. However, you can only qualify for premium tax credits if your job-based plan — whether it is a grandfathered plan or not — is unaffordable or if it doesn't meet minimum value. Whether your employer's health plan meets minimum value will depend on a number of factors. The marketplace application includes a form with questions about job-based coverage. You should take this form to your employer and ask them to fill it out. With that information the marketplace will determine whether the plan meets minimum value. If it doesn't, you may be able to qualify for premium tax credits to help pay for marketplace coverage.

54. If I'm eligible for other coverage but haven't enrolled in it yet, can I qualify for premium tax credits in the marketplace?

For certain types of coverage, if you are eligible but not enrolled, then you can still qualify for premium tax credits. These include:

- Retiree health coverage offered by a former employer
- COBRA coverage
- Student health plan coverage
- Medicare Part A coverage requiring payment of premiums

However, if you are eligible for job-based coverage (that is affordable and meets minimum value) or for Medicaid or CHIP, but you didn't enroll, then you are not eligible for premium tax credits.

55. My kids are eligible for the Children's Health Insurance Program. Can I enroll them in our marketplace health plan and get premium tax credits for them instead?

You can add your children to your marketplace plan, but because they are eligible for your state's Children's Health Insurance Program (CHIP), they are not eligible for premium tax credits. The exception to that is if you live in a state that has a waiting period for enrolling in CHIP. During the waiting period, your children are eligible for a premium tax credit; when the waiting period has ended and they can enroll in CHIP, your children will become ineligible for the tax credit.

56. I have an individual insurance policy. Can I drop it and go into the health insurance marketplace and qualify for premium tax credits?

Yes, having an individual policy does not disqualify you from buying coverage through a health insurance marketplace with premium tax credits. As long as you meet the other eligibility criteria for premium tax credits, you will likely qualify. Even if you don't qualify for premium tax credits, you may want to look at the coverage options in the health insurance marketplace, to see if there is a plan that would work better for you than the one you have now.

57. I'm a college student enrolled in my college's student health plan. Can I drop it and go to the health insurance marketplace?

Yes. You may apply for premium tax credits and enroll in a health plan through the health insurance marketplace, as long as you drop your student health plan before coverage begins through the marketplace.

58. I'm eligible for COBRA but haven't elected it yet. Does that affect my eligibility for marketplace subsidies?

No, Just being eligible for COBRA doesn't affect your eligibility for premium tax credits or cost-sharing assistance if you enroll in a marketplace plan.

59. I think I'll qualify for a tax credit based on my income, but I see there are bronze plans that are really affordable. Is that the best plan for me?

It depends. If your household income qualifies you for cost-sharing reductions as well as a premium tax credit, you will probably get a better deal with a silver level plan. You can use premium tax credits to buy a plan in any of the four coverage levels (bronze, silver, gold or platinum), but the cost-sharing reductions only apply to plans in the silver level. Depending on your health status, a very low premium bronze plan may be a better deal for you, but if your health care use turns out to be more than you anticipated, you will likely have a high deductible and higher out-of-pocket costs, with no cost-sharing reductions to help lower those.

Eligibility for Premium Tax Credits – Income Rules

60. How much can I earn and qualify for premium tax credits in the marketplace?

Premium tax credits are available to people who buy marketplace coverage and whose income is between 100 percent and 400 percent of the federal poverty level (See Appendix A for more information on the federal poverty level for individuals and families).

61. Is the value of my house counted in determining my eligibility for premium tax credits in the marketplace?

No, assets are not counted. So the value of your house, car, retirement savings, etc. will not affect your eligibility for premium tax credits. Only your income is considered.

62. My income is below the federal poverty level and my state has not elected to expand Medicaid eligibility. Can I qualify for premium tax credits?

No, your income is too low to qualify for premium tax credits, but check with your state's marketplace to see if there are other options you might be eligible for.

63. I earn enough to qualify for premium tax credits, but I'm concerned my income may drop later this year to less than 100 percent of poverty. If that happens, will I have to pay back the premium tax credits I get?

No, you will not have to pay back the premium tax credits you get if the marketplace said you were eligible for premium tax credits and your income drops below 100 percent of poverty. In fact, you may get a refund. When you file your taxes, the credit you receive will be compared to the credit you should have received based on your actual income for the year. If your income goes down, you will get a refund for the difference between the two.

64. What income is counted in determining my eligibility for premium tax credits?

Eligibility for premium tax credits is based on your Modified Adjusted Gross Income, or MAGI. When you file a federal income tax return, you must report your adjusted gross income (which includes wages and salaries, interest and dividends, unemployment benefits, and several other sources of income). MAGI modifies your adjusted gross income by adding to it any non-taxable Social Security benefits you receive, any tax-exempt interest you earn, and any foreign income you earned that was excluded from your income for tax purposes.

Note that eligibility for Medicaid and CHIP is also based on MAGI, although some additional modifications may be made in determining eligibility for these programs. Contact your marketplace or your state Medicaid program for more information.

65. I get Social Security benefits and don't make enough to pay federal income taxes on them. Do I count my tax-free Social Security benefits when I apply for premium tax credits?

Yes, all of your Social Security benefits will be counted as income in determining your eligibility.

66. I'm divorced and receive child support payments from my ex-husband. Do I count that in determining eligibility for subsidies?

No, child support payments you receive are not counted.

67. I'm divorced and I pay alimony to my ex-spouse. Should I deduct that from my income in determining my eligibility for subsidies?

Alimony that is paid is deducted from gross income to determine adjusted gross Income. It will be excluded from income in determining your eligibility for subsidies.

68. My income is very low, but I just inherited $10,000 from my aunt. Will that affect my eligibility for subsidies?

No. Inheritances are not counted.

69. I'm currently collecting workers compensation benefits. Are those counted in determining my eligibility for subsidies?

Worker's compensation payments are generally not taxable, so they would not be counted in determining your eligibility.

70. I have a college scholarship that covers my tuition and fees. Do I count that as income in determining my eligibility for subsidies?

Scholarship and fellowship payments for tuition and fees and course-related expenses required of all students are not counted as income in determining your eligibility. Payments for room and board are included.

71. My wife and I have a teenager who has a part-time job. Do we count her income as part of our household income when we apply for marketplace subsidies?

The answer depends on whether she earns enough income to be required to file a federal income tax return on her own. Generally, kids aren't required to file a return or pay taxes on their income if they earn less than $5,950 in a year. If your daughter earns less than that in a year, you would not count her income as part of your household income, but if she earns more than that amount, you would count it.

Eligibility for Premium Tax Credits - Rules for Counting Household Size and Income

72. I understand eligibility for premium tax credits is based on our household income. Who counts as being in my household?

A household, for purposes of determining eligibility for premium tax credits, includes any individuals for whom a taxpayer claims a personal exemption on the federal tax form. That includes yourself, your spouse, and dependents. Dependents include children who meet certain requirements:

- U.S. citizen or resident of the U.S., Mexico or Canada
- Live with you for more than half the year
- Under age 19 at the end of the year (or under age 24 if a full-time student); a child is considered to live with the taxpayer while he or she is temporarily away from home due to education, illness, business, vacation or military service.
- Doesn't provide more than 50 percent of his or her own support

Other individuals who can count as dependents include relatives, in-laws or full-time members of your household who are:

- U.S. citizen or resident of the U.S., Mexico or Canada
- Receive more than 50 percent of their support from you
- Are related to you or live in your home all year
- Make less than $3,900 (in 2013), generally excluding Social Security

A household can include individuals even if they are ineligible for tax credits (for example, individuals who are not lawfully present). Your household size can change during a year due to family changes, including the birth or adoption of a child, a child moving out of the house, and divorce or legal separation. When such changes take place you should report them to the marketplace as they may affect your eligibility for subsidies. Family changes also can trigger a special enrollment opportunity when you can change health plans outside of the regular open enrollment period.

Note that the definition of household for determining eligibility for premium tax credits sometimes differs from the definition of household for determining Medicaid eligibility. Ask your marketplace for more information about who should be counted in your household.

73. My partner and I live together but are unmarried. Is our combined household income what we should report?

Because you are not married, you will be considered two separate households for the purposes of

determining eligibility for premium tax credits and Medicaid. Assuming that neither of you are claiming any dependents on your tax returns, you will each be considered as a household of one and your own income will be used to determine eligibility for premium tax credits and Medicaid as well as the amount of any premium tax credit and cost-sharing reduction you may qualify for. If you are eligible for premium tax credits, you will each receive a separate determination of the amount of your credit and whether you are eligible for a cost-sharing reduction. Whether you can use your credits to buy a family policy rather than two individual policies will depend on the offerings in your state marketplace.

74. I'm raising my grandchild and claim her as a dependent. If I apply for marketplace subsidies, will we be considered a household of two?

Yes, you will be considered as a household of two for both Medicaid and premium tax credits. However, your grandchild will be considered as her own household for Medicaid and CHIP and your income will not count in determining her eligibility for these programs. Assuming she does not have her own income she will likely be eligible for Medicaid or CHIP and not eligible for premium tax credits for coverage in the marketplace. You could of course purchase coverage for her in the marketplace but you would not be eligible for a premium tax credit to help pay for her plan. Whether you could include her on your policy would depend on what insurers offer in your marketplace.

75. We are a married, same-sex couple. We no longer live in the state where we got married and our current state of residence doesn't recognize same-sex marriages. If we apply for marketplace subsidies, are we considered a household of one or two?

Assuming you plan to file your federal income taxes as a married couple, yes you can apply for premium tax credits as a married couple. It does not matter if you no longer live in the state where your marriage was celebrated.

76. My partner and I are unmarried and we have two children. How do we count our household size and income when we apply for subsidies in the marketplace? Can we buy one policy to cover the whole family?

Assuming you are eligible for premium tax credits, the amount of your credit will be calculated based on how you file your taxes. If, for example, you each claim one of your children, you each will be considered as a household of two. The income of each household would be evaluated separately to calculate eligibility for and the amount of premium tax credits and cost-sharing reductions. Using a different example, if you claim both children as dependents on your tax return, then you and your children will be considered a household of three, and your income will be the basis for determining subsidy eligibility for the three of you. Your partner will be a household of one and his/her eligibility for premium tax credits will be determined separately.

Cost-Sharing Subsidies

77. I can't afford to pay much for deductibles and co-pays. Is there help for me in the marketplace for cost-sharing?

Yes. If your income is between 100 percent and 250 percent of the federal poverty level, you can also qualify for cost-sharing reductions. These will reduce the deductibles, co-pays, and other cost-sharing that would otherwise apply to covered services.

The cost-sharing reductions will be available through modified versions of silver plans that are offered on the marketplace. These plans will have lower deductibles, co-pays, coinsurance and out-of-pocket limits compared to regular silver plans. Once the marketplace determines you are eligible for cost-sharing reductions, you will be able to select one of these modified silver plans, based on your income level.

See Appendix A for more information on the federal poverty level for individuals and families.

78. If I use my premium subsidy for a bronze plan, I can save even more money on the premium. Can I get also get my cost-sharing reduction through a bronze plan?

No, you can only get cost-sharing reductions by enrolling in a silver marketplace plan. You will not receive cost-sharing reductions if you enroll in a bronze, gold, or platinum plan. Note that this is different from the rule for premium tax credits. You can apply premium tax credits to all four types of plan. However, if you are eligible for both kinds of help (that is, if your income is between 100 percent and 250 percent of the federal poverty level), you can only receive both types of subsidies if you enroll in a silver plan. See Appendix A for more information on the federal poverty level for individuals and families.

As for the type of coverage your family can purchase, that may vary based on the marketplace rules where you live. For example, some insurers may offer family coverage only to married couples. If you buy one policy for the entire family, all the tax credits you are eligible for can be used to reduce the premium for that policy. If you buy separate policies, you can allocate the premium tax credits across two plans.

Immigrants

79. Can immigrants enroll in Medicaid or Children's Health Insurance Program (CHIP) coverage?

Most lawfully present immigrants who meet Medicaid and CHIP program requirements, such as income and state residency, can enroll in Medicaid or CHIP after they have been in the United States

for five years or more.

Some groups of lawfully present immigrants do not have to wait five years before they may enroll in Medicaid and CHIP. These include refugees, asylees, and other humanitarian immigrants; veterans and military families; and pregnant women and children in some states.

Some lawfully present immigrants who are authorized to work in the United States cannot enroll in Medicaid, even if they have been in the country for five or more years.

Undocumented immigrants may not enroll in Medicaid or CHIP coverage.

80. Can immigrants buy health insurance through the new health insurance marketplace?

Most lawfully present immigrants can buy health insurance through the new health insurance marketplaces. This group includes lawfully present immigrants who cannot enroll in Medicaid. Undocumented immigrants may not purchase coverage through the new health insurance marketplaces.

81. Can immigrants get help paying premiums and/or cost-sharing for health insurance in the new health insurance marketplaces?

Lawfully present immigrants can get tax credits to help pay premiums and cost-sharing for health insurance through the marketplaces. Like citizens, they can get tax credits to help pay premiums if they make between 100 percent and 400 percent of the federal poverty level. The amount they pay for care will also be lowered if they make between 100 percent and 250 percent of the federal poverty level (See Appendix A for more information on the federal poverty level for individuals and families). To get this help, they cannot be offered affordable health insurance through their job or be eligible for Medicaid.

Lawfully-present immigrants who make less than 100 percent of the federal poverty level also can get help paying premiums and cost-sharing if they cannot enroll in Medicaid. Many lawfully-present immigrants cannot enroll in Medicaid until they have been in the United States for five or more years.

Undocumented immigrants cannot receive help paying for premiums or cost-sharing for marketplace coverage and may not buy health insurance through the marketplaces even at full cost.

82. Can family members in families with mixed immigration status, where some family members are lawfully present and others are undocumented, enroll in Medicaid or CHIP or receive help buying coverage through the marketplaces?

Citizen and lawfully present family members can get health insurance coverage through Medicaid, CHIP, and marketplaces even if other family members are not lawfully present. Family members who are not

lawfully present, including undocumented immigrants, may apply for health insurance for citizen and lawfully present family members. For example, an undocumented immigrant parent may apply for health insurance for a citizen child.

When a family with mixed immigration status applies for health insurance, it only has to give citizenship and immigration status for those family members applying for coverage. Non-applicants, such as a parent applying for a child, do not have to provide citizenship or immigration status. Non-applicants will be asked to provide a Social Security number, but do not have to provide one unless the family is applying for help with costs for marketplace coverage and the individual is the tax-filer for the household.

83. How will an individual's citizenship and immigration status be checked?

Only those individuals in a family who are applying for health insurance are required to provide citizenship and immigration status. Applicants also must provide a Social Security number if they have one.
Citizenship and immigration status for those applying for health insurance will be checked electronically with several systems, including the Social Security Administration, the Department of Homeland Security, and SAVE (Systematic Alien Verification for Entitlements).

If an individual's status cannot be checked through an electronic match, the individual can give other documentation of his or her status.

84. Will getting health insurance through Medicaid, CHIP, or health insurance marketplaces affect an individual's ability to obtain lawful permanent status or citizenship?

In general, getting health insurance through Medicaid, CHIP, or the marketplaces will not prevent an individual from obtaining lawful permanent status or citizenship.

85. Will getting health insurance through Medicaid, CHIP, or health insurance marketplaces put undocumented family members at risk?

Medicaid, CHIP, and the marketplaces must protect individuals' information and keep it private. Information can be used only for eligibility and enrollment purposes.

86. Are immigrants required to have health insurance coverage under the Affordable Care Act's individual mandate?

Most immigrants who are residents lawfully present in the U.S., including "green card holders," must have health insurance coverage by 2014 or they will pay a tax penalty unless they qualify for an exemption. Check with your marketplace for more information about how the requirement applies to you, or if you want to apply for an exemption.

Immigrants who are not lawfully present in the U.S. will not pay a tax penalty if they do not have health insurance.

87. Who is a lawfully present immigrant for health insurance purposes?

Lawfully present immigrants generally include:

- Lawful permanent residents (or "green card holders");
- Persons fleeing persecution, including refugees and asylees;
- Other humanitarian immigrants, including those granted temporary protected status;
- Cuban/Haitian entrants; and
- Survivors of domestic violence, trafficking, and other serious crimes.

See www.HealthCare.gov/immigration-status-and-the-marketplace/ for more information and other groups that are lawfully present.

88. Are individuals granted deferred action under "Deferred Action for Childhood Arrivals" eligible for Medicaid, CHIP, and the health insurance marketplaces?

Some undocumented youth have been given temporary permission to stay in the United States under a program called Deferred Action for Childhood Arrivals. These individuals are lawfully present in the United States and can be granted work authorization and Social Security numbers. However, they are not eligible for Medicaid, CHIP, or the marketplaces.

89. Where can immigrants who cannot enroll in Medicaid or CHIP or get coverage through the marketplaces get health care or health coverage?

Hospitals are required to provide emergency care and treatment to all individuals regardless of immigration or insurance status, though afterwards they can bill for their services. In addition, individuals may get low-cost care at community health centers.

Individuals may purchase health coverage through an employer or a spouse's employer or the individual insurance market outside of the marketplace. Some states and counties also offer health programs for immigrants.

How Do Premium Tax Credits and Cost-Sharing Reductions Work?

Background

Beginning in 2014, individuals who purchase a plan in the health insurance marketplace may qualify for federal premium tax credits that will help lower premiums. (See "Eligibility for Premium Tax Credits" to learn more about how individuals may qualify for the credit). The credit can be used at the time premiums are paid, with the credit sent directly from the federal government to the individual's health insurer. Individuals may also qualify for cost-sharing reductions, which help lower their deductibles and other forms of cost-sharing.

How the premium tax credit works. Individuals who qualify for the tax credit have the choice to have the full amount of the credit in advance, to reduce premiums up front, or wait to get the credit when they file their taxes. Individuals can also take a lower advance credit than the full amount for which they are eligible, and receive the rest when they file their taxes.

The premium tax credit is provided on a sliding-scale basis, in order to give more financial help to lower income buyers (beginning at 100 percent of the federal poverty level, or $11,490 for an individual in 2013) and less help to those at the higher end of the income scale (400 percent of poverty, or $45,960 for an individual in 2013). The credit lowers premiums based on how much individuals must pay for health insurance as a share of their income. For example, families with incomes of 100 percent of poverty ($23,550 for a family of 4 in 2013) will pay annual premiums that are no more than 2 percent of their household income. At 400 percent of poverty ($94,200 for a family of four in 2013), families will pay annual premiums that are no more than 9.5 percent of their household income. See Appendix A for more information on the federal poverty level for individuals and families.

The credit is pegged to the cost of the premium for the second lowest cost silver plan in a health insurance marketplace, known as the benchmark plan. A consumer can "buy up" from this benchmark by buying a more expensive gold or platinum plan, but the tax credit won't cover as much of the premium as it will for a silver plan. Conversely, a consumer could "buy down" by looking for an inexpensive bronze plan. Because the premium tax credit is pegged to the cost of a silver plan, it will cover a greater percentage of the premium for a bronze plan.

For example, if John has income of 100 percent of poverty ($11,490 in 2013), his premium would be capped at 2 percent of his income, or $230. If the benchmark plan costs $5,000 a year, John would owe $230 and the credit would cover $4,770. If John chose to buy a plan with a higher premium (for example, either a higher cost silver plan or a gold plan), he would pay more than $230. For example, if the premium for the plan he buys is $5,500, John would pay $730 ($5,500 minus the $4,770 credit based on the benchmark).

Because the amount of the credit is based on income, any changes in income must be reported to the health

insurance marketplace right away. An individual whose income goes down may qualify for a bigger premium tax credit. Someone whose income goes up may be eligible for a smaller credit and will be responsible for repaying the difference between the smaller credit they should have gotten and the larger one they were getting based on old income information.

How cost-sharing reductions work: Beginning in 2014, individuals and families with income below 250 percent of poverty may also qualify for help paying out-of-pocket costs for services covered by their plan (See Appendix A for more information on the federal poverty level for individuals and families). The subsidy, known as a "cost-sharing reduction," lowers the out-of-pocket limit and increases the generosity of coverage for eligible individuals depending on income. The subsidy goes directly to the insurer to reduce an enrollee's out-of-pocket costs at the time the covered service is received. However, the cost-sharing reduction is only available for people enrolled in a silver plan. Where the standard value of a silver plan is 70 percent of total average costs for covered services, individuals eligible for the cost-sharing reduction will get a silver plan that covers 73 percent, 87 percent or 94 percent of total average costs for covered services, depending on income, with lower out-of-pocket limits as indicated below in Table 1.

Table 1. Cost-Sharing Reductions Based on Income

Income	Actuarial Value	Out-of-Pocket Limit
100 - 150 % FPL	94 %	$2,250 Individual; $4,500 Family
150 - 200 % FPL	87 %	$2,250 Individual; $4,500 Family
200 - 250 % FPL	73 %	$5,200 Individual; $10,400 Family

Frequently Asked Questions

90. Can I get premium tax credits for health plans sold outside of the marketplace?

No. Premium tax credits are only available for coverage purchased in the marketplace.

91. Can I use the premium tax credit to reduce the cost of any marketplace health plan?

You can apply the premium tax credit to any bronze, silver, gold, or platinum plan offered through the marketplace. Premium tax credits cannot be applied to Catastrophic plans or to stand-alone dental plans. If you are also eligible for cost-sharing reductions, be aware that these can only be obtained through silver plans offered in the marketplace.

92. Can I use a premium tax credit and cost-sharing reductions for a separate dental plan?

Premium tax credits can be applied to a separate dental plan only when a consumer qualifies for a tax credit larger than the total cost of his/her health plan premium. In this case, any "leftover" tax credit

amount may be applied to the part of the dental plan premium that covers essential health benefits (that is, dental benefits for children, but not for adults). However, because the tax credit is calculated based on the cost of the second-lowest-cost silver plan in a marketplace, consumers will likely find there is no "leftover" tax credit unless they purchase a very inexpensive marketplace plan, such as a bronze plan with a very high deductible. Cost-sharing reductions are not available for stand-alone dental plans.

93. Should I claim a premium tax credit in advance or at the end of the year or some of both?

That's up to you. You can have 1/12 of your annual premium tax credit paid directly to your health plan each month to reduce your monthly premium right away. Or, if you can afford to, you can pay the entire health plan premium yourself up front and collect the premium tax credit in a lump sum next year when your file your tax return. Or you can have some of the tax credit paid directly to your insurer in advance but save some to be collected at year end.

Keep in mind that when you apply for the premium tax credit this fall, during open enrollment, you won't necessarily know for sure what your 2014 income will be, so you will apply based on your best estimate of your 2014 income. Later, when you file your 2014 tax return, the IRS will compare your actual income to the amount of premium tax credit you claimed in advance. If you underestimated your income and claimed too much premium tax credit, you might have to pay back some or all of the difference. If you didn't receive all of the premium tax credit you're entitled to during the year, you can claim the difference when you file your tax return.

If you're uncertain about your 2014 income, it's also important to remember that you can modify the amount of premium tax credit during the year if your income changes. So, for example, if you are unemployed now, you can apply for a premium tax credit based on your current low income; then if you get a new job during the year, you can report this increase in income to the marketplace and reduce the amount of premium tax credit you're receiving at that time.

94. How do I apply for premium tax credits?

On the health insurance marketplace website, you will find an Application for Health Coverage and Help Paying Costs. You can apply online, submit a paper application, or call your marketplace call center and apply over the phone. The Application will ask you basic information about yourself (and any family members who are applying for coverage with you) including your Social Security number and information about your citizenship or immigration status. It will also ask employment and income information, including what's on your most recent income tax return. Once you've submitted the application, the marketplace will let you know if you qualify for help paying for Qualified Health Plans it offers. It will also let you know if you (or any members of your family) may be eligible for coverage through Medicaid or the Children's Health Insurance Program.

To complete the Application for Health Coverage and Help Paying Costs online, you will need to create a secure personal account with a login ID and password.

95. I've picked the plan I want. Now do I send my premium to the marketplace?

No, you will make your premium payments directly to the health insurance company. Once you've selected your plan, the marketplace will direct you to your insurance company's website to make the initial premium payment. Insurance companies must accept different forms of payment and they cannot discriminate against consumers who do not have credit cards or bank accounts. The insurance company must receive and process your payment at least one day before coverage begins. Make sure you understand your insurance company's payment requirements and deadlines and follow them so your coverage begins on time. Your enrollment in the health plan is not complete until the insurance company receives your first premium payment.

Note that if you have qualified to receive an advanced premium tax credit, the government will pay the credit directly to your insurer and you will pay the remainder of the premium directly to the insurer.

96. I don't have a checking account. Can the insurance company require that I get one and pay my premiums through automatic monthly withdrawals?

No. Insurers offering coverage in the health insurance marketplace are required to provide a variety of payment methods and cannot require a consumer to pay by automatic bank withdrawals (sometimes called electronic funds transfers, or EFT.) Federal rules require the insurer to accept paper checks, cashier's checks, money orders, and all general-purpose pre-paid debit cards, as well as EFT. These methods must be available to consumers for both the initial premium payment (at enrollment) and ongoing payments.

97. Can I pay my health insurance premium with a credit card, debit card, money order, or cash?

At least within the health insurance marketplace, insurers are required to accept money orders and pre-paid debit cards. They do not have to accept credit card or debit card payments unless states make that a requirement, although many insurers currently accept all of these forms of payment. Therefore, it may vary from state to state and between insurers.

98. Can my brother (or my church or another third party) pay my portion of the monthly health insurance premium for me?

Yes, a third party can make a premium payment on behalf of an enrollee.

99. What happens if I'm late with a monthly health insurance premium payment?

The answer depends on whether you are receiving advanced premium tax credits. For people receiving advanced premium tax credits, if a payment due date is missed, insurers must provide a 90-day grace period during which consumers can bring their premium payments up-to-date and avoid having their coverage terminated. However, the grace period only applies if an individual has paid at least one month's premium.

If, by the end of the 90-day grace period, the amount owed for all outstanding premium payments is not paid in full, the insurer can terminate coverage.

In addition, during the first 30 days of the grace period, the insurer must continue to pay claims. However, after the first 30 days of the grace period, the insurer can hold off paying any health care claims for care received during the grace period, which means the enrollee may be responsible to cover any health care services they receive during the second and third months if they fail to catch up on the amounts they owe before the end of the grace period. Insurers are supposed to inform health care providers when someone's claims are being held. This could mean that providers will not provide care until the premiums are paid up so that they know they will be paid.

People not receiving advanced premium tax credits are expected to get a much shorter grace period; currently, the general practice is 31 days but it may vary in each state.

100. I'm behind on my payments and trying to catch up, but meanwhile I got sick and so had to make more health care claims. Does my health plan have to pay them?

If you are receiving advanced premium tax credits, the insurer is required to pay your claims during the first 30 days of the grace period. After that, during the second and third month of the grace period, the insurer is allowed to hold your claims and only pay them if and when you get caught up in your premium payments.

101. My income is very low, so I'm only required to pay about $30/month for my health insurance premium. The tax credit picks up the rest, which is more than 90 percent of the total premium. I've missed four premium payments in a row. Can the insurance company cancel my coverage even though they got 90 percent of the payment on time from the IRS?

Yes. A person receiving an advanced premium tax credit has a 90-day grace period to pay all premiums that are owed. If the amount owed for all outstanding premium payments is not paid in full by the end of the grace period, the insurer can terminate coverage. The insurer would then have to return funds it received from the federal government for all but the first 30 days of the grace period.

102. How do I project my household size/income for next year if I'm pregnant now? I'm married and this pregnancy will be our first child. We want to find subsidized coverage in the marketplace.

This fall you and your husband will apply as a household of two. When the baby is born, you can update your family information with the marketplace to reflect that you have become a household of three. At that point, you may qualify for a larger premium tax credit. (For example, if you and your spouse together earned $30,000, as a household of two you would be required to contribute 6 percent of your household income toward the premium for the benchmark plan in the marketplace. Once the baby is born and you are a household of three, you would only be required to contribute 4.17 percent of your income.) When you report your new family status to the marketplace you will also have a 60-day special enrollment opportunity to add the baby to your plan, and you will be able to change health plans during that period if you want to do that.

Projecting Income for Calculating Advanced Premium Tax Credits

103. What if I don't know what my income will be next year?

When you apply for the premium tax credit, you will be asked to estimate your expected income for the upcoming year. Often a good place to start is to consider what your income is this year, or what income you reported on your tax return last year. However, if your circumstances have changed since then, for example, if you recently lost your job, you should make your best estimate of what your income will be next year. The health insurance marketplace will compare your income estimates against records at the Internal Revenue Service, Social Security Administration and other sources. If your estimate and official records don't match, but you meet all other eligibility requirements, you will be asked to provide documentation to support your income projections.

If you don't have that documentation handy, the marketplace will provide premium tax credits for up to 90 days while you gather and submit your documentation for verification. It is very important that you provide any documentation requested by the marketplace in a timely manner; if you don't your premium tax credits might be reduced or terminated.

Keep in mind that if you estimate your income incorrectly and end up claiming more help than you are eligible for, you may have to pay back some or all of the premium tax credit you received. If you over-estimate your income and end up claiming less help than you are entitled to, the difference will be refunded to you when you file your income taxes the following year.

104. My income is uneven during the year. Some months I earn very little, other months are much better. I think my annual income will be low enough to qualify for subsidies next year, but I'm not sure. What if I'm wrong?

It's common for income to fluctuate, particularly if you are self-employed, perform seasonal work or

have multiple jobs. To achieve the most accurate premium tax credit amount, you should report income changes to the health insurance marketplace during the year, as they happen. Otherwise, if you claim a premium tax credit during the year and your actual 2014 income edges over 400 percent FPL, you will need to pay back the full credit amount. To avoid this result, if you estimate your 2014 income will be close to 400 percent FPL, you could also consider waiting until you file your 2014 taxes to take all or a portion of the premium tax credit on your tax return instead of receiving advance payments.

105. What's the most I would have to repay the IRS?

That depends on what your actual 2014 income turns out to be. If your income goes over 400 percent FPL you will have to repay the full advance premium tax credit amount you received. If your actual 2014 modified adjusted gross income is higher than what you projected but less than 400 percent FPL, there are repayment limits based on income. On your tax return, you will compare the actual amount of advance premium tax credit you received during 2014 to the amount you should have received based on your modified adjusted gross income, and then pay back the excess up to the repayment limit.

Repayment Limits for Advance Premium Tax Credits

Income As Percentage Of Poverty Line	Annual Income For An Individual	Repayment Limit For Single Taxpayers	Annual Income For A Family Of Four	Repayment Limit For Married Taxpayers Filing Jointly
Under 200 %	Under $22,980	$300	Under $47,100	$600
At Least 200% But Less Than 300%	$22,980 – $34,470	$750	$47,100 – $70,650	$1,500
At Least 300% But Less Than 400%	$34,470 – $45,960	$1,250	$70,650 – $94,200	$2,500
400 % and Above	$45,960 and Higher	Full Amount	$94,200 and Higher	Full Amount

106. I estimate my 2014 income will be 140 percent of the federal poverty level, so I need a premium tax credit and I need to have it all paid in advance. If, by the end of the year, it turns out my annual income was even lower – 130 percent of the federal poverty level — so I could have enrolled in Medicaid, will I have to pay back the premium subsidy?

No, your final premium credit amount will be determined based on your income for the year as reported on your tax return. The fact that it ended up being 130 percent of the poverty line does not mean you have to pay back the premium tax credit you received. In fact, your final credit amount will likely be larger than the amount you received in advance.

107. How often during the year can I adjust my premium tax credit amount? What documentation is required to make an adjustment? How long after I request the adjustment will it take effect?

There is no limit to the number of times a person may report income, family or insurance-eligibility changes to the marketplace. Changes that are reported by enrollees will be verified by the marketplace. Then the marketplace will send you a notice (called a redetermination notice) showing your revised eligibility for premium tax credits and cost-sharing reductions. In addition, people can always ask the marketplace to provide them with a monthly advance premium credit below the amount the marketplace determines based on the household's income if they want to minimize the chance of needing to owe money at the end of the year.

The adjustment will take effect by the first day of the month following the date of the redetermination notice. For example, if an enrollee reports a change in income on June 25 and the marketplace verifies the change and sends a redetermination notice to the enrollee on July 3, the change will be implemented on August 1.

108. If I request an adjustment in my marketplace premium subsidy, how long before that takes effect?

The adjustment will take effect by the first day of the month following the date of the redetermination notice. For example, if an enrollee reports a change in income on June 25 and the marketplace verifies the change and sends a redetermination notice to the enrollee on July 3, the change will be implemented on August 1.

Non-Tax Filers and New Tax Filers

109. I have never filed an income tax return before. Can I claim a premium tax credit in 2014?

Yes. There is no requirement to have filed a tax return for any prior year in order to qualify for a premium tax credit. However, there is a requirement to file a return in the year in which you receive a premium tax credit (e.g., if a premium credit is received for in 2014, the taxpayer must file a 2014 tax return, due April 15, 2015).

110. What happens to a young adult who applies for premium tax credits the first year he or she is independent, and so he or she hasn't filed a return in prior years?

The biggest challenge a young adult may face in his or her first year of independent tax filing is verifying income, since one of the prime sources of income data is a prior year tax return. However, other methods of verification are available; for instance, the marketplace will have access to monthly wage data that can verify current income. In the case of someone who is self-employed or who has fluctuating income, additional documentation of income may be accepted. The fact that a young adult has not filed in the past will not prevent him or her from receiving premium tax credits.

111. If I've not filed taxes in a prior year, how will the marketplace determine my income?

If an applicant did not file taxes in a prior year, income will be verified by the marketplace through use of electronic wage data. If the information cannot be verified electronically, the applicant may be asked to submit additional paper documentation within 90 days, such as pay stubs, a work contract, or other verification of income.

Cost-Sharing Subsidies

112. How much are the cost-sharing subsidies?

That depends on your income and where you live. To give a general idea, a typical silver plan might have an annual deductible of $2,000 to $3,000 and an annual out-of-pocket limit on all cost-sharing of $6,350. But if your income is between 100 percent and 150 percent of the federal poverty level, the cost-sharing reductions will modify a silver plan so that the annual deductible might be closer to $0 and the annual out-of-pocket limit on all cost-sharing would be no more than $2,250.

If your income is between 150 percent and 200 percent of the federal poverty level, the cost-sharing reductions will modify the silver plan so that the annual deductible might be around $500 and the annual out-of-pocket limit would be no more than $2,250.

If your income is between 200 percent and 250 percent of the federal poverty level, the cost-sharing reductions will be more modest. At this income level, your annual out-of-pocket limit will be reduced to no more than $5,200.

See Appendix A for more information on the federal poverty level for individuals and families.

Check the marketplace website for more information about cost-sharing reductions in silver plans in your area based on your level of income.

113. If I underestimate my income and end up earning more than 250 percent of the federal poverty level next year, will I have to pay back the cost-sharing subsidies?

No. Unlike premium tax credits, which are reconciled each year based on the income you actually earned, cost-sharing reductions are not reconciled.

114. What happens if we have different plans for different family members?

The members of your family can enroll in separate plans in a health insurance marketplace, for example, because a grown child lives in another part of the state or because your spouse needs a plan

with a different provider network than the one you choose. The premium tax credit will be allocated to the plans in which different family members enroll. However, you may have higher out-of-pocket costs if you have separate plans (for example, with separate deductibles) as opposed to one family plan (with one deductible for the entire family).

Comparing Plans: Benefits and Costs

Background

Beginning in 2014, all new plans sold to individuals and small businesses must meet federal standards for the adequacy and affordability of coverage. The federal rules establish minimum standards for benefits and cost-sharing, limit the factors that insurance companies can use to set premiums, and require plan benefits to be more standardized so that it's easier for consumers to make comparisons among plans.

However, states can establish stronger consumer protections.

(See also Appendix B for a chart outlining how rules apply to different insurance markets and types of coverage.)

Every insurance company and group health plan must provide consumers with a Summary of Benefits and Coverage, which will use a standard format to outline the benefits, cost-sharing and coverage limits of plans. Consumers can also obtain a uniform glossary of commonly used terms. The Summary of Benefits and Coverage must be made available to consumers at open enrollment and upon renewal of coverage, upon request, and whenever there is a significant change in the plan. The Summary of Benefits and Coverage helps consumers understand the benefits and costs of a plan and makes plan comparisons easier.

Consumer Protections

All new plans sold to individuals and small businesses, including those sold through a health insurance marketplace, must meet the following requirements:

- Minimum essential benefit standard. Insurers are required to cover a minimum set of benefits within at least the following 10 categories: ambulatory patient services, emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
- Access to key services. Health plans must cover recommended preventive care at no cost-sharing (co-payments, coinsurance and deductible); allow individuals to designate any

participating pediatrician to be their child's primary care doctor; and use emergency services without prior authorization or higher cost-sharing for out-of-network emergency room care.

- Prohibition on discrimination based on health status. Prior to the Affordable Care Act, insurers could refuse to accept applicants. Under the Affordable Care Act, health insurers can no longer do this.
- Prohibition on pre-existing condition exclusions. Prior to the Affordable Care Act, some insurers would refuse to cover care for an individual's pre-existing conditions for up to 12 months. Under the Affordable Care Act, health insurers are no longer allowed to exclude pre-existing conditions from covered benefits under the plan.
- Minimum generosity of coverage. Individual coverage must provide a minimum level of financial protection for health costs, at least 60 percent of total average costs for covered benefits. Further, the Affordable Care Act requires plans to be offered at specified coverage levels, so that individuals can more easily compare them. The lowest level of coverage (60 percent) is called the bronze level. A silver level plan will cover 70 percent of total average costs for covered benefits, a gold plan covers 80 percent, and a platinum plan covers 90 percent. Individuals under age 30 or who cannot find "affordable" coverage are eligible to purchase catastrophic coverage.
- Modified community rating. Insurers are no longer allowed to charge higher premiums based on the health status or claims experience of an individual. However, insurers may charge more if the individual is older than average (up to three times more) or if he or she uses tobacco products. Premiums can also vary by geography.
- Prohibition on annual and lifetime limits. Prior to the Affordable Care Act, health plans could limit how much they paid toward benefits, for example, no more than $100,000 in a year or $1 million in a lifetime of coverage. Under the Affordable Care Act, health plans can no longer impose annual or lifetime dollar limits on benefits.
- Limits on out-of-pocket costs. Health plans must limit out-of-pocket costs for essential health benefits to no more than $6,350 for an individual or $12,700 for a family in 2014 (this amount will grow each year to track increases in medical costs). Depending on household income, the limits may be lower for individuals and families that qualify for cost-sharing reductions in a health insurance marketplace.
- Covers young adults up to age 26. Health plans must allow families to keep their adult children on the family plan, up to age 26. This applies even if the child isn't a student, doesn't live at home, or is not financially dependent on his or her parents.
- Sufficient access to providers. In addition to the above rules, plans offered in a health insurance marketplace must also meet federal standards for network adequacy, ensuring

access to primary care doctors, specialists, and “essential community providers,” such as community health clinics, without unreasonable delay.

Frequently Asked Questions

115. What health plans are offered through the marketplace?

All health plans offered through the marketplace must meet the requirements of “qualified health plans.” This means they will cover essential health benefits, limit the amount of cost-sharing (such as deductibles and co-pays) for covered benefits and satisfy all other consumer protections required under the Affordable Care Act.

Health plans may vary somewhat in the benefits they cover. Health plans also will vary based on the level of cost-sharing required. Plans will be labeled bronze, silver, gold, and platinum to indicate the overall amount of cost-sharing they require. Bronze plans will have the highest deductibles and other cost-sharing, while platinum plans will have the lowest. Health plans will also vary based on the networks of hospitals and other health care providers they offer. Some plans will require you to get all non emergency care in-network, while others will provide some coverage when you receive out-of-network care.

116. What health benefits are covered under marketplace plans?

All qualified health plans offered in the marketplace (as well as non-grandfathered individual plans sold outside the marketplace) will cover essential health benefits. Categories of essential health benefits include:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization
- Maternity and newborn care (care before and after your baby is born)
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including dental and vision care

The precise details of what is covered within these categories may vary somewhat from plan to plan.

117. Will my marketplace health plan cover dental benefits?

Some marketplace health plans offer coverage of dental benefits and others do not. In addition, all marketplaces offer separate, stand-alone dental plans for children and often for adults, as well. Consumers who wish to have dental coverage should examine whether the plans they are comparing include coverage for dental benefits. Those who purchase a stand-alone dental plan should be aware that a separate plan means separate premiums, deductibles, co-pays, and a separate limit on total out-of-pocket costs.

118. Will covered benefits under all marketplace plans be the same? How can I compare?

Not necessarily. All marketplace health plans are required to cover the 10 categories of essential health benefits. However, insurers in many states will have flexibility to modify coverage for some of the specific services within each category. Any modifications must be approved by the marketplace before plans can be offered. All health plans must provide consumers with a Summary of Benefits and Coverage (SBC). This is a brief, understandable description of what a plan covers and how it works. The SBC will also be posted for each plan on the marketplace website. The SBC will make it easier for you to compare differences in health plan benefits and cost-sharing.

Plans might differ in other ways, too. For example, the network of health providers might be different from plan to plan.

119. I notice marketplace plans are labeled "bronze," "silver," "gold," and "platinum." What does that mean?

Plans in the marketplace are separated into categories — bronze, silver, gold, or platinum — based on the amount of cost-sharing they require. Cost-sharing refers to health plan deductibles, co-pays and coinsurance. For most covered services, you will have to pay (or share) some of the cost, at least until you reach the annual out-of-pocket limit on cost-sharing. The exception is for preventive health services, which health plans must cover entirely.

In the marketplace, bronze plans will have the highest deductibles and other cost-sharing. Silver plans will require somewhat lower cost-sharing. Gold plans will have even lower cost-sharing. And platinum plans will have the lowest deductibles, co-pays and other cost-sharing. In general, plans with lower cost-sharing will have higher premiums, and vice versa.

120. How can I find out if my doctor is in a health plan's network?

Each plan sold in the marketplace must provide a link on the marketplace website to its health provider directory so consumers can find out if their health providers are included. However, these lists are subject to change and may not be up-to-date. Be sure to confirm your provider is "in-

network" if it matters to you or if the cost-sharing you'd be required to pay for "out-of-network" care is significant.

The provider network information that insurance companies provide may or may not tell you whether a provider is accepting new patients, or whether a provider speaks your language. It is up to your marketplace to require insurers to provide you with this information.

121. What happens if I end up needing care from a doctor who isn't in my plan's network?

Plans are not required to cover any care received from a non-network provider, though many plans today do, at least to some extent. If you do receive care out-of-network, it could be costly to you. Generally, plans that provide an out-of-network option cover such care at a lower rate (eg, 80 percent of in-network costs might be reimbursed but only 60 percent of non-network care.) In addition, when you get care out-of-network, insurers may apply a separate deductible and are not required to apply your costs to the annual out-of-pocket limit on cost-sharing. Non-network providers also are not contracted to limit their charges to an amount the insurer says is reasonable, so you might also owe "balance billing" expenses.

If you went out-of-network because you felt it was medically necessary to receive care from a specific professional or facility – for example, if you felt your plan's network didn't include providers able to provide the care you need – or if you inadvertently got non-network care while hospitalized if the anesthesiologist or other physicians working in the hospital don't participate in your plan network – you can appeal the insurer's decision. If there is a Consumer Assistance Program in your state, staff in this program can help you file your appeal.

122. How can I find out if a health plan covers the prescription drugs that I take?

Health plans in the marketplace must include a link to their prescription drug "formulary" with other on-line information about the plan. The "formulary" is a list of prescription drugs the plan will cover. If you don't find your drug on the formulary but your doctor says it's medically necessary for you to take that specific drug, you can appeal for an exception to the plan formulary. If there is a Consumer Assistance Program in your state, staff in this program can help you file your appeal.

123. Is dental coverage an essential health benefit?

Under the health care law, dental insurance is treated differently for adults and children 18 and under.

Dental coverage for children is an essential health benefit. This means it must be available to you, either as a covered benefit under your health plan or as a free-standing plan. This is not the case for adults. Insurers don't have to offer adult dental coverage.

124. I'm buying coverage on the marketplace for my family. I notice many health plans don't cover pediatric dental care, but there are also stand-alone dental plans for sale. Is that allowed?

Each health insurance marketplace can decide whether to require all insurers to cover pediatric dental benefits or whether to allow the sale of stand-alone dental policies. When stand-alone dental policies are allowed, health insurers in the marketplace might not be required to cover pediatric dental benefits. If your health plan covers dental benefits, you will pay one premium for everything. If you get dental benefits through a stand-alone plan, you will have to pay a separate premium for the dental benefits.

125. It looks like pediatric dental benefits are only offered through stand-alone plans in my state marketplace. Will my tax credit premium cover the cost of the stand-alone dental plan?

No, the premium tax credit will not be increased to also cover the cost of a stand-alone dental plan.

126. I can't afford the cost of a stand-alone dental plan in addition to buying major medical health insurance. Will I owe a penalty for not having minimum essential coverage if I don't buy the separate dental plan?

No. You do not need to have pediatric dental coverage to avoid the penalty.

127. Most of my doctors are in-network but not all. Can I get care out-of-network?

If you see a provider that is not included in your plan's contracted network of providers (i.e., "out-of-network"), you are likely to pay more for that care. You may have a separate deductible to meet for out-of-network care, and/or be required to pay higher co-payments or coinsurance for the care you receive. It's important to note that the limit on out-of-pocket costs that plans must meet applies only to services received in-network. Any care you get outside your plan's network will not apply to the limit set in the new law ($6,350 for individuals, $12,700 for families) and may not have any limit at all.

Catastrophic Plans

128. What is a Catastrophic Health Plan?

A "Catastrophic Plan" is a qualified health plan offered through the marketplace that covers essential health benefits and requires the highest level of cost-sharing allowable for essential health benefits. In 2014, under a "catastrophic policy," the annual deductible for covered services is $6,350 for an individual ($12,700 for a family policy.) After you have satisfied the deductible, the plan will pay 100 percent for covered essential health benefit services for the remainder of the year. "Catastrophic policies" may also be sold by insurers outside of the health insurance marketplace.

129. Who can buy a Catastrophic Plan?

In general, only young adults up to the age of 30 are eligible to buy a Catastrophic Plan. However, older adults can buy a Catastrophic Plan if no other qualified health plan offered through the marketplace would cost less than 8 percent of income.

130. If I qualify for a premium tax credit, can I use that to reduce my cost of a Catastrophic Plan?

No. Catastrophic Health Plans are not eligible for premium tax credits or cost-sharing reductions.

131. I also notice "Catastrophic Plans" that look even cheaper. What are those and can I buy one if I want?

Insurers can also offer "Catastrophic" Plans. Catastrophic Plans have the highest cost-sharing. In 2014, Catastrophic Plans will have an annual deductible of $6,350 ($12,700 in family plans). You will have to pay the entire cost of covered services (other than preventive care) until you've spent $6,350 out-of-pocket; after that your plan will pay 100 percent of covered services for the rest of the year. Not everybody will be allowed to buy Catastrophic Plans. They are only for adults up to age 30, and for older people who can't find any other marketplace policy that costs less than 8 percent of their income.

Marketplace Health Plan Premiums – General

132. Can I be charged more if I have a pre-existing condition?

No. Starting in 2014, as insurance policies are sold or renewed, health plans are not allowed to charge you more based on your health status or pre-existing condition.

133. Can I be charged more because of my age?

Yes, in most states you can, within limits. Federal rules allow insurers to charge older adults (e.g., in their sixties) up to three times the premium they would charge younger adults (e.g., in their early twenties).

134. I'm 59, my wife is 55, and our kids are 24, 17, 15, and 13. What age premium will we be charged for health insurance in the marketplace?

Family premiums will reflect the composition of family members, their ages and their tobacco use. To compute a "family premium," insurers will add together a separate premium for each adult age 21 and older. In addition, insurers can charge a separate premium for up to three children under age 21. In your example, your family premium will reflect three adult premiums and three child premiums.

Premiums – the Tobacco Surcharge

135. What does it mean to "use tobacco?" I'm pretty sure my teenager has smoked at least a couple of times. Do I have to pay a higher rate because of her?

"Tobacco use" means a person has used a tobacco product an average or four or more times per week for the past six months. A state can increase the number of times per week or reduce the "look-back" period to less than six months. Check with your state marketplace to learn more about tobacco surcharges and how they work.

The surcharge on tobacco users can only be applied to an individual who can legally purchase a tobacco product in the state. Thus, the surcharge does not generally apply to a person under age 18.

136. I smoke cigarettes and I buy my own health insurance. Can I be charged more because I smoke?

Yes, in most states you can. Insurers are allowed to increase premiums by up to 50 percent more for people who use tobacco, although many insurers apply a lower surcharge for tobacco use. If you qualify for premium tax credits, this tobacco surcharge will not be covered by the tax credit. States are allowed to limit tobacco surcharges and a few have decided to prohibit tobacco rating by health insurers.

137. My income is less than 400 percent of the FPL and I smoke. Will the tobacco surcharge to the premium be covered by my premium tax credit?

No. A tobacco surcharge is not covered by the health insurance premium tax credits. The premium tax credit will reduce what you have to pay for the regular health insurance premium, but you will have to pay the entire additional tobacco surcharge. For example, if the regular premium for a policy is $200 per month and you qualify for a premium tax credit of $75 but you also use tobacco and so would be subject to a 50 percent tobacco use surcharge, you would have to pay $225 for that policy ($200 for the regular premium minus $75 for your premium tax credit plus $100 for the tobacco surcharge).

138. The tobacco surcharge makes my health insurance unaffordable so I can't buy coverage. Even after taking into account the tax credit, my premium will cost more than 8 percent of my income. Will I owe a penalty?

No. If the cost of health insurance, taking into account both your premium tax credit and the tobacco surcharge, exceeds 8 percent of your income, you are not subject to the penalty for failure to obtain insurance.

139. I smoke but I'm trying to quit. What happens if I don't disclose to an insurance company that I use tobacco?

If you report inaccurate or false information about your tobacco use on an application, an insurer is allowed to retroactively impose the tobacco surcharge to the beginning of the plan year. However, the insurer is not allowed to cancel your coverage because of the false or incorrect information.

140. What happens if I take up smoking after I bought the policy?

You would be subject to the tobacco surcharge when you renew your plan the following year.

Chapter 3: Outside The Health Insurance Marketplaces

Outside The Marketplace: Coverage Options

Background

The Affordable Care Act creates new health insurance marketplaces that will exist in each state. These marketplaces will enable consumers to shop for and compare health plans, and access premium tax credits and cost-sharing reductions to make health insurance more affordable. However, in most states, consumers will continue to be able to buy health coverage outside the marketplace. Health insurers selling this coverage outside the health insurance marketplace will have to provide many of the same consumer protections that insurers inside the health insurance marketplace provide. However, some types of coverage sold outside the marketplace are exempted from the new rules, and consumers should fully review the terms of their coverage to ensure it provides adequate protection. In addition, not all coverage sold outside the marketplace meets the federal standard for "minimum essential coverage" and consumers could face a tax penalty if they do not have this minimum coverage.

Frequently Asked Questions

Eligibility for Job-Based Coverage

141. I work full time for a large employer (more than 50 full time employees). Is my employer required to offer me health benefits?

Your employer is not required to offer health benefits. However, starting in 2015, employers with 100 or more employees will be required to offer health benefits to their full-time employees, but not to their dependents. If they do not offer coverage to their workers, they face a tax penalty if an employee qualifies for premium tax credits in the marketplace. Beginning in 2016, employers with 50 or more employees that don't offer health benefits to their full-time employees may also be liable for

a tax penalty. Employers will also be required in 2016 to offer health benefits to dependent children; however, employers are not required to offer coverage to the spouses of employees.

If your employer doesn't offer you health benefits, you can apply for coverage in the marketplace; and, if your income is between 100 percent and 400 percent of the federal poverty level, you may apply for a premium tax credit that may reduce the cost of coverage in the marketplace (See Appendix A for more information on the federal poverty level for individuals and families).

Note that a full-time employee is one who works, on average, at least 30 hours per week. If your hours vary during the year, your employer may have some options in determining your status as a full-time or part-time worker. Your employer can tell you whether you are a full or part-time worker.

142. I work full time for a large employer (more than 50 full time employees) and I'm married and we have kids. Is my employer required to offer health benefits that cover my spouse and kids?

Your employer is not required to offer health benefits. However, starting in 2015, employers with 100 or more employees that don't offer health benefits to their full-time employees may be liable for a tax penalty. Beginning in 2016, employers with 50 or more employees that don't offer health benefits to their full-time employees and to their dependent children (but not their spouse) may also be liable for a tax penalty. Large employers do not face a tax penalty if they don't offer health benefits to the spouses of their workers.

If your employer doesn't offer coverage to your spouse or children, they can apply for coverage in the marketplace and, if your family income is between 100 percent and 400 percent of the federal poverty level, a premium tax credit that may reduce the cost of coverage in the marketplace. See Appendix A for more information on the federal poverty level for individuals and families.

If your employer offers health benefits that are affordable and meet minimum value to you and your spouse and children, you still may choose to purchase coverage through a marketplace, but your family will not be eligible for premium tax credits to help pay for the coverage.

143. I work part-time for a large employer. Is my employer required to offer me health benefits? What about benefits for my spouse and kids?

No, large employers are not required to offer health benefits to part-time employees and there is no penalty for large employers that don't offer health benefits to part-time employees or their dependents. If you work part-time and you are not offered health benefits, you (and your family) can apply for coverage in the marketplace; and, if your income is between 100 percent and 400 percent of the federal poverty level, you can apply for a premium tax credit that may reduce the cost of coverage in the marketplace (See Appendix A for more information on the federal poverty level for individuals and families).

Note that a part-time employee is one that works, on average, fewer than 30 hours per week. If your hours vary during the year, your employer may have some options in determining your status as a full-time or part-time worker. Your employer can tell you whether you are a full or part-time worker.

144. I work for a large employer (more than 50 full time employees) but my hours vary during the year. I work full-time during the summer but part-time the rest of the year. Does my employer have to offer me health benefits?

Beginning in 2015, employers with 100 or more employees must offer health benefits to employees who work, on average, at least 30 hours per week or they may be liable for a penalty. Beginning in 2016, employers with 50 or more employees must also offer health benefits to employees who work, on average, at least 30 hours per week or they may be liable for a penalty. Check with your employer/human resources department to find out if your hours worked over the year meet this threshold. If your hours vary during the year, your employer may have some options in determining your status as a full-time or part-time worker. Your employer can tell you whether you are a full or part-time worker.

145. I work full time for a small business (fewer than 50 employees). Does my employer have to offer me health benefits?

No, small businesses are not required to offer health benefits to either full-time or part-time employees, or to their dependents. Small businesses are not subject to tax penalties when they don't offer health benefits. If your small employer doesn't offer health benefits, you (and your family) can apply for coverage in the marketplace; and, if your income is between 100 percent and 400 percent of the federal poverty level, you can apply for a premium tax credit that may reduce the cost of coverage in the marketplace (See Appendix A for more information on the federal poverty level for individuals and families).

Outside the Marketplaces: Buying Non-Group Health Insurance

146. If I buy an individual health plan outside the health insurance marketplace, is my coverage going to be the same as it would be inside the marketplace?

For the most part, yes. Health plans inside and outside the health insurance marketplace must provide the same basic set of benefits, and they are no longer allowed to exclude coverage of a pre-existing condition. In addition, plans both inside and outside must provide a minimum level of financial protection to their policyholders. Specifically, plans must cover at least 60 percent of what the average person would spend on covered benefits. However, individual policyholders might spend more or less, depending on their health status and choice of providers.

There are some key differences between plans sold inside and outside the health insurance marketplace. First, you may only obtain premium tax credits and cost-sharing reductions through the

health insurance marketplace. Second, plans sold through the health insurance marketplace must be certified by the marketplace as meeting minimum coverage and quality standards. Plans sold outside the marketplace may not always meet those standards.

147. Why should I buy a plan on the health insurance marketplace?

First, depending on your income, you may be eligible for premium tax credits or cost-sharing reductions to help lower the cost of coverage. You can only obtain those tax credits and cost-sharing reductions if you buy a plan through the health insurance marketplace.

Second, if you use the health insurance marketplace, you can compare plans and shop with confidence that all the plans displayed have been certified as meeting a minimum standard for coverage and quality. If you shop for a plan outside the marketplace, you will need to do your own research to determine whether the plan provides the kind of financial protection and access to providers that is right for you and your family.

148. When can I buy coverage outside the health insurance marketplace?

You will have an opportunity to enroll in a health plan during an initial open enrollment period that extends from October 1, 2013 to March 31, 2014. This is true whether you are looking for a plan inside or outside the health insurance marketplace.

For coverage that will start in 2015, the open enrollment period will be November 15, 2014 to February 15, 2015. You may also be eligible to enroll in a plan during a special enrollment period (see FAQ #38).

NOTE: Some states may allow for longer or additional open enrollment periods.

149. If I buy a plan outside the health insurance marketplace, how do I know it is minimum essential coverage so I don't have to pay a tax penalty?

To meet the coverage requirement, individuals must have "minimum essential coverage." Most people that have health coverage today have a plan that will count as minimum essential coverage, and will not need to do anything more than continue the coverage that they have. If you have any of the following coverage, you likely have minimum essential coverage:

- Employer sponsored coverage, including COBRA continuation coverage and retiree coverage
- Coverage purchased in the individual market, including a plan purchased in a health insurance marketplace

- Medicare Part A coverage and Medicare Advantage Plans
- Most Medicaid coverage
- Children's Health Insurance Program coverage
- Certain types of veteran's health coverage administered by the Veterans Administration
- TRICARE (coverage for members of the military)
- Self-funded student health coverage (for 2014; may change in 2015)
- High-risk pool coverage (for 2014; may change in 2015)
- Coverage for Peace Corps volunteers
- Refugee Medical Assistance from the federal Administration for Children and Families
- Department of Defense health benefit program for civilian employees known as "non-appropriated fund" personnel

If you don't currently have coverage, will soon lose coverage, or are thinking of changing coverage, you can obtain minimum essential coverage by purchasing a plan on your state's health insurance marketplace. You can also buy a traditional individual or family health insurance policy outside of the marketplace, but be aware that some types of coverage do not qualify as minimum essential coverage, such as discount plans (see FAQ #151), fixed indemnity plans (see FAQ #153) or plans that provide coverage only for a specific disease (i.e., cancer-only). Such plans are required to notify you if they don't qualify as minimum essential coverage. If you receive such a notice, you may have to pay a tax penalty for not having adequate coverage.

If you are uncertain whether your plan qualifies as minimum essential coverage, contact your employer's human resources department or your health insurer.

150. What are health care sharing ministries? What are the risks and benefits of signing up for one?

It is important to understand that a health care sharing ministry is not health insurance, and may not provide the kind of financial protection you can obtain through a health plan on the health insurance marketplace. However, if you are a member of a health care sharing ministry, you are exempt from the tax penalty for failing to maintain minimum essential coverage.

Typically health sharing ministries operate by having all of their members pay a monthly "share" or fee. Those fees are then used to pay other members' medical bills, if they qualify and if the reason for needing care was not due to "un-Christian" behavior. Names and the current needs of members are published in a monthly newsletter, and members are able to support each other financially and through prayer. Health care sharing ministries do not have to comply with the consumer protections outlined in the Affordable Care Act, and many states have exempted them from the state's insurance laws. As a result, consumers could be at greater financial risk in these programs than they would be in traditional insurance. In particular, if there's a dispute between you and the heath care sharing ministry about

covered benefits, or if you're having trouble getting your medical bills paid, many state insurance regulators do not have jurisdiction to help you.

NOTE: Some states may have exempted health care sharing ministries from state health insurance rules.

151. What is a discount medical plan? What are the risks and benefits of buying one?

A discount medical plan is not health insurance, and will not provide the kind of financial protection that you can obtain through a health plan on the health insurance marketplace. Companies selling these plans are supposed to notify their policyholders that the plan does not qualify as minimum essential coverage (see FAQ #14) under the Affordable Care Act, meaning the consumer could be required to pay a tax penalty if they do not obtain health insurance. However, consumers should be aware that some of these discount plans may use marketing materials that suggest they provide traditional insurance.

Generally, consumers who sign up for a discount plan must pay an upfront enrollment fee plus a monthly subscription. In exchange, the plan offers discounts on medical services from doctors, hospitals and dentists. However, a number of state insurance regulators have had to shut down these plans because of fraudulent activity, and often the discounts they provide are no better than what you could negotiate on your own. Consumers who suspect that a discount plan is falsely advertising itself as health insurance should report the company to the State Department of Insurance.

152. What is a mini-med (or limited benefit) plan? What are the risks and benefits of buying one?

A mini-med plan is a type of health insurance, but it pays only a small percentage of your medical costs. Its sale to individuals is banned under the Affordable Care Act. If you believe you are enrolled in or are sold a mini-med plan, contact your state insurance department. You can also call the federal toll free help line at 1-800-318-2596.

153. An agent offered me a policy that pays $100 per day when I'm in the hospital. It's called a "fixed indemnity plan"? What are the risks and benefits of buying one?

A fixed indemnity plan is not traditional health insurance and enrollment in one does not constitute minimum essential coverage under the Affordable Care Act (see FAQ #14). These companies are supposed to provide policyholders with a notice that the coverage is inadequate. If you have one of these plans and no other coverage, you will be subject to the law's tax penalty for failing to have health insurance.

Historically, fixed indemnity policies have been income replacement policies, to help compensate people for time out of work. The plan will provide a fixed amount of money per day or over a set period while the policyholder is in the hospital or under medical care. The amount provided is often far below the patient's actual costs. Thus, consumers can find that they pay more in premiums than they get in return. Consumers who suspect that a fixed indemnity plan is falsely advertising itself as health insurance should report the company to the state department of insurance. (See Appendix C for a list of state Departments of Insurance)

154. My insurance company is offering me a short-term policy (less than 365 days of coverage). The premiums are a lot lower than they would be for a 12-month policy. What are the risks and benefits of enrolling in a short term policy?

A short-term insurance policy, which is defined as a policy that covers you for less than a 12-month period, is not considered traditional health insurance and does not constitute minimum essential coverage under the Affordable Care Act (see FAQ #14). If you are enrolled in one of these plans, even if it lasts 364 days, you will be subject to the law's tax penalty for failing to have health insurance. In addition, short-term policies are exempt from many of the Affordable Care Act's consumer protections, and as a result the policy may not provide the kind of access to health services and financial protection that you may need or want. You should carefully review the terms of the policy and any limits or exclusions before purchasing it.

SECTION 2: INDIVIDUALS WHO CURRENTLY HAVE COVERAGE OR AN OFFER OF COVERAGE FROM THEIR EMPLOYER

Section 2 covers enrollment issues for individuals who have coverage or an offer of coverage—whether through an employer-sponsored plan, individual plan, high-risk pool, retiree plan, or student health plan—and want to understand their options, including eligibility for premium tax credits through the marketplace.

Chapter 1: Employer Sponsored Coverage

Background

Most people who have private coverage in the U.S. have coverage through an employer. More than 56 percent of Americans under age 65 have coverage through an employer-sponsored plan. For most people enrolled in a plan sponsored by a large employer, the coverage is relatively affordable and comprehensive. As a result, the Affordable Care Act insurance reforms focus on coverage in the individual and small group markets, where historically there have been more problems with access to affordable, adequate coverage. However, some reforms apply broadly to all group health plans, including large employers.

For more information on consumer protections that apply to employer-sponsored coverage — based on factors such as the size of the company, whether the plan is self-insured or fully-insured, and whether the plan is a grandfathered plan or new — refer to Appendix B.

Premium Tax Credits and Employer-Sponsored Coverage. Most people enrolled in employer-sponsored coverage, or with an offer of employer-sponsored coverage, will not be eligible for premium tax credits and would have to forgo a contribution from their employer toward their health care premiums in order to buy coverage in a health insurance marketplace.

To be eligible for premium tax credits, the employer-sponsored coverage must be "unaffordable" or fail to meet minimum value standards (i.e., considered "inadequate"). To be unaffordable, the cost of self-only coverage in the employer's lowest cost plan must be more than 9.5 percent of the individual's household income. To fail to provide minimum value, the plan must have an actuarial value of less than 60 percent, meaning that the plan covers less than 60 percent of the total average costs for covered benefits. If the individual's employer-sponsored coverage fails either test, the individual may be eligible for a premium tax credit for a plan purchased in a health insurance marketplace. See Section 1, Chapter 2, Eligibility for Premium Tax Credits and Cost-Sharing Reductions.

Enrolling in Employer-Sponsored Coverage. Employers cannot use health factors to determine eligibility for health benefits or premiums. However, employers are allowed to establish different health benefits or eligibility rules for different categories of employees (such as salaried workers vs. hourly workers). Under the Affordable Care Act, employers are allowed to impose a waiting period for health benefits for new employees of no more than 90 days.

Employers typically have an annual open enrollment period that gives employees an opportunity to change plans or add dependents. However, there are circumstances under which employees may enroll in coverage or add dependents outside an annual open enrollment period. For example, if a worker loses coverage under his or her spouse's plan, or has a new child by birth or adoption, they can enroll in the employer-sponsored plan or add new dependents, so long as they do so within 30 days of their change of circumstances.

All health plans, including employer plans, must provide individuals with a Summary of Benefits and Coverage, which uses a standard format to outline the benefits, cost-sharing and coverage limits of plans. The Summary of Benefits and Coverage must also state whether the plan meets minimum value and counts as minimum essential coverage, although in 2014, that information may be provided separately in a cover letter. The Summary of Benefits and Coverage must be made available to consumers at open enrollment and upon

renewal of coverage, upon request, and whenever there is a significant change in the plan. This can be an important tool for consumers to understand their plan options in employer-sponsored coverage or who want to compare plan benefits and costs for employer coverage to coverage in a health insurance marketplace.

Employers must also provide each employee with a Summary Plan Description within 90 days after they become a participant in a plan. The Summary Plan Description must contain information on benefits, eligibility for benefits, plan limits, and whether the health plan is fully insured or self-insured. However, it doesn't have to be presented in a standard format, and only has to be provided after the employee enrolls in the plan, so it is not useful for comparing plan choices prior to enrollment.

All non-grandfathered employer-based plans must cover recommended preventive services with no cost-sharing. Employer plans must have a cap on out-of-pocket costs ($6,350 for individuals in 2014, $12,700 for family coverage), although in 2014, plans that have separate limits for medical and prescription drug benefits can maintain those limits, so long as neither limit exceeds $6,350 for individuals and $12,700 for family coverage. In addition, employer plans cannot impose annual or lifetime dollar limits on covered "essential" health benefits. The scope of those essential health benefits is determined by what is covered under a typical employer-sponsored plan in the state, but would generally cover categories of services such as doctor visits, hospitalization, maternity and newborn care, prescription drugs, laboratory services, mental health and substance use disorder services, rehabilitative and habilitative services, and pediatric care. For more information on essential health benefits see FAQ #116.

Employers cannot set premiums for their employees based on their health status, although there is an exception to this prohibition for "non-discriminatory wellness programs." Employers can modify premiums and/or cost-sharing in an amount up to 30 percent of the total premium (including the employer's contribution to the premium) for workplace wellness programs, and up to 50 percent for programs that target tobacco cessation. The financial incentives can be applied as a discount (e.g., lower premiums or deductibles) or as a penalty (higher premiums and deductibles), as long as the programs meet federal rules for being non-discriminatory.

Frequently Asked Questions

155. I have an offer of employer-sponsored coverage, but the premiums are too expensive and I have to pay a lot out-of-pocket. Can I get premium tax credits in the health insurance market place?

If your premiums for self-only coverage in your employer's plan are 9.5 percent or more of your household income and your income is between 100 percent and 400 percent of the federal poverty level (or between $11,490 and $45,960 for individuals in 2013), you may be eligible for a premium tax credit for coverage in your state's health insurance marketplace (See Appendix A for more information on the federal poverty level for individuals and families). The coverage must also provide minimum value (meaning it covers at least 60 percent of the average costs of covered services).

The application for coverage in a health insurance marketplace includes questions your employer can answer to help determine whether your health benefits qualify you for a premium tax credit.

156. I want to add my spouse and/or children to my plan but I can't afford the family premium. Can my spouse buy a more affordable plan on the health insurance marketplace?

It depends. If the premium for self-only coverage in the lowest cost plan is less than 9.5 percent of your household income, no one in your family who is eligible to join your employer's plan can qualify for a premium tax credit, no matter how expensive the premiums are for a family plan. However, if family members forgo coverage because the employer plan premiums are too expensive, they may not be subject to the requirement that individuals purchase health insurance (the individual responsibility requirement or mandate). Specifically, if the premiums for family coverage through your employer's plan are more than 8 percent of your household income, your family members will not be subject to a penalty for not enrolling in coverage. Your children may also be eligible for your state's Children's Health Insurance Program, depending on your income and the eligibility rules of your state.

157. When can I enroll in my employer plan?

Most employers have an annual open enrollment period, often in the fall of each year (for plan coverage that starts January 1st). In addition, there are special circumstances that trigger a "special enrollment period," in which you can enroll in coverage outside the annual open enrollment period. These include loss of eligibility for coverage because of divorce or legal separation, loss of dependent status, or reduction in hours or loss of job, or certain life events such as gaining a dependent through marriage, birth or adoption. Be aware, your employer may require you to enroll within 30 days of your change in circumstances.

158. We just had a baby. Can I add my baby to my family plan?

Yes, having a baby is one of the special circumstances that allow you to add dependents outside the annual open enrollment period. You have 30 days from the date of your child's birth to request enrollment in your employer-sponsored coverage.

159. We just had a baby. Before that my husband and I were each covered under our own health plans at our own jobs, but now we want the family covered under one policy. Can we all switch to my employer plan now?

Yes. Having a baby is one of the special circumstances that allows you to add dependents to your health plan, even outside of the regular open season. You have 30 days from the date of your child's birth to notify your employer and request that your husband and your baby be enrolled in your coverage.

160. Is my employer required to offer and pay for coverage for my dependents?

Large employers are not required to offer coverage to an employee's dependent or spouse. If an employer's plan does provide for dependent coverage, it must make that coverage available to dependents to age 26. However, there is no requirement that they contribute to the premiums for dependent coverage. If the employer does not contribute to premiums for dependent coverage, it may be too costly for your children to enroll, or for your spouse, if the employer's plan includes them. Unfortunately, the fact that your dependents and/or spouse are eligible for this coverage, even though it is too expensive, makes them ineligible for premium tax credits through the health insurance marketplace. That's because the test for "affordable" employer-sponsored coverage is based only on the premiums for self-only coverage. If the premium for self-only coverage in your employer's lowest cost plan is less than 9.5 percent of your household income, no one who would be covered by a family plan at your work can qualify for a premium tax credit, no matter how expensive the family plan premiums are.

161. Is my employer required to offer benefits to part-time workers?

No. Under the Affordable Care Act, employers are not required to offer health benefits to employees who work on average fewer than 30 hours a week. If they aren't eligible for their employer's plan, those workers are likely able to buy coverage in the health insurance marketplace, and may be eligible for premium tax credits, depending on their household income and their eligibility for other coverage programs, such as Medicaid.

162. Is my employer required to offer benefits to retirees?

No, there is no requirement to offer retiree health benefits. Retirees not yet eligible for Medicare may be eligible for coverage in a health insurance marketplace, possibly with a premium tax credit, depending on income and other factors. For more information on this, see Section 2, Chapter 3, Retiree Coverage.

163. I will start a new job next month with benefits. Can I enroll right away in my employer plan?

Maybe – ask your employer. Under federal law, employers can impose a waiting period for health benefits after you start your job, but the waiting period can be no more than 90 days. If you are concerned that your employer requires a waiting period longer than 90 days, you can contact the U.S. Department of Labor at 1-866-444-3272.

164. I work and am eligible for health benefits. Do I have to sign up for my job-based plan or will my employer do that for me?

You generally are responsible for enrolling in a health plan offered by an employer, so it's up to you to sign up for coverage under the rules and procedures established by your employer health plan.

Some employers may use auto-enrollment, which means that your employer will enroll you in a plan and you must opt-out of the plan if you do not want to be covered. If your employer auto-enrolls you in the group health plan, you must be given the opportunity to disenroll if you want or to change plans if your employer offers more than one option. If you have concerns with the way auto-enrollment in health coverage is handled at your job, you can contact the U.S. Department of Labor at 1-866-444-3272.

165. My employer offers a workplace wellness program that increases premiums for employees who don't participate and/or can't meet certain targets for healthy behavior. I don't think I'll be able to afford the premiums if I don't participate or miss the mark. Can I leave my employer-sponsored plan and get one on the health insurance marketplace?

It depends on how much your costs go up based on any premium increases you face due to the wellness program. If your premiums with the wellness penalty would be 9.5 percent of your income or more, or if your cost-sharing increases enough to lower the value of your plan below the minimum value standard (60 percent of average costs of covered services), then you may be eligible for premium tax credits. This test applies whether you are actually penalized or not, and in advance of the penalty being applied (for example, if your employer gives you time to try to meet the health standard that triggers a penalty or reward).

166. I have COBRA and it's too expensive. Can I drop it during open enrollment and enroll in a marketplace plan instead?

During open enrollment, you can sign up for a marketplace plan even if you already have COBRA. You will have to drop your COBRA coverage effective on the date your new marketplace plan coverage begins. After open enrollment ends, however, if you voluntarily drop your COBRA coverage or stop paying premiums, you will not be eligible for a special enrollment opportunity and will have to wait until the next open enrollment period. Only exhaustion of your COBRA coverage triggers a special enrollment opportunity.

167. I have COBRA and am finding it difficult to afford, but open enrollment is over. Can I drop my COBRA and apply for non-group coverage outside of open enrollment?

No, voluntarily dropping your COBRA coverage or ceasing to pay your COBRA premiums will not trigger a special enrollment opportunity. You will have to wait until you exhaust your COBRA

coverage or until the next open enrollment (whichever comes first) to sign up for other non-group coverage.

168. I'm leaving my job and will be eligible for COBRA. Can I shop for coverage and subsidies on the marketplace instead?

Yes, leaving your job and losing eligibility for job-based health coverage will trigger a special enrollment opportunity that lasts for 60 days. You can apply for marketplace health plans and (depending on your income) for premium tax credits and cost-sharing reductions during that period. If you enroll in COBRA coverage through your former employer, however, you will need to wait until the next marketplace open enrollment period if you want to switch to a marketplace plan.

169. I thought there was supposed to be a cap on my out-of-pocket costs, but when I look at my plan options, it looks like there is more than one cap, depending on what health care I use. How can that be?

All non-grandfathered group health plans must cap out-of-pocket costs at $6,350 for an individual plan and $12,700 for a family plan. The cap applies to essential health benefits obtained in-network. However, this requirement has been delayed for group health plans for one year. In 2014, plans can maintain separate out-of-pocket limits for benefits if they are separately administered. For example, sometimes prescription drug benefits are administered separately from medical benefits. In such a case, your group health plan is allowed to have separate out-of-pocket caps for each of those separately administered benefits, as long as each cap is no more than $6,350 for an individual plan and $12,700 for a family plan. However, there cannot be a separate out-of-pocket limit for mental health and substance use disorder benefits.

By 2015, group health plans will be allowed to have only one out-of-pocket spending cap.

170. I thought my employer plan couldn't have any annual or lifetime limits on benefits but I heard that there may still be some limits in our plan. Is that allowed?

All non-grandfathered group health plans are prohibited from imposing annual or lifetime dollar limits on "essential health benefits" (see FAQ #116). There may be some benefits that your plan covers that aren't considered "essential health benefits," and for those services, your plan can include an annual or lifetime dollar limit. Plans can also include non-dollar limits on benefits, such as limits on the number of visits, or days in the hospital, even on "essential health benefits."

Your Summary of Benefits and Coverage must include information on limitations and exceptions on services that are covered, as well as lists of excluded services and "other covered services," which may include services that have greater restrictions and/or higher out-of-pocket costs than would apply to "essential health benefits."

171. I'm eligible for health benefits at work. My employer didn't provide my enrollment materials on time and as a result, I missed the company's open enrollment. Can I apply for coverage in the marketplace now? Or is my employer required to give me a second chance to enroll at work?

If your employer failed to provide you enrollment materials on time and, as a result, you missed your opportunity to enroll in your employer's plan, you can ask your employer for – and you must be offered – another opportunity to enroll.

172. My employer asked me to enroll in the company health plan last summer, before I knew about the options in the marketplace or the requirement that I have coverage or pay a penalty. I didn't sign up last summer when I had the chance. Can I still sign up for coverage in the marketplace and apply for premium tax credits?

Eligibility for premium tax credits is based on whether or not your employer coverage is affordable and adequate, regardless of whether you actually enrolled in the plan when you had the chance last summer. However, a special rule applies in 2014 for people whose employer plan year starts in the middle of a calendar year rather than on January 1 – for example, some employer plans begin July 1 of each year and continue through June 30 of the following year. In such cases, your responsibility to obtain coverage won't begin until the next plan year that starts in 2014. So, for example, if your employer plan year is July 1 to June 30, and if you didn't enroll in that plan last year, you won't be subject to a tax penalty for being uninsured for the remainder of that plan year (January 1 to June 30 of 2014.) However, you will be responsible for having coverage for the rest of 2014, so you will have to enroll in your employer plan at your next opportunity, or else face a tax penalty.

173. My employer won't fill out the form that asks about the affordability of our job-based health plan. I think my job-based plan is unaffordable and that's why I'm not enrolled in it. Can I go ahead and apply for marketplace coverage and premium tax credits without that form?

Your employer is not required to fill out the form that asks about affordability of your job-based health plan. If for any reason you cannot obtain this information from your employer, you should report to the marketplace what you know yourself about your eligibility for employer-sponsored coverage, the cost of that coverage, and whether it meets minimum value. The marketplace may try to follow up with your employer and collect or verify this information. The marketplace will determine your eligibility for premium tax credits based on the information you provided or based on any information the marketplace was able to obtain.

174. I'm eligible for health benefits at work. However, unfortunately, I didn't turn in my enrollment papers on time during the company open season, so now I'm not covered. Can I get a policy in the marketplace instead? Can I apply for premium tax credits?

If you missed your opportunity to enroll in your employer plan during the company's open enrollment season, you can still apply for coverage in the marketplace during open enrollment, which runs from October 1, 2013 to March 31, 2014. You can also apply for premium tax credits but you will have to provide information on the health coverage you are eligible for at work, even if you're not enrolled in the plan. If the plan offered meets standards for affordability and minimum value, you will not be eligible for premium tax credits or cost-sharing reductions.

175. My large employer offers health benefits to me. My wife works and has coverage through her job. To figure out whether my coverage is affordable, do I just count my income or do I count my wife's salary, as well?

If you are considering applying for premium tax credits for coverage in the marketplace, the test for whether your employer coverage is affordable is based on the cost of self-only coverage in the lowest cost plan your employer offers, compared to your household income (and not just your salary).

176. My employer offers a "mini-med" plan. It only covers preventive services and a few doctor visits each year. I want better coverage. Can I apply for coverage and premium tax credits in the marketplace?

You can apply for coverage in the marketplace and if your employer plan doesn't meet the Affordable Care Act's standard for minimum value, you may qualify for premium tax credits. To meet the minimum value standard, the plan must cover at least 60 percent of covered services for an average population. If your employer plan only covers preventive services and a few doctor visits, it is likely it doesn't meet the minimum value standard (which means it would be considered inadequate and you could be eligible for premium tax credits to help buy a marketplace plan). However, if your employer offers another plan or plans, in addition to the mini-med plan, that is found to be adequate and the premiums for self-only coverage in that plan would be considered affordable for you, you will not qualify for premium tax credits in the marketplace.

Chapter 2: Coverage for Employees of Small Businesses

Background

Most people who have private coverage in the U.S. have coverage through an employer. More than 56 percent of Americans under age 65 have coverage through an employer-sponsored plan. However, because of high costs and limited options, many small businesses have struggled to offer health insurance to their workers, and the number of small businesses doing so has declined over time.

Currently, the states define a small business to include at least one but no more than 50 employees. However, by 2016, the Affordable Care Act will expand the definition of small business to include those with up to 100 employees.
The Affordable Care Act builds on a prior federal law – HIPAA – to improve the accessibility, adequacy and affordability of health insurance for small businesses through a series of reforms. Many of the Affordable Care Act's reforms apply to small business health insurance but not to large businesses.

NOTE: States can enact stronger consumer protections. Specific reforms include:

- Modified community rating. Insurers are no longer allowed to charge higher premiums based on the health status or claims experience of an employer group. However, insurers may charge more if the employer group is older than average (up to three times more) or if a number of employees use tobacco products and the employer doesn't offer tobacco users services to help them quit.
- Prohibition on pre-existing condition exclusions. Prior to the Affordable Care Act, some small employer plans would refuse to cover care for employees' pre-existing conditions. In many states this period could last for up to 12 months. Under the Affordable Care Act, health insurers are no longer allowed to exclude pre-existing conditions from covered benefits under the plan.
- Minimum essential benefit standard. Insurers are required to cover a minimum set of benefits within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
- Minimum generosity of coverage. Small employer coverage must provide a minimum level of financial protection for health costs, at least 60 percent of total average costs for covered benefits. Further, the Affordable Care Act requires plans to be offered at specified coverage levels, so that employers and employees can more easily compare them. The lowest level of coverage (60 percent) is called the bronze level. A silver level plan will cover 70 percent of total average costs for covered benefits, a gold plan covers 80 percent, and a platinum plan covers 90 percent.
- Maximum out-of-pocket costs. Insurers are required to limit how much consumers can pay in out-of-pocket costs (including deductibles, co-payments, and co-insurance) for covered benefits in a given year. In 2014, the limits are $6,350 for individuals and $12,700 for families. However, some employer-sponsored plans may have higher limits in the first year, to provide

a transition period for employers that use one company to administer its primary medical benefits and another company to administer certain benefits, such as prescription drugs. In these cases, the maximum out-of-pocket limit will apply to the primary set of medical benefits but a separate limit – or in some cases no limit at all – will apply to any benefits administered by another company.

- Creation of a Small Business Health Options Program (SHOP), designed to simplify the process of buying health insurance for small business. In the SHOP, employers can compare health plans online and may qualify for a small business health care tax credit worth up to 50 percent of premium costs.

Frequently Asked Questions

177. I have an offer of coverage from my employer, but the premiums are too expensive and I have to pay a lot out-of-pocket. Can I get financial help in the health insurance marketplace?

If your premiums for self-only coverage in your employer plan are 9.5 percent or more of your household income and your income is between 100 percent and 400 percent of poverty, you may be eligible for a premium tax credit for coverage in a health insurance marketplace (see Appendix A for more information on the federal poverty level for individuals and families). The coverage must also provide minimum value (at least 60 percent of average costs of covered services).

The application for coverage in a health insurance marketplace includes questions your employer can answer to help determine whether your health benefits qualify you for a premium tax credit.

178. My employer just told us we are enrolling in the "SHOP." What is the SHOP?

The SHOP, or Small Business Health Options Program, is a new marketplace in which small employers can go online to compare health plans on an "apples-to-apples" basis. Depending on the size of employer and average employee salaries, your employer may also qualify for federal premium tax credits to help pay for employees' coverage.

All health plans offered on the SHOP have been certified to meet minimum standards for the adequacy and quality of coverage. All plans also must cover a similar set of benefits, and each plan will be assigned to a precious metal level of coverage – bronze, silver, gold, or platinum – that reflects how much protection against cost-sharing the plan provides to the average enrollee. Bronze plans expose the average consumer to the greatest amount of cost-sharing, while platinum plans provide the most protection. Bronze plans will tend to have lower monthly premiums, while the premiums for platinum plans will be more expensive.

On the SHOP website, depending on your state, you may be able to select and enroll in a health plan. In some states, your employer may only provide one plan choice; in other states, your employer may be able to offer you a range of plans to choose from. Either way, you can see standardized information about your plan options online so you can better understand the coverage you are purchasing. If you need additional assistance picking a plan or understanding how to enroll in coverage, in-person and telephone assistance is also available.

179. The company I work for is buying coverage through the SHOP. Can I choose any plan I want?

In most states in 2014, if you are purchasing coverage through the SHOP, your employer will select your plan options for you. However, certain states running their own health insurance marketplaces may allow your employer to provide you with greater choice. For example, your employer may allow employees to pick any plan at a given precious metal level of coverage (for example, any silver level of coverage plan); or to pick between multiple plans offered by a selected insurer (for example, any metal level of coverage offered by a particular insurer). In some states, employers also may allow their employees to pick from a wider selection of plans. Typically, if your employer chooses to provide greater choice to you and your co-workers, they will select a "reference plan" to calculate how much they will contribute to your premium. If you choose to purchase a more expensive plan than the "reference plan," you may be responsible for the additional cost. If you choose to purchase a less expensive plan, you may be able to reduce your portion of premium expenses compared to what you would owe if you selected the reference plan. In 2015, all SHOPs will at least allow employers to let their employees pick any plan at a given actuarial value.

180. My employer's plan is changing and they'll now pay a pre-set dollar amount toward my coverage. What does this mean for the coverage I buy?

Your employer is shifting to a defined contribution plan, meaning that the employer defines in advance the dollar amount he or she is willing to contribute to employees' premiums. This is different from the more traditional defined benefit approach to employer-sponsored coverage, in which the employer chooses the benefit package and agrees to pay a percentage of the premiums. With a defined benefit approach, if the plan's premiums go up, so does the employer's contribution.

If your employer is shifting to a defined contribution approach, and offers only one plan option, your coverage may not look very different to you in the first year. However, over time, your employer's level of contribution may not keep pace with increases in the cost of health insurance – leaving you to make up the difference.

If your employer is offering more than one plan option, your employer may peg the amount of their contribution to one of the options – often referred to as a "benchmark" or "reference plan." If you choose to purchase a more expensive plan than the "reference plan," you may be responsible for

the additional cost. If you choose to purchase a less expensive plan, you may be able to reduce your portion of premium expenses compared to what you would owe if you selected the reference plan. However, if your employer's level of contribution does not increase at the same rate as premiums, over time, you will be responsible for a greater portion of costs regardless of your plan selection.

181. I've heard there is a tax credit if my employer buys through the SHOP. Can I get it?

Since 2010, certain small businesses – specifically, those that cover at least 50 percent of premiums for their employees (not including dependents) and have fewer than 25 full-time employees whose average annual wages are less than $50,000 – have been able to receive a small business health care tax credit. Beginning January 1, 2014, the maximum value of this sliding scale tax credit will increase significantly – from 35 percent to 50 percent of premiums paid by small businesses. To qualify, they must purchase coverage through the SHOP. The amount of the tax credit is only based on your employer's contribution to premiums, and it is up to your employer to determine how to use the money. However, if your offer of employer-sponsored health insurance is unaffordable or does not provide adequate protection against cost-sharing, you may be eligible for premium tax credits and cost-sharing reductions if you purchase coverage in the health insurance marketplace. For more information, see FAQ #48.

182. Does my employer have to offer these essential health benefits or other consumer protections in the Affordable Care Act?

That depends. Some employer-sponsored plans may be exempt from many of the Affordable Care Act's requirements, including the essential health benefit rules. If your plan is "grandfathered," for example, your employer does not have to comply with the essential health benefits standard. For more on grandfathered plans, see Appendix B.

In addition, if you are covered by a "self-insured" or "self-funded" plan, your employer is exempt from many of the Affordable Care Act's rules, including the requirement to cover the essential health benefits. Under such an arrangement, your employer acts as the insurer, rather than purchasing a plan from a health insurance company. Sometimes these plans can look very similar to traditional health insurance – for example, your employer may still pay an insurance company to administer your benefits. Self-funded plans must comply with certain federal rules, including bans on annual and lifetime limits and rescissions, and requirements to cover recommended preventive health services without cost-sharing and extend dependent coverage to age 26.

Lastly, if your plan year started in 2013, many of the Affordable Care Act's protections, including essential health benefits, will not go into effect until your plan renews later in 2014.

183. When can I enroll in my small employer plan?

Your employer can choose to begin offering coverage at any point during the year. If your employer is purchasing coverage through the SHOP, you will have an annual open enrollment period lasting no less than 30 days during which you can compare your options and enroll in coverage. If you are a new employee, the SHOP must provide you an enrollment period to seek coverage beginning on the first day of your eligibility for coverage. For more information, see FAQ #163.

Outside of your employer's annual open enrollment period, there may be changes in your coverage or circumstances, known as "triggering events," that allow you or your dependent to enroll in or change a plan during a special enrollment period. Special enrollment periods will be provided if you or a dependent (if your employer covers dependents):

- Lose minimum essential coverage (for example, if you or your dependent were previously covered by your spouse's health plan, but are dropped from that coverage; or if the insurer providing the plan you were enrolled in through your employer discontinues the plan)
- Gain a dependent or become a dependent through marriage, birth, adoption or placement for adoption
- Were erroneously enrolled in the wrong health plan or not enrolled in a health plan due to administrative error by the SHOP
- Demonstrate that the health plan you or your dependent are enrolled in violated its contract with you
- Gained access to new health plans as a result of a permanent move
- Lose eligibility for coverage under Medicaid or Children's Health Insurance Program coverage
- Become eligible for assistance with your employer-sponsored plan through Medicaid or Children's Health Insurance Program coverage
- Meet other exceptional circumstances as the SHOP may provide

In most instances, you will have 30 days from the triggering event to select and enroll in a plan through the SHOP. However, if your special enrollment period relates to the gain or loss of Medicaid or Children's Health Insurance Program eligibility, you will have 60 days to select and enroll in a health plan. Your coverage will become effective on the first day of the following month if you make your selection between the first and fifteenth day of the month. If you make your selection later in the month, your coverage will typically not become effective until the first day of the second following month. However, exceptions are provided in certain circumstances. First, coverage is effective on the date of birth, adoption, or placement for adoption. Second, if you get married or lose minimum essential coverage, the SHOP must ensure your coverage is effective on the first day of the following

month. In addition, if you are an American Indian/Alaska Native, you may enroll in a health plan or change from one health plan to another one time per month.

When it's time to renew your coverage, you will remain in the health plan you selected the previous year, unless you choose to terminate your coverage in that plan, you enroll in another health plan through the health insurance marketplace, or the plan is no longer available to you.

184. My employer offers a workplace wellness program that increases premiums for employees who don't participate and/or can't meet certain targets for healthy behavior. I don't think I'll be able to afford the premiums if I don't participate or miss the mark. Can I leave my employer-sponsored plan and get one on the health insurance marketplace?

It depends on how much your costs go up based on any premium increases you face due to the wellness program. If your premiums with the wellness penalty would be 9.5 percent of your income or more, or if your cost-sharing increases enough to lower the value of your plan below the minimum value standard (60 percent of average costs of covered services), then you may be eligible for premium tax credits. This test applies whether you are actually penalized or not, and in advance of the penalty being applied (for example, if your employer gives you time to try to meet the health standard that triggers a penalty or reward).

185. I work for a small business who buys health insurance in the marketplace and I smoke. Will my company be charged more because of me?

Yes, assuming your coverage is purchased in a state that allows the tobacco surcharge. An insurer can adjust the premiums of health plans sold to small businesses based on the number of workers who use tobacco, unless your employer offers tobacco users services to quit.

Chapter 3: Retiree Coverage

Background

Retirees who are not yet eligible for Medicare may have a plan sponsored by their former employer as their primary source of health coverage. If the retiree is enrolled in Medicare, the retiree benefits serve as a secondary source of coverage, supplementing Medicare by reducing cost-sharing or covering benefits like prescription drugs.

For pre-Medicare retirees with employer-sponsored coverage, the Affordable Care Act may provide new protections. If the plan in which the retirees are enrolled also covers active workers, the consumer protections will apply, including limits on out-of-pocket costs and coverage of recommended preventive services without cost-sharing. However, if the plan only covers retirees, as is more often the case, the coverage does not have to comply with the Affordable Care Act consumer protections.

Retiree health coverage is considered "minimum essential coverage," which means no individual mandate penalty applies to those who have retiree health benefits. However, individuals with an offer of retiree health benefits are only eligible for the premium tax credit as long as they are not enrolled in retiree coverage.

Frequently Asked Questions

186. I have retiree coverage from my former employer, but the premiums are too expensive and I have to pay a lot out-of-pocket. Can I drop my retiree plan and get financial help in the health insurance marketplace?

Yes, as long as you drop your retiree health plan, you may be eligible for coverage in a health insurance marketplace, and depending on your income, for premium tax credits. There are a few important considerations to keep in mind:

- You must apply for coverage during the annual open enrollment period. If you drop your plan expecting to enroll at another time, you will have to wait.
- In order to avoid a gap in coverage, be sure to coordinate the date your retiree coverage will end with the date your health insurance marketplace coverage will begin.
- If you are eligible for premium tax credits, you will be able to shop for coverage and see the premiums you would pay, taking into account the tax credit.
- If you want to compare benefits and cost-sharing under your retiree plan to those you would get in a plan in a health insurance marketplace, keep in mind that plans that cover only retirees (and not active workers as well) don't have to comply with the same consumer protections as plans in a health insurance marketplace.

187. I'm 62 and already collecting Social Security. Are my Social Security benefits counted in determining my eligibility for subsidies in the marketplace?

Yes, Social Security benefits are counted as income in determining eligibility for premium tax credits in the marketplace.

188. I'm a retired veteran collecting VA pension benefits. Are those benefits counted in determining my eligibility for subsidies in the marketplace?

Yes, VA pension benefits, like Social Security benefits, are counted as income in determining eligibility.

189. Does my retiree health coverage count for the individual responsibility requirement (individual mandate), or will I have to change my coverage?

Yes, retiree health coverage counts as "minimum essential coverage," so you won't have to pay a tax penalty or change plans.

190. Does my retiree coverage have to comply with the Affordable Care Act?

It depends. If the plan in which the retirees are enrolled also covers active workers, the consumer protections will apply, including limits on out-of-pocket costs and coverage of recommended preventive services without cost-sharing. However, if the plan only covers retirees, as is more often the case, the coverage does not have to comply with the Affordable Care Act consumer protections. Your former employer can tell you which type of plan you have.

191. My spouse is covered under my plan at work. If I retire and sign up for my retiree plan, will my husband be eligible to buy a plan on the marketplace?

Probably. Most people are eligible to buy a plan on the health insurance marketplace. However, depending on your household income and his access to other coverage options, he may not be eligible for premium tax credits to lower the cost of a marketplace plan. For example, if he is eligible for Medicare and doesn't sign up for your retiree plan, he would not be eligible for premium tax credits. However, if he's not eligible for Medicare and doesn't enroll in your retiree health plan, he could be eligible for premium tax credits, assuming your household income is less than 400 percent of the federal poverty level ($62,040 for a couple in 2013).

192. I'm 63 and about to retire. I'll be offered a retiree health plan. Can I look for better coverage and subsidies in the marketplace instead?

Yes. Most early retiree health plans are considered minimum essential coverage, and thus meet an individual's requirement for coverage. However, if you want to obtain coverage through the marketplace, you may do so, and if your income is at or below 400 percent of the federal poverty level, you are eligible for premium tax credits. Eligibility for retiree coverage will not affect your eligibility for marketplace coverage and subsidies. See Appendix A for more information on the federal poverty level for individuals and families.

193. My spouse is an early retiree with affordable retiree health benefits from his former employer, but I'm not eligible to be on his plan. Can I apply for coverage and subsidies in the marketplace?

Yes, assuming you meet the other requirements, you can apply for health plans and premium tax

credits in the marketplace. Your spouse's eligibility for early retiree coverage will not affect your ability to seek coverage and financial help in the marketplace.

194. I'm 63 and my husband is 65 and on Medicare. Our income is less than 400 percent of the FPL so I need help affording the premium in the marketplace. Can we count what my husband has to pay for his Medicare premiums and supplemental and Part D premiums against what I will be required to contribute toward coverage in the marketplace?

No. Your eligibility for premium tax credit subsidies and the amount of your premium tax credit will be based on your family income. The amount your husband pays for his Medicare, Part D and supplemental insurance premium costs will not be taken into account.

Chapter 4: Individual Health Insurance

Background

The Affordable Care Act creates new health insurance marketplaces that will exist in each state. These marketplaces will enable consumers to shop for and compare health plans, and access premium tax credits and cost-sharing reductions to make health insurance more affordable. In most states, consumers will continue to be able to buy health coverage outside the marketplace.

For the most part, health insurers selling this coverage outside the health insurance marketplace coverage will have to provide many of the same consumer protections that insurers inside the health insurance marketplace provide. However, some types of coverage sold outside the marketplace are exempted from the new rules, and consumers should fully review the terms of their coverage to ensure it provides adequate protection. In addition, not all coverage sold outside the marketplace meets the federal standard for "minimum essential coverage" and consumers could face a tax penalty if they do not have this minimum coverage.

Health insurance marketplace. Consumers are eligible to purchase health insurance coverage through the marketplace if they:

- Live in the state in which they are applying;
- Are a citizen of the U.S. (or are lawfully present); and
- Are not currently incarcerated.

Consumers will need to go through additional eligibility screening to determine whether they are eligible for premium tax credits or cost-sharing reductions to help make their marketplace plan more affordable.

Premium tax credit. Starting in January 2014, individuals may qualify for financial help with premiums and out-of-pocket costs for coverage purchased through a health insurance marketplace. Financial help is available in two forms: a premium tax credit and cost-sharing reductions.

To be eligible for the premium tax credit, the individual must meet all of the following criteria:

- Be enrolled in a health plan through the health insurance marketplace
- Is not eligible for minimum essential coverage, other than coverage offered in the individual market (see FAQ #48), and
- Has household income between 100 percent and 400 percent of the federal poverty level (i.e., between $11,490 and $45,960 for an individual in 2013). See Appendix A for more information on the federal poverty level for individuals and families.

Getting more information about your coverage options. All health plans must provide individuals with a Summary of Benefits and Coverage, which uses a standard format to outline the benefits, cost-sharing and coverage limits of plans. The Summary of Benefits and Coverage must also state whether the plan meets minimum value and counts as minimum essential coverage, although in 2014, that information may be provided separately in a cover letter. The Summary of Benefits and Coverage must be made available to consumers at open enrollment and upon renewal of coverage, upon request, and whenever there is a significant change in the plan.

Comparing plans and understanding options. Beginning in 2014, all non-grandfathered plans sold to individuals and small businesses must meet federal standards for the adequacy and affordability of coverage. The federal rules establish minimum standards for benefits and cost-sharing, limit the factors that may be used to set premiums, and require plans to be standardized so that it's easier for consumers to make apples-to-apples comparisons of plans.

See also Appendix B for a chart outlining how rules apply to different insurance markets and types of coverage.

All non-grandfathered plans sold to individuals and small businesses, including those sold through a health insurance marketplace or SHOP, must meet the following requirements:

(NOTE: States may enact stronger laws or rules to protect consumers)

- Minimum essential benefit standard. Insurers are required to cover a minimum set of benefits within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use

disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

- Access to key services. Health plans must cover recommended preventive care at no cost-sharing (co-payments, coinsurance and deductible); allow individuals to designate any participating pediatrician to be their child's primary care doctor; and use emergency services without prior authorization or higher cost-sharing for out-of-network emergency room care.
- Prohibition on discrimination based on health status. Prior to the Affordable Care Act, insurers could refuse to accept applicants. Under the Affordable Care Act, health insurers can no longer do this.
- Prohibition on pre-existing condition exclusions. Prior to the Affordable Care Act, some insurers would refuse to cover care for an individual's pre-existing conditions for up to 12 months. Under the Affordable Care Act, health insurers are no longer allowed to exclude pre-existing conditions from covered benefits under the plan.
- Minimum generosity of coverage. Individual coverage must provide a minimum level of financial protection for health costs, at least 60 percent of total average costs for covered benefits. Further, the Affordable Care Act requires plans to be offered at specified coverage levels, so that individuals can more easily compare them. The lowest level of coverage (60 percent) is called the bronze level. A silver level plan will cover 70 percent of total average costs for covered benefits, a gold plan covers 80 percent, and a platinum plan covers 90 percent. Individuals under age 30 or who cannot find "affordable" coverage are eligible to purchase catastrophic coverage.
- Modified community rating. Insurers are no longer allowed to charge higher premiums based on the health status or claims experience of an individual. However, insurers may charge more if the individual is older than average (up to three times more) or if he or she uses tobacco products. Premiums can also vary by geography.
- Prohibition on annual and lifetime limits. Prior to the Affordable Care Act, health plans could limit how much they paid toward benefits, for example, no more than $100,000 in a year or $1 million in a lifetime of coverage. Under the Affordable Care Act, health plans can no longer impose annual or lifetime dollar limits on benefits.
- Limits on out-of-pocket costs. Health plans must limit out-of-pocket costs for essential health benefits to no more than $6,350 for an individual or $12,700 for a family in 2014 (this amount will grow each year to track increases in medical costs). Depending on household income, the limits may be lower for individuals and families that qualify for cost-sharing reductions in a health insurance marketplace.

- Covers young adults up to age 26. Health plans must allow families to keep their adult children on the family plan up to age 26. This applies even if the child isn't a student, doesn't live at home or is not financially dependent on his or her parents.
- Sufficient access to providers. In addition to the above rules, plans offered in a health insurance marketplace must also meet federal standards for network adequacy, ensuring access to primary care doctors, specialists, and "essential community providers" such as community health clinics without unreasonable delay.

Frequently Asked Questions

195. I have my own health insurance. Why should I consider shopping for a new plan on the health insurance marketplace?

If you use the health insurance marketplace, you can compare plans and shop with confidence that all the plans displayed have been certified as meeting a minimum standard for coverage and quality, and will qualify as "minimum essential coverage" to avoid the tax penalty. If you shop for a plan outside the health insurance marketplace, you will need to do your own research to determine whether the plan provides the kind of financial protection and access to providers that is right for you and your family.

Second, premium tax credits and cost-sharing reductions to help lower the cost of coverage are only available through plans purchased in a health insurance marketplace. In addition, even if you are not currently eligible for premium tax credits, if you have a change in household income that may make you eligible for premium tax credits and cost-sharing reductions later, you can only enroll in the subsidies outside the annual open enrollment period if you already have coverage through a health insurance marketplace.

196. Can I buy or change private health plan coverage outside of open enrollment?

In general, you can have a special enrollment opportunity to sign up for private, non-group coverage during the year, other than during open enrollment period, if you have a qualifying life event. Events that trigger a special enrollment opportunity are:

- Loss of eligibility for other coverage (for example, if you lose your employer-sponsored coverage because you quit your job, were laid off, or if your hours were reduced, or if you lose student health coverage when you graduate). Note that loss of eligibility for other coverage because you didn't pay premiums does not trigger a special enrollment opportunity

- Gaining a dependent (for example, if you get married or give birth to or adopt a child). Note that pregnancy does NOT trigger a special enrollment opportunity
- Divorce or legal separation
- Loss of dependent status (for example, “aging off” a parent’s plan when you turn 26)
- Moving to another state or within a state if you move outside of your health plan service area
- Exhaustion of COBRA coverage
- Losing eligibility for Medicaid or the Children’s Health Insurance Program
- For people enrolled in a marketplace plan, income increases or decreases enough to change your eligibility for subsidies
- Change in immigration status
- Enrollment or eligibility error made by the marketplace or another government agency or somebody, such as an assister, acting on their behalf

Note that some triggering events will only qualify you for a special enrollment opportunity in the health insurance marketplace; they do not apply in the outside market. For example, if you gain citizenship or lawfully present status, the marketplace must provide you with a special enrollment opportunity.

When you experience a qualifying event, your special enrollment opportunity will last 60 days from the date of that triggering event.

States have flexibility to expand special enrollment opportunities for consumers. Check with your State marketplace for more information.

197. An agent offered to sell me a policy that pays $100 per day when you’re in the hospital. Does that count as minimum essential coverage?

No. Some types of coverage do not qualify as minimum essential coverage. These include hospital indemnity policies (that pay a fixed dollar amount per day when you are hospitalized), discount plans, short-term nonrenewable policies, or plans that provide coverage only for a specific disease (i.e., cancer-only policies). Companies that sell these products, also called “excepted benefits,” are required to notify you if they don’t qualify as minimum essential coverage. If you receive such a notice, and don’t obtain other coverage that is minimum essential coverage, you may have to pay a tax penalty.

198. What is a grandfathered plan? How do I know if I have one?

Grandfathered plans are those that were in existence on March 23, 2010 and have stayed basically

the same. If you buy coverage on your own and you first purchased your policy prior to March 23, 2010, it may be a grandfathered plan. If you first purchased the policy after that date, it is not grandfathered. As your non-grandfathered policy comes up for renewal in 2014, it will have to change to follow all the new rules required of other health plans. If you currently are covered under a non-group policy – whether it is grandfathered or not – starting October 1, 2013, you can also explore other qualified plans offered through the marketplace and, if you prefer, you can switch to one of the new plans during open enrollment. To be eligible for a tax credit to help pay your premium – which will be based on your income – you would have to switch to a plan offered through the marketplace.

Some group plans offered by employers may also be grandfathered plans. A grandfathered group plan also must have been first established prior to March 23, 2010. To retain grandfather status, the group plan cannot be significantly changed (that is, the employer can't significantly change covered benefits or cost-sharing, or the share of the plan premium that you are required to contribute). Because employer plans tend to change from year to year, most have already lost grandfather status or will lose it over time. Meanwhile, however, grandfathered plans are not required to provide all of the benefits and consumer protections required of other health plans. For example, a grandfathered health plan might not cover preventive health services. Employers with grandfathered group health plans are allowed to enroll new employees in the grandfathered plan. So even if you first joined a group health plan after March 23, 2010, you should ask about its grandfathered status. Your employer or your insurer must let you know if your health plan is grandfathered.

199. My insurance company is offering me the option to renew my current policy before the end of year. What are the pros and cons of doing that?

Some individuals may find that their insurer is offering lower rates if they renew early. However, doing so would exempt your coverage from many of the new protections going into effect in 2014, including modified community rating and the essential health benefit standard. In addition, because you will not be insured through the health insurance marketplace, you would be ineligible for the premium tax credit and cost-sharing reduction. Some insurers are asking individuals to decide to early renew before they have the opportunity to learn about what their plan options and rates would be if they buy through the health insurance marketplace or wait to renew on schedule. Individuals should take the time to compare all of their options before making a decision.

NOTE: Some states have enacted protections for individuals who are in coverage that renewed before the Affordable Care Act consumer protections take effect January 1, 2014.

200. What if I sign up for a plan and change my mind. Can I switch my plan during open enrollment?

Once you enroll in coverage, you can change plans prior to the coverage effective date. Once the coverage takes effect, you cannot change plans again until the next annual open enrollment period,

or you have a change in circumstances that qualifies you for a special enrollment period. See FAQ #38 for more on events that trigger a special enrollment period.

201. How do I know that the coverage I have counts for purposes of the individual responsibility requirement (individual mandate)?

All health insurers and employer-sponsored group health plans must provide people with a Summary of Benefits and Coverage, which uses a standard format to outline the benefits, cost-sharing and coverage limits of plans. The Summary of Benefits and Coverage must also say whether the plan meets minimum value and counts as minimum essential coverage, although in 2014, that information may be provided separately in a cover letter.

202. I'm in a grandfathered plan that doesn't cover prescription drugs. Does that count as minimum essential coverage?

Yes, grandfathered plans count as minimum essential coverage.

203. If I switch plans, how do I make sure I can keep my doctor?

All health insurers must provide individuals with a Summary of Benefits and Coverage, which uses a standard format to outline the benefits, cost-sharing and coverage limits of plans. The Summary of Benefits and Coverage must also include information on how applicants and enrollees can obtain a list of participating, or "in-network" providers. However, these lists can quickly become out of date and may not contain the most current and accurate list of participating providers. Furthermore, you can incur significantly higher out-of-pocket costs if you obtain services outside your plan's network. Therefore, if you have a provider that you really want to keep seeing, you should contact the provider and confirm that they participate in the plans you're considering.

204. If I switch plans, how do I make sure the drug I am taking is covered under the new plan?

All health insurers must provide individuals with a Summary of Benefits and Coverage, which uses a standard format to outline the benefits, cost-sharing and coverage limits of plans. The Summary of Benefits and Coverage must also include information on how applicants and enrollees can obtain a list of covered prescription drugs, known as the plan's formulary.

205. When I graduated from college I bought a short-term policy that will help fill the gap until I get a job with health benefits. Does my short-term plan satisfy the individual responsibility requirement (individual mandate)?

No, short term policies are not required to meet the Affordable Care Act consumer protections and do not count as minimum essential coverage. Therefore, if you remain enrolled in the short

term policy, you may face a tax penalty. However, you can enroll in a plan on the health insurance marketplace during the open enrollment period and drop that plan if and when you become eligible for employer-sponsored coverage. Be aware that if you don't enroll in a plan on the health insurance marketplace and wait until your short-term policy expires, you will not be entitled to a special enrollment opportunity and will have to wait until the next open enrollment period to enroll.

206. I have health insurance through an association. How do I find out if my coverage qualifies as minimum essential coverage?

It is likely you have minimum essential coverage, because association health plans should meet the same standards as those required of an individual health insurance policy. If you are not sure whether your association's plan qualifies as minimum essential coverage, contact your plan administrator.

207. I own my own business and have no employees, what are my options?

While you are not eligible to purchase small group health insurance through the SHOP marketplace, you can purchase individual market coverage and may be able to qualify for financial assistance through the health insurance marketplace for individuals.

Chapter 5: High-Risk Pools

Background

Thirty-five states operate high-risk pools for individuals who cannot get coverage on their own because of pre-existing conditions. Premiums are typically 150 percent or more of what an individual would pay for a private health insurance, and the coverage often comes with limits on benefits. The Affordable Care Act prohibits insurers from denying individuals coverage, or charging more or limiting benefits because of a pre-existing condition. As a result, individuals with pre-existing conditions will no longer need to rely on high-risk pools as a last-resort option for coverage. Therefore, some states are developing plans to close their high-risk pools and transition enrollees to other coverage.

The Affordable Care Act's consumer protections don't apply to high-risk pool coverage. For example, high-risk pools can:

- Set rates based on factors other than those that are required by the Affordable Care Act, including gender, and can charge more based on age than is required under the health reform law
- Retain annual and lifetime limits on benefits

- Impose greater cost-sharing than is allowed under the out-of-pocket maximum that applies to all insurance sold to individuals
- Impose cost-sharing for recommended preventive services
- Cover a more limited set of benefits than required under the Affordable Care Act

If the high-risk pool remains open, and an individual chooses to remain enrolled in a high-risk pool plan, their coverage will be considered minimum essential coverage in 2014 and they won't be subject to a tax penalty under the individual responsibility requirement (individual mandate). However, high-risk pool coverage won't automatically be considered minimum essential coverage in 2015 unless they provide consumer protections similar to those required by the Affordable Care Act.

NOTE: These high-risk pools are separate from the Pre-existing Condition Insurance Plan (PCIP) operated in each state under a temporary program established by the Affordable Care Act. Those pools will terminate coverage on March 31, 2014, in anticipation of individuals with pre-existing conditions gaining coverage under the new insurance rules and coverage options.

Frequently Asked Questions

208. I got a notice from my insurance company that the high-risk pool is phasing out by the end of the year and I should sign up for coverage through the health insurance marketplace. What should I do?

You can sign up for coverage through a health insurance marketplace during the open enrollment period that runs from October 1, 2013 through March 31, 2014. However, to maintain coverage without a gap between your high-risk pool coverage and coverage in a health insurance marketplace, be sure to sign up in time for the coverage effective date to coordinate with the end of your high-risk pool coverage. For example, if your high-risk pool coverage will end on December 31, 2013 and you need coverage beginning January 1, 2014, you must enroll in a health insurance marketplace by December 15. This process includes applying for coverage and any premium tax credits or cost-sharing reductions you might be eligible for, selecting a plan and paying your first month's premium.

209. I got notice that my high-risk pool plan is continuing into next year. Should I change plans or stick with my high-risk pool?

It depends. You may want to stay in your high-risk pool plan if you are in the middle of a course of treatment, or wish to continue to see a particular provider. However, staying in a high-risk pool has significant downsides that you'll want to carefully consider:

- High-risk pools don't have to comply with the consumer protections of the Affordable Care

Act. That means they can maintain annual and lifetime limits on benefits, don't have to limit out-of-pocket costs, can limit benefits based on pre-existing conditions, and don't have to comply with the minimum benefits standard required by the Affordable Care Act – all of which can mean individuals with significant health needs may be getting less from their coverage than they would under a plan that must comply with the Affordable Care Act rules.

- Only those enrolled in a plan on the health insurance marketplace can qualify for financial assistance to reduce the cost of premiums and out-of-pocket costs. That can be a critical benefit for individuals in high-risk pool plans with high premiums and cost-sharing.

210. If I keep my high-risk pool coverage, does that count as coverage for purposes of the individual responsibility requirement (individual mandate)?

Yes, at least for 2014. Coverage through a high-risk pool will be considered minimum essential coverage in 2014 so you won't be subject to an individual mandate penalty. However, high-risk pool coverage won't automatically be considered minimum essential coverage in 2015 unless the high-risk-pool in which you are enrolled provides consumer protections similar to those required by the Affordable Care Act.

Chapter 6: Issues For Young Adults: Student Health Plans and Coverage On Parent's Health Plans

Background

In recent years, many colleges have begun requiring proof of health insurance for students. Coverage options include insurance through family policies, Medicaid, and coverage through school-sponsored student health plans. Approximately 60 percent of all colleges currently offer student health plans. In addition, many students will soon be able to purchase coverage through the new health insurance marketplaces, and most will qualify for premium tax credits and cost-sharing reductions to make that coverage more affordable. While historically there has been a wide variation in the cost and benefits provided by school-sponsored plans, under the Affordable Care Act most student plans are required to provide some important consumer protections, such as:

- Student plans are no longer allowed to impose an annual cap on prescription drugs and other health coverage, meaning they can't cut off paying for students' care if they get really sick.
- Student plans are now required to provide free preventive care, such as free STD testing and birth control.

However, some types of student plans offered by colleges and universities are exempt from consumer protections under the Affordable Care Act. These are called "self-funded" student plans, in which the

sponsoring college or university bears the financial risk for the health costs of enrollees. Students should be aware that there can be significant differences in the cost and benefits of these plans, and some plans may not provide adequate financial protection if a student gets sick or injured.

Frequently Asked Questions

Student Health Plans

211. What is a student health plan?

"Student health plan" refers to a special policy of health coverage that colleges and universities make available to their enrolled students. Typically the student health plan is different from the employer-sponsored group coverage that colleges and universities offer their faculty and staff.

212. Does a student health plan count as minimum essential coverage?

Yes.

213. Does a student health plan have to cover essential health benefits?

It does if it is a "fully insured" student health plan. A fully insured plan is one that your college or university purchases from a health insurance company. If your student health plan is fully insured, it must cover essential health benefits, which include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services including oral and vision care

However, if the student health plan is "self-insured," it might not be required to cover essential health benefits. It's up to states to regulate self-insured student health plans. Check with your college or university to find out what type of student health plan they offer, or check with your state insurance

regulator to find out what rules apply to your student health coverage.

214. Does my student health plan have to cover contraceptives?

Generally, yes it does, if it is a fully insured plan. A fully insured plan is one that your college or university purchases from a health insurance company. These plans are required to provide, without cost-sharing, access to all FDA-approved contraceptive methods, sterilization procedures, patient education and counseling prescribed by a health care provider. Exceptions are made for religious institutions of higher education that have religious objections to providing contraceptive services. If you attend such a college or university, you will be able to seek contraceptive coverage at no cost directly from the health insurance company.

If your student health plan is a self-insured plan, it might not be required to cover contraceptive services. It's up to states to regulate self-insured student health plans. Check with your college or university to find out what type of student health plan they offer, or check with your state insurance regulator to find out what rules apply to your student health coverage.

215. I'm a part-time student. Does my college have to let me enroll in the student health plan?

It is up to the college or university to establish eligibility rules for student health plans.

216. I'm eligible for the student health plan but haven't signed up yet. Do I have to take that or can I apply for coverage and subsidies in the marketplace?

Eligibility for a student health plan does not make you ineligible for marketplace coverage and subsidies. Even if you are eligible for student health coverage, you can get coverage through the marketplace. In addition, if your income is between 100 percent and 400 percent of the federal poverty level and you meet other requirements, you can qualify for premium tax credits; if your income is between 100 percent and 250 percent of the federal poverty level, you can also qualify for cost-sharing reductions. See Appendix A for more information on the federal poverty level for individuals and families.

In addition, eligibility for a student health plan does not make you ineligible for Medicaid. Check with your state to find out if you meet the income and other eligibility standards to enroll in Medicaid coverage.

217. I'm enrolled in student health coverage now, but I think I can get a better deal in the marketplace. Can I drop student health plan coverage and go to the marketplace instead?

IIf you are currently enrolled in a student health plan, you can still qualify for marketplace policies

and subsidies if you apply during open enrollment. During open enrollment, you can sign up for a marketplace plan and, if your income is between 100 percent and 400 percent of the poverty level you can also apply for premium tax credits (See Appendix A for more information on the federal poverty level for individuals and families). You will have to drop your student health coverage before your marketplace plan becomes effective in order to be eligible for premium tax credits.

Outside of open enrollment, you cannot voluntarily drop your student health plan coverage in order to qualify for coverage and premium tax credits. However, if you involuntarily lose eligibility for student health plan coverage mid-year – for example, if you drop out of school and so lose eligibility for the student health plan – you will qualify for a special enrollment opportunity and be able to apply for marketplace coverage and premium tax credits. The special enrollment opportunity will last 30 days, so be sure to contact the marketplace promptly to notify them of your qualifying event.

218. I'm a foreign student studying in the U.S. Does the requirement to have health coverage apply to me?

In general, yes. There is no group exemption for international students to the individual responsibility to have health coverage. However, you might qualify for another exemption to the requirement.

219. I'm an American college student and I plan to study abroad next semester. Am I required to have U.S. health insurance while I'm living in another country?

Yes, unless you qualify for another exception. In general, U.S. citizens with a tax home outside the U.S. and who are residents of a foreign country for the entire taxable year are exempt from the requirement to have health insurance in the U.S. But if you are a student temporarily living abroad for part of the year, and don't qualify for any other exceptions, you would be required to have health insurance or else pay a penalty.

Coverage on a Parent's Health Plan

220. I'm about to turn 19 and I'm covered under my parent's health plan as a dependent. How long can I stay covered as a dependent?

Health plans that offer dependent coverage must cover dependents up to their 26th birthday.

221. I'm going to a college that offers a student health plan. Can I stay covered as a dependent on my parent's policy or do I have to take the student health coverage?

Yes. Eligibility for student health coverage does not make you ineligible to be covered as a dependent on your parent's policy up to the age of 26.

222. I just got a job that offers health benefits, but my parent's policy is better and less expensive to me. Can I stay on my parent's policy?

Generally, yes. Eligibility for group health benefits through your own job does not make you ineligible to be covered as a dependent on your parent's policy up to the age of 26. One exception to this rule applies to grandfathered group health plans. These are plans offered by employers that were established prior to March 23, 2010 and that have not significantly changed since that date. If your parent's policy is a grandfathered group health plan, it can refuse to cover you as a dependent if you are eligible for health benefits through your own job. However, this exception ends in 2014 as the grandfathered plan year renews. You will have to ask your parent's health benefits administrator to find out about the grandfather status of the plan.

223. I'm 24 and I used to be covered as a dependent on my parent's policy. I dropped off last year when I found other coverage, but now I've lost that other coverage and want to get back on my parent's policy. Can I do that?

Yes. You are still eligible to be covered as a dependent. Your parent's plan must offer you a special opportunity to re-enroll because you lost other coverage. That special enrollment opportunity must last at least 30 days from the date you lost other coverage.

224. Do my parents have to claim me as a tax dependent for me to be on their health plan to age 26?

No. You do not need to be a tax dependent of your parents to continue to be covered as a dependent on their health plan.

225. I'm 25 years old and eligible for coverage as a dependent under my parent's employer plan. If I apply for my own marketplace plan with premium tax credits, will the marketplace consider the coverage available to me under my parent's plan?

It depends. If your parent claims you as a dependent when he or she files taxes, you will be considered part of your parent's household when applying for premium tax credits and the marketplace will consider whether the employer plan available to you is affordable and meets minimum value. See FAQ #48 for more information on employer coverage and premium tax credits. However, if you are not claimed as a dependent on your parent's tax filings and instead file your own taxes, you have the choice to enroll in your parent's employer plan or apply on your own for coverage in the marketplace with premium tax credits. If this is the case, you should compare your costs under the employer plan to those under a marketplace plan (potentially with premium tax credits, if you qualify) to determine which plan is better for you.

226. Do I have to live in my parent's home to be covered as a dependent under their policy?

No, living in your parent's home is not a requirement for eligibility to be covered as a dependent under their policy.

227. I'm covered under my parent's policy but I'm moving to another state. Can I remain covered as a dependent?

Yes, you are eligible to be covered as a dependent up to age 26 regardless of where you actually live. However, your parent's health plan probably has a network of participating providers and it may be difficult for you to find in-network care when you are living in another state. If you find that your parent's plan doesn't cover health providers in the state where you live, you can also explore the option of signing up for coverage on your own. Moving will qualify you for a special enrollment opportunity to enroll in other coverage. Check the marketplace website in your state for more information about qualified health plan options and your eligibility for premium tax credits.

228. My wife and I want to cover our 25-year-old son as a dependent on our policy. We have no other children. We don't claim him as a dependent, he doesn't live with us, and he has a job. We also have modest income and hope we can qualify for premium tax credits in the marketplace. Do we have to count our son as a member of our household when we apply? Do we have to count his income when we apply?

No. You and your husband will be counted as a household of two and the income you and he report on your joint tax return will be counted for purposes of determining your eligibility. Your son will be counted separately as a household of one, and his income will be counted separately to determine his eligibility. After the marketplace decides the amount of premium tax credit each of your "households" are eligible for, the three of you can apply for a family policy offered on the marketplace and you can apply your combined premium tax credits to reduce what your family has to pay for that policy.

229. Can I be covered under my parent's plan if I'm married?

Yes, as long as you are younger than 26. Being married does not affect your eligibility to be covered as a dependent under your parent's plan.

230. I'm under age 26, covered on my parent's plan as a dependent, and I'm getting married. Does my parent's plan have to cover my spouse?

No. Your parent's plan is not required to cover your spouse.

231. I'm covered as a dependent under my parent's plan and I'm pregnant. Will my parent's plan cover my prenatal care and delivery? Will my parent's plan cover my baby after he's born?

Your parent's plan is required to cover your maternity care and delivery. However, after that, the plan is not required to cover your child as a dependent. You will be responsible for obtaining coverage for your baby. Depending on your income, your child may be eligible for coverage under the Medicaid/CHIP program in your state. Or, you can buy a child-only policy through the marketplace and, depending on your income, you may be eligible for a premium tax credit to reduce your cost of that coverage.

232. I'm covered as a young adult dependent on my parent' s policy now, but my 26th birthday is next summer, at which point I won't be eligible for dependent coverage any longer. Should I apply for marketplace health plans and subsidies now, during open enrollment?

You can remain covered as a dependent on your parent's policy until you turn 26. Once you lose eligibility as a dependent, you will qualify for a special enrollment opportunity. At that point, you will also be able to apply for health coverage and assistance through the marketplace, even though it won't be during a regular open enrollment period.

233. My parents are self-employed and buy coverage through the marketplace. They earn too much to qualify for subsidies. I'm 24 and only earn $30,000 a year (about 260 percent of FPL.) My parents don't claim me as a tax dependent, I file my own return. Can I be covered as a dependent under their marketplace policy? If so, can I qualify for a premium tax credit and apply that to their premium?

Yes, you can be covered as a dependent up to age 26 on your parent's marketplace policy. If your parents don't claim you as a tax dependent (and you file independently), then your eligibility for premium tax credits will be based on your income alone. With your income at 260 percent FPL, you will qualify for a premium tax credit. Once you know the amount, you can decide to sign up for a marketplace policy on your own, or be covered as a dependent on your parent's policy until you are 26. If you enroll in your parent's plan, you can elect to have your premium tax credit paid directly to your parent's insurer each month, or you can claim it on your tax return later when you file.

234. My son goes to college in another state but we want him on our family plan in the health insurance marketplace. Can we do that?

Yes. If your son or daughter is a member of your tax household, they can join your family plan on the health insurance marketplace, even if they live out of state. However, your child may need to return home in order to access care within your plan's network. If he or she gets health care services in another state, the providers may be outside your plan's network and you may have to pay high co-payments or coinsurance. Your son or daughter is also likely eligible to buy coverage in the state where they attend school. If they do so, they would have a greater choice of in-network providers.

SECTION 3: COVERAGE FOR SMALL BUSINESS EMPLOYERS

Section 3 covers enrollment issues for small employers who want to understand and compare their coverage options for their employees.

Section 3 covers enrollment issues for small employers who want to understand and compare their coverage options for their employees. Background:

Because of high costs and limited options, many small businesses have struggled to offer health insurance to their workers, and the number of small businesses doing so has declined over time. Currently, the states define a small business to include at least one but no more than 50 employees. However, by 2016, the Affordable Care Act will expand the definition of small business to include those with up to 100 employees.

The Affordable Care builds on a prior federal law – HIPAA – to improve the accessibility, adequacy and affordability of health insurance for small businesses through a series of reforms. Many of the Affordable Care Act's reforms apply to small business health insurance but not to large businesses. Specific reforms include the following requirements:

(NOTE: States may enact stronger laws or rules to protect consumers)

- Modified community rating. Insurers are no longer allowed to charge higher pre miums based on the health status or claims experience of an employer group. However, insurers may charge more if the employer group is older than average (up to three times more) or if a number of employees use tobacco products and the employer doesn't offer tobacco users services to help them quit.
- Prohibition on pre-existing condition exclusions. Prior to the Affordable Care Act, some small employer plans would refuse to cover care for employees' pre-existing conditions. In many states this period could last for up to 12 months. Under the Affordable Care Act, health insurers are no longer allowed to exclude pre-existing conditions from covered benefits under the plan.
- Minimum essential benefit standard. Insurers are required to cover a minimum set of benefits within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
- Minimum generosity of coverage. Small employer coverage must provide a minimum level of financial protection for health costs, at least 60 percent of total average costs for covered benefits. Further, the Affordable Care Act requires plans to be offered at specified coverage levels, so that employers and employees can more easily compare them. The lowest level of coverage (60 percent) is called the bronze level. A silver level plan will cover 70 percent of total

average costs for covered benefits, a gold plan covers 80 percent, and a platinum plan covers 90 percent.

- Maximum out-of-pocket costs. Insurers are required to limit how much consumers can pay in out-of-pocket costs (including deductibles, co-payments, and co-insurance) for covered benefits in a given year. In 2014, the limits are $6,350 for individuals and $12,700 for families. However, some employer-sponsored plans may have higher limits in the first year, to provide a transition period for employers that use one company to administer its primary medical benefits and another company to administer certain benefits, such as prescription drugs. In these cases, the maximum out-of-pocket limit will apply to the primary set of medical benefits but a separate limit – or in some cases no limit at all – will apply to any benefits administered by another company.
- Creation of a Small Business Health Options Program (SHOP), designed to simplify the process of buying health insurance for small business. In the SHOP, employers can compare health plans online and may qualify for a small business health care tax credit worth up to 50 percent of premium costs.

Frequently Asked Questions

235. I own my own business and have no employees, what are my options?

While you are not eligible to purchase small group health insurance through the SHOP marketplace, you can purchase individual market coverage and may be able to qualify for financial assistance through the health insurance marketplace for individuals.

236. I'm self employed and the only employee I have is my spouse or child. What are my options?

While you are ineligible to purchase small group health insurance through the SHOP exchange, you can purchase individual market coverage and may be able to qualify for financial assistance through the health insurance marketplace.

237. I have 47 employees and I'm trying to decide if I should hire more. What are the implications if I have more than 50 employees?

With 47 employees you can purchase coverage either inside or outside of the SHOP. If you choose to purchase through the SHOP now, you will be able to continue in your SHOP plan even if you go over 50 employees, so long as you meet all other eligibility rules (for example, you must offer coverage to all full-time employees). However, before 2016 – when all health insurance marketplaces must open to groups up to 100 – you will not be eligible to purchase coverage through the SHOP if you wait until after you go over 50 employees.

Until 2016, groups with more than 50 employees will be subject to different rules than groups with 50 or fewer employees. For example, insurers offering coverage to large groups will not need to provide the essential health benefit package, while they are required to offer such coverage to small groups. Beginning in 2016, however, these protections will extend to groups with up to 100 employees. The Affordable Care Act applies "shared responsibility" requirements to employers with more than 50 full-time or full-time equivalent employees. While it does not directly require such employers to offer health insurance, it imposes financial penalties if their employees qualify for premium tax credits for individual coverage, either because the employer did not offer coverage or offered coverage that was deemed unaffordable or to not provide adequate protection against cost-sharing. These rules take effect in January 2015 for employers with 100 or more employees and in January 2016 for employers with between 50 and 99 employees.

238. I'm a small business owner. Can I qualify for a tax credit to buy insurance?

Beginning in 2014, the small business tax credit is only available for coverage bought through the SHOP. To qualify for a small business health insurance tax credit, you must cover at least 50 percent of premiums for your employees (not including dependents) and have fewer than 25 full-time employees whose average annual wages are less than $50,000.

The number of full-time employees is calculated based on the total number of hours of service for which you pay wages to employees during the year, up to 2,080 hours per employee. This number is then divided by 2,080 and rounded down to the next lowest whole number to determine your number of full-time employees (or full-time equivalent employees). Seasonal workers are not included unless they work for more than 120 days during the tax year. Business owners and their family members generally are not included either. For more information, see http://www.taxpayeradvocate.irs.gov/calculator/SBHCTC.htm

Average wages are determined by adding up the total amount of wages you paid during the tax year, and dividing by your number of full-time employees for the year. Round down to the nearest $1,000.

The amount of the tax credit is set on a sliding scale based on the number of employees and average wages, with the maximum credit going to firms with 10 or fewer full-time employees and average wages equal to or less than $25,000. Employers who are not tax-exempt are eligible for a higher tax credit than employers who are tax-exempt.

Beginning January 1, 2014, the maximum value of this sliding scale tax credit will increase significantly – from 35 percent to 50 percent of premiums paid by small businesses. Small businesses can claim the credit on your annual income tax return, using Form 8941. Tax-exempt employers can claim the tax credit as a refundable credit by filing Form 990-T with an attached Form 8491.

239. If I offer coverage to my employees, is there a minimum requirement for what I must contribute to the cost of my employees' premiums?

Minimum contribution requirements will vary based on where you purchase your coverage. For example, insurers offering coverage through the federally-facilitated SHOP are prohibited from requiring employers to make a minimum contribution. However, outside of the federally facilitated SHOP and in some states operating their own SHOPs, minimum contribution rules may still apply. However, minimum contribution requirements must be waived between November 15 and December 15 of each year, allowing employers that do not meet the minimum contribution requirements to still access coverage. In addition, states may independently require employers offering coverage to make a minimum contribution to the cost of their employees' premiums.

240. If I offer coverage, is there a minimum threshold for the number of employees that must enroll?

In most, but not all, states, if you purchase coverage through the SHOP, 70 percent of eligible employees must enroll in coverage. SHOPs in some states may have slightly higher or lower thresholds, while only a few have prohibited such rules. Outside of the SHOP, minimum thresholds may vary across insurers. However, all insurers are required to waive this requirement between November 15 and December 15 of each year, allowing employers that do not meet the minimum participation requirements to still access coverage.

241. My insurance company is offering me the option to renew my current policy before the end of the year. What are the pros and cons of doing that?

Some employers may find that their insurer is offering lower rates if they renew early. However, doing so would exempt your coverage from many of the new protections going into effect in 2014, including modified community rating and the requirement to cover a set of minimum essential health benefits. In addition, because you will not be insured through the SHOP, you would be ineligible for the small business health insurance tax credit in 2014 (For more information on the tax credit, see FAQ #238). Also, some insurers are asking employers to decide to early renew before they have the opportunity to learn about what their plan options and rates would be if they buy through the SHOP or wait to renew on schedule. Employers should take the time to compare all of their options before making a decision.

Early renewing also may require you to make changes to related documents, such as your Summary Plan Description, and other employee benefits. Employers should consult a benefits advisor or ERISA attorney to understand the financial and legal implications of early renewing.

NOTE: Some states have limited or prohibited this practice.

242. I'm going to buy a plan through the SHOP. When can I enroll in coverage?

Small employers can generally enroll in coverage at any time during the year, either through the SHOP or in the outside market. During most of the year, insurers may condition enrollment on meeting minimum participation rules and/or contribution requirements. (While insurers participating in the federally run SHOP cannot apply minimum contribution requirements, insurers in the outside market and some state-based health insurance marketplaces may apply such rules.) However, insurers must waive these rules from November 15 to December 15 each year and allow groups that don't meet these rules to enroll in coverage.

243. I want to buy coverage through the SHOP. Can my employees pick their own plan?

In most states in 2014, if you are purchasing coverage through the SHOP, you will only be able to provide your employees with one plan option. However, certain states are running their own health insurance marketplaces and these may allow you to provide your employees with greater choice. For example, in some of these states you may allow your employees to pick any plan at a given precious metal level, such as silver, or to pick between multiple plans offered by a selected insurer. In other states, you also may allow your employees to pick from an even wider selection of plans. Typically, if you choose to provide greater choice to your employees, you will select a "reference plan" to calculate how much you will contribute to your employees' premiums. If they choose to purchase a more expensive plan than the "reference plan," they may be responsible for the additional cost. If they choose to purchase a less expensive plan, they may be able to reduce their portion of premium expenses compared to what they would owe if they selected the reference plan. In 2015, all SHOPs will at least allow employers to let their employees pick any plan at a given precious metal level of coverage. Check with your health insurance marketplace to determine what plan choice options your employees may have.

244. Does SHOP allow me to buy a pre-established level of coverage and let my employees buy a higher level of coverage if they make up the difference?

In most states, the SHOPs will only offer a traditional shopping approach in the first year. You will be able to pick one plan for your employees and determine what percentage you want to contribute. However, in some states operating their own SHOPs, you will be able to choose a benchmark plan on which you base your contribution level, which can be a pre-set dollar amount instead of a percentage of premium, and your employees can choose that plan or more or less expensive plans. If they buy a more expensive plan, they would make up the difference, while they could reduce their premium if they purchased a less expensive plan.

245. I'm interested in the SHOP but there aren't any participating insurers in my area (or there's only one insurer participating but I don't like them). Can I still get coverage through the SHOP, and can I still get the tax credit?

In most states, you can purchase coverage outside the SHOP. However, beginning with your first plan year starting in 2014, you will not be eligible for the small business health insurance tax credit if you choose to purchase coverage outside of the SHOP.

The District of Columbia and Vermont plan to only allow individuals and small groups to purchase coverage through their state-based health insurance marketplace. In Vermont, this rule will go into effect across the board in 2014. In D.C., small groups newly purchasing coverage will be required to seek coverage through the SHOP in 2014, while small employers that are renewing their coverage are provided a one year transition and will not need to purchase coverage through the SHOP until 2015.

246. I run a small farm (less than 50 employees) with a mix of full-time and part-time workers. Am I required to offer coverage?

No, there is no requirement for small employers to offer health benefits to their workers.

SECTION 4: POST-ENROLLMENT ISSUES

Section 4 covers post-enrollment issues, including questions that may arise as individuals use their coverage.

Employer-Sponsored Coverage

Background

Beginning in 2014, plans sold to individuals and small businesses must meet federal standards for the adequacy and affordability of coverage. The federal rules establish minimum standards for benefits and cost-sharing, limit the factors that insurance companies can use to set premiums, and require plan benefits to be more standardized so that it's easier for consumers to make comparisons among plans. Some Affordable Care Act reforms also apply to group health plans sponsored by large employers, including limits on out-of-pocket costs, coverage of preventive services with no cost-sharing, and a prohibition on annual and lifetime limits. Whether and how the Affordable Care Act rules apply to coverage will vary based on insurance market, type of coverage, and status as a grandfathered or non-grandfathered plan. See Appendix B for a chart outlining how the Affordable Care Act rules apply to different insurance markets and types of coverage.

The Affordable Care Act also established new appeal rights for consumers facing a denial of a benefit or service from their health plan. Consumers in new (non-grandfathered) plans have a right to an "internal appeal," in which consumers have a right to ask their health plan for a full and fair review of an unfavorable decision, and an "external review," in which an independent third party reviews the health plan's decision.

Frequently Asked Questions

247. I was denied coverage for a service my doctor said I need. How can I appeal the decision?

If your plan denied you coverage for a service your doctor said you need and it's for a benefit covered by your plan, you can appeal the decision and ask the plan to reconsider their denial.This is known as an internal appeal. If the plan still denies you coverage for the service and it is not a grandfathered plan, you can take your appeal to an independent review organization or a state external review process to review the plan's decision. This is known as an external review.

You will have 6 months from the time you received notice that your claim was denied to file an internal appeal. The Explanation of Benefits form that you get from your plan must provide you with information on how to file an internal appeal and request an external review. If your plan is fully insured, you can get help filing an appeal from your state Department of Insurance. Your state may have a program specifically to help with appeals. If there is none listed for your state on this list: https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/#statelisting ask your Department of Insurance if there is one in your state. If you have a self-funded plan and have questions or need help, contact the Department of Labor (See Appendix C for a list of state Departments of Insurance and contact information for the Department of Labor.)

For more information about the appeals process, including how quickly you can expect a decision from your plan when you file an internal appeal, go to www.HealthCare.gov at www.HealthCare.gov/how-do-i-appeal-a-health-insurance-companys-decision/

248. I got a letter saying my employer plan didn't meet the medical loss ratio requirement (MLR). Will I get a rebate?

Yes, you will get a rebate check or the equivalent value of a rebate. The Affordable Care Act requires health insurers, including those providing employer group plans, to meet a minimum medical loss ratio (MLR) standard. The MLR, also called the 80/20 rule, is a limit on how much premium revenue an insurer can devote to profits and administrative costs (20 percent in the individual and small employer markets and 15 percent in the large employer market) compared to what they spend on patient care. In the employer group market, if an insurance company does not meet this standard, they are required to return the difference to the policyholder (usually the employer) or directly to subscribers (employees) in the form of a rebate or reduction on future premiums. If the rebate goes to the employer, it must be used for "the benefit of subscribers," i.e., in the form of a cash check or a discounted employee premium.

249. I heard not all plans have to meet all rules. How do I know if my plan has to comply?

That's right. Plans that were in existence on March 23, 2010 are known as "grandfathered" plans and don't have to meet all the rules. See FAQ #198 for more on what a grandfathered plan is. Grandfathered plans are exempt from many of the Affordable Care Act rules for plans, including the requirement to cover preventive services without cost-sharing and to limit out-of-pocket costs. Your plan must tell you if it is grandfathered in any plan documents they send you. Over time, all plans will lose their grandfathered status and have to comply with rules that only apply to new plans. Note, however, that some rules don't apply to self-insured plans, even if they are new (non-grandfathered). See Appendix B for more information on how the Affordable Care Act's insurance rules apply to plans.

250. My employer plan still has an annual limit. Is that still allowed?

Plans can no longer have annual or lifetime limits on benefits that are considered essential health benefits (See FAQ #116 for more information on essential health benefits). However, plans can apply annual limits to services that are not part of the essential health benefits, even if they are covered services. Plans are also allowed to impose non-dollar limits on benefits, such as visit limits. Check the details of your plan to see how the annual limit is applied in your coverage. Your Summary of Benefits and Coverage will provide that information.

251. I thought there was a cap on my out-of-pocket costs, but I'm getting billed for something that puts me well above the limit. How can that be?

All new (non-grandfathered) plans must limit out-of-pocket costs to $6,350 for individuals and $12,700 for a family in 2014 for services that are considered part of the essential health bene-

fits and that are obtained in-network. There are a few possible explanations for why you are getting billed for something that puts you above the limit. First, if you obtained an item or service not considered part of the essential health benefits, or received care out-of-network, your health plan is not required to apply those costs towards the limit on your out-of-pocket costs. Plans can also exclude non-covered services. Second, it's possible that your plan is grandfathered and doesn't have to comply with this rule. Finally, if your plan has separately administered benefits, for example, for prescription drug coverage, it can have separate out-of-pocket limits, as long as each of the out-of-pocket limits is no more than $6,350 for an individual or $12,700 for a family. In 2014, employer plans can also have no out-of-pocket limit at all on separately administered prescription drug benefits. Check the details of your plan to see how the out-of-pocket limit is applied in your coverage. Your Summary of Benefits and Coverage will provide that information.

252. My plan wants me to participate in a health risk assessment in order to get a discount on my premium. What are my rights?

Your employer can offer rewards or penalties to encourage employees to take a health risk assessment. As long as you aren't required to meet some health standard that the assessment will reveal, such as a target body mass index (BMI) or cholesterol level, there are no limits on employers who choose to do that.

253. I had to complete a health risk assessment and now my employer is offering me a discount on my health insurance premiums if I lose weight, stop smoking, and lower my blood pressure. What are my rights?

Your employer can offer rewards or penalties to encourage employees to take a health risk assessment, and there are no limits on employers that do just that. If, however, you must also meet a health standard, like losing weight or lowering your blood pressure, your employer must meet additional requirements. Those requirements are:

a. Every individual must be given an opportunity to qualify for the reward (or avoid the penalty) once a year;
b. The rewards or penalties can total no more than 30 percent of the cost of coverage (including both your share and your employer's share of the premium) or 50 percent of your premiums for programs to reduce tobacco use; this can be in the form of lower (or higher) premiums, deductibles or co-pays (but the limit applies to the total value of all penalties/rewards);
c. The workplace wellness program must have a reasonable chance of improving health or preventing disease and not just be a way to discriminate against workers based on their health; and
d. Those individuals who can't meet the health standard must be given a reasonable

alternative standard to meet. Where the program focuses on activities related to a health condition – such as weight loss programs for people with high body mass indices (BMIs) – an individual may be required to show proof that his/her doctor has advised against the program. But programs that require individuals to meet the standard (for example, a BMI of 29) or pay more must make a reasonable alternative standard available to anyone who can't meet the health target. Any plan materials that describe the program must also give you information on how to request an alternative standard.

If you have concerns about the program your employer is offering, you can contact the Department of Labor at https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html or call 1-866-444-3272.

254. My employer offers a smoking cessation program for smokers like me but I didn't join it when I had the opportunity to do so in January and now I have to pay more for my premiums. Can I join the program now, in the middle of the year, and get my premiums lowered?

Probably not. If you were given a reasonable opportunity to enroll in a smoking cessation program when your coverage started and you turned it down, your plan isn't required to lower your premiums for the rest of the year if you join the program now. However, your plan can choose to do that, or give you other rewards, if you join late.

255. When can I add family members to my employer plan?

You can only add family members under certain qualifying circumstances, such as marriage, birth, or adoption of a child, or if your spouse loses coverage through his or her employer or another plan. In cases like these, you are eligible for a special enrollment opportunity to add a family member. If you want to enroll your family member in your employer plan, you have 30 days from the date of the triggering event to do so. See FAQ #38 for more information on special enrollment periods.

256. I'm leaving employment and have been given the option to sign up for COBRA. What are the pros and cons of doing that?

COBRA – a coverage program named after the Consolidated Omnibus Budget Reconciliation Act, a law enacted in 1986 – is considered minimum essential coverage, so if you sign up for COBRA you will meet the requirement to have coverage. However, your plan can require you to pay the full cost of your COBRA premiums – what you were paying before plus the amount your employer paid on your behalf. If you are in the middle of a course of treatment, you may want to use COBRA to maintain the plan that has provided you with coverage for the care you are receiving, regardless of the cost. But if that is not the case, or when your treatment ends, you may find coverage in the marketplace to be more affordable, especially if you qualify for premium tax credits. Keep in mind that having an opportunity to sign up for COBRA doesn't prevent you from qualifying for premium tax credits. But if you sign up for COBRA, you will not be able to qualify for premium tax credits through

the health insurance marketplace at the same time. If you have COBRA, you generally would have to wait until the next marketplace open enrollment period to enroll in a marketplace plan and receive premium tax credits, unless you exhaust your COBRA coverage. Dropping COBRA outside of open enrollment will not qualify you for a special enrollment opportunity to sign up for coverage in the marketplace. See FAQ #166 for more information on COBRA and premium tax credits.

257. I thought there was a cap on out-of-pocket costs but my prescription drug benefit requires me to pay co-pays even after I've met the out-of-pocket limit for other medical benefits. Is that allowed?

Yes, for 2014, employer plans that have separately administered benefits – for example, the drug benefit is administered under one plan and the medical benefits under another – can keep separate out-of-pocket limits, as long as each of the out-of-pocket limits is no more than $6,350 for an individual or $12,700 for a family. In 2014, employer plans can also have no out-of-pocket limit at all on separately administered prescription benefits. However, beginning in 2015, employer plans must ensure that each separately administered benefit has an out-of-pocket cap and the total of all caps combined cannot be more than $6,350 for an individual or $12,700 for a family (note that the 2015 caps will be slightly higher because of inflation).

258. I heard experts now say some women should take tamoxifen to prevent breast cancer. Does that mean it will be covered without co-pays?

For some women, yes, tamoxifen must be available without co-pays. If tamoxifen is recommended for you and your plan is not grandfathered, your doctor may prescribe tamoxifen or another drug that experts say may reduce the risk of breast cancer, and your plan must cover it without any cost-sharing. This update to the preventive services benefit takes effect with plans that start after September 24, 2014.

Coverage for Employees of Small Businesses

259. I thought all plans had to get rid of their annual limit but my plan has said I've met mine. How can that be?

Plans can no longer have annual or lifetime limits on benefits that are considered essential health benefits (see FAQ #116 for more information on essential health benefits). However, plans can apply annual limits to services that are not part of the essential health benefits, even if they are covered services. Plans are also allowed to impose non-dollar limits on benefits, such as visit limits. Check the details of your plan to see how the annual limit is applied in your coverage. Your Summary of Benefits and Coverage will provide that information.

260. I thought there was a cap on my out-of-pocket expenses but I'm getting charged for services that go well beyond that. How can that be?

All new plans must limit out-of-pocket costs to $6,350 for individuals and $12,700 for a family in 2014 for services that are considered part of the essential health benefits and for care obtained in-network. Plans can – but aren't required – to apply the out-of-pocket limit to services that are not part of the essential health benefits (even if they are covered services) or for care that is obtained out-of-network. Plans can also exclude non-covered services. It's also possible that your plan is grandfathered and doesn't have to comply with this rule, or that this requirement has not yet taken effect for this plan. Check the details of your plan to see how the out-of-pocket limit is applied in your coverage. Your Summary of Benefits and Coverage will provide that information.

261. I thought prescription drugs were supposed to be covered in all plans, but my plan doesn't include them. Is that allowed?

All new plans sold to small employers must offer essential health benefits, which includes prescription drugs. However, it's possible your plan is a grandfathered plan or is self-insured and doesn't have to meet this requirement. Your insurer must tell you if your plan is grandfathered.

Individual Health Insurance

262. I was denied coverage for a service my doctor said I need. How can I appeal the decision?

If your plan denied you coverage for a service your doctor said you need, you can appeal the decision and ask the plan to reconsider its denial. This is known as an internal appeal. If the plan still denies you coverage for the service and it is not a grandfathered plan, you can take your appeal to an independent third party to review the plan's decision. This is known as an external review.

You will have 6 months from the time you received notice that your claim was denied to file an internal appeal. The Explanation of Benefits you get from your plan must provide you with information on how to file an internal appeal and request an external review. Your state may have a program specifically to help with appeals. If there is none listed for your state on this list: https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/#statelisting, ask your Department of Insurance if there is one in your state.

For more information about the appeals process, including how quickly you can expect a decision from your plan when you file an internal appeal, go to www.HealthCare.gov at www.HealthCare.gov/how-do-i-appeal-a-health-insurance-companys-decision/

263. My individual plan was retroactively cancelled even though I've been paying my premiums. I think it might be because I was recently diagnosed with a serious health condition. Can they do this?

No. Under the Affordable Care Act, insurers are not allowed to cancel (or rescind) an individual's coverage unless that individual commits fraud or intentionally lies on his or her application for insurance. Further, insurers are no longer allowed to discriminate against any individual because of his or her health status. However, insurers may cancel coverage if a policyholder fails to pay premiums. If you believe your insurer has cancelled your coverage because of a recent diagnosis or your need for health care services, contact your state Department of Insurance (see Appendix C for a list of state Departments of Insurance).

264. My plan sent me a notice that it didn't meet the medical loss ratio (MLR). Will I get a rebate?

Yes, you will get a rebate check or the equivalent value of a rebate. The Affordable Care Act requires health insurers to meet a minimum medical loss ratio (MLR) standard. The MLR, also called the 80/20 rule, is a limit on how much premium revenue an insurer can devote to profits and administrative costs (20 percent in the individual market) compared to what it spends on patient care. If an insurance company does not meet this standard, it is required to return the difference to the policyholder. If this happens with your health plan, you will receive a notice from your insurer, including the amount you are owed. Your insurance company can provide that rebate to you in the form of a reduced premium, a lump-sum check, or, if you paid by credit or debit card, by a lump-sum reimbursement to that account.

265. I thought I was entitled to maternity coverage. Why isn't it covered?

All new plans sold to individuals must offer essential health benefits, which includes maternity coverage. However, it's possible your plan is a grandfathered plan and doesn't have to meet this requirement, or doesn't yet have to meet this requirement. Your insurer must tell you if your plan is grandfathered. Alternatively, you may have purchased an insurance product that is not subject to the Affordable Care Act's requirements because it is not traditional health insurance. For example, medical discount plans, short-term insurance, and cancer-only policies are not considered health insurance and therefore not subject to the requirement to cover maternity care. If you believe you purchased one of these policies – and thought you were purchasing health insurance – you should notify your state Department of Insurance (see Appendix C).

266. I qualified for the cost-sharing reduction when I signed up for coverage in the marketplace. But now I'm getting more hours at work and I might not qualify anymore. Will I have to change plans now and start all over with a new deductible and out-of-pocket cap?

No one is forced to change plans. However, if your income changed and you now earn more than 250 percent of poverty (which is the income limit to qualify for cost-sharing reductions), you are enti-

tled to a special enrollment period, which gives you an opportunity to see if there is a better option based on your new circumstances. Once your insurer is notified by the marketplace about such a change in eligibility, the insurer is required to change your plan to the correct standard silver plan or plan variation, if you are enrolled in a silver plan. If your income drops and you become eligible for a cost-sharing reduction, you would be able to use a special enrollment period to move from, for example, a bronze plan to a silver plan that allows you to receive the cost-sharing reduction.

If you stay in the same silver plan (but with different cost-sharing, appropriate to your income), then cost-sharing charges already paid during that year must be counted against the cost-sharing required under the new version of the plan. However, if you move from a silver plan to a bronze plan (even with the same insurer), your new plan isn't required to count the cost-sharing you already paid, although the insurer could choose to do that.

267. I was in the hospital on January 1, 2014, when my coverage changed from my old plan to my new, marketplace plan. My provider during that episode of treatment is no longer in my plan's network and I'm worried I'll face higher cost-sharing as a result. Is this allowed?

Yes, plans can charge you more for your providers who are out-of-network, but you may be able to get a break on your costs because you were in the middle of a hospital stay when your plan changed. Marketplace plans are encouraged – though not required – to adopt policies to prevent disruptions in treatment of episodes of care. Insurers can do this by considering a provider as being in the plan's network when there is an acute episode of care, such as your hospital stay, at the start of the plan year. However, insurers that choose to adopt a policy like this to help patients transition to new coverage can make the policies apply only temporarily.

268. My doctor says I need a prescription drug, but it's not in my health plan's formulary. I didn't realize that when I enrolled in the plan. Shouldn't my plan be required to cover a drug that my doctor says I need?

All new plans sold to individuals and small employers must have procedures in place to allow enrollees to request and gain access to clinically appropriate drugs even if they are not on the formulary. However, that process may take time, and you may need immediate access to drugs your doctor prescribed. Therefore, marketplace insurers are encouraged to temporarily cover non-formulary drugs (including drugs that are on the plan's formulary but require prior authorization or step therapy) as if they were on the formulary. This policy would apply for a limited time – for example, during the first 30 days of coverage – and is not required of insurers. But hopefully it will give you enough time to request an exception to the formulary so you can get your prescription covered.

269. What should I do if my marketplace plan doesn't adopt these policies and I have to pay out-of-network charges or can't get the drug I need?

As with any coverage denial, you can appeal the health plan's decision, first for a review by the plan (known as an internal appeal) and then by an independent third party (known as an external appeal). The plan must notify you of their decision regarding your appeal within specific timeframes: within 30 days for services you have not yet received, and within 60 days for services already received. If you require urgent care, you can request an internal and external review at the same time, and you must receive a decision as soon as is required by your condition and at least within 4 days of your request. You should also report the issue to your state insurance regulator.

270. I pay more for my plan because I'm a smoker. If I stop smoking after I sign up, will my rates go down?

Your insurer doesn't have to lower your rates to reflect your new non-smoker status until you renew your coverage.

APPENDIX A

Income Thresholds for Premium Tax Credits and Cost-sharing Reductions in 2014 by Household Size

% of FPL	Annual Income for Household Size:			
	1	2	3	4
100% FPL	$11,490	$15,510	$19,530	$23,550
138% FPL	$15,856	$21,404	$26,951	$32,499
150% FPL	$17,235	$23,265	$29,295	$35,325
200% FPL	$22,980	$31,020	$39,060	$47,100
250% FPL	$28,725	$38,775	$48,828	$58,875
300% FPL	$34,470	$46,530	$58,590	$70,650
400 % FPL	$45,960	$62,040	$78,120	$94,200

2014 Federal Income Tax Filing Threshold:	
$10,000	Filing Single
$20,000	Filing Jointly

APPENDIX B

How to Know If the ACA Consumer Protections Apply to Your Private Coverage

The Affordable Care Act includes new rules and consumer protections for private health coverage, making coverage more accessible, adequate and affordable for consumers. Although the Affordable Care Act focuses primarily on new consumer protections in the individual and small group market, there are new rules for large employer-sponsored plans, as well. How these rules apply to health coverage depends on a number of factors, including whether the coverage is provided to employer groups or individuals; whether the employer groups are large or small; whether the group is self-insured or fully insured; and whether the plan is "new" or "grandfathered."

Types of Private Health Coverage: There are two main types of private health coverage: employer-sponsored insurance and coverage sold to individuals.

- **Employer-sponsored coverage:** most people who have private coverage in the U.S. have coverage through an employer. More than 56 percent of Americans under age 65 have coverage through an employer-sponsored plan.
  - Insured vs. self-insured employer-sponsored coverage: private health coverage is generally provided by state-licensed health insurers and self-insured (sometimes called self-funded) employer health plans.
    - Fully-insured plans are those in which health insurers collect premiums for each enrollee in the group in exchange for providing coverage for medical services.
    - Self-insured plans are sponsored by employer and/or employee organizations and the sponsor directly pays for enrollees' health claims. The plan sponsor – not an insurer – assumes the financial risk of providing coverage for the plan enrollees. Self-insured plans are exempted from many of the Affordable Care Act's health insurance reforms. See Exhibit 1.
  - Large employers vs. small: The Affordable Care Act defines small employer to mean an employer who employs at least one but no more than 100 employees (two to 100). However, until 2016, states may limit the definition of small employer to mean an employer who employs at least one but no more than 50 employees two to 50). Most states have taken advantage of this option and define small employer to mean one who

has two to 50 employees. Many of the Affordable Care Act's health insurance reforms apply to small employers but not large employers. See Exhibit 1.

- **Individual health coverage:** Plans sold to individuals directly, and not through an employer, make up the individual market (sometimes called the non-group market). Plans may be sold to a single person or to a family. Most of the Affordable Care Act's health insurance reforms apply to individual health coverage. See Exhibit 1.

Grandfathered plans vs. new: One of the Affordable Care Act's goals is to allow people to keep the coverage they have if they like it. To achieve that, the Affordable Care Act exempts plans that were in existence when the law was signed on March 23, 2010 from having to comply with some of the insurance rules. These plans are known as "grandfathered" plans and include both individual and group health coverage. As grandfathered plans make changes to their cost-sharing and benefits, they may lose their status and have to come into compliance with all applicable Affordable Care Act rules. Any plan document describing benefits, including the Summary of Benefits and Coverage, must include notice of whether the plan is grandfathered.

Exhibit 1. Application of Affordable Care Act Rules Across Types of Coverage and Markets

Provision	Individual Market	Small Group Market	Large Group Market	Self-Insured	Grandfathered
Guaranteed Issue and Renewal Insurers Must Accept Every Individual and Employer That Applies for Coverage, and Cannot Refuse to Renew Coverage Based on Claims or Health Status.	Yes	Yes	No, but HIPAA Protects Against Discrimination Based on Health Status	No, but HIPAA Protects Against Discrimination Based on Health Status	No
Pre-Existing Condition Exclusions Prohibits Plans From Excluding Pre-Existing Conditions From Covered Benefits Under the Plan.	Yes	Yes	Yes	Yes	Yes, Except for Grandfathered Individual Market Plans
Waiting Periods Group Health Plans Cannot Impose a Waiting Period Of More Than 90 Days for Coverage to Begin.	No	Yes	Yes	Yes	Yes
Rating Rules Insurers Can Only Vary Rates Based on Age, Tobacco Use, Geographic Area and Family Composition. They Cannot Vary Rates Based on Health Status.	Yes	Yes	No	No	No
Essential Health Benefits Insurers Must Provide Coverage That Includes 10 Categories of Defined Benefits.	Yes	Yes	No	No	No
Coverage Levels Coverage Must Provide a Minimum Level of Financial Protection, and Must be Offered at Specified Coverage Levels.	Yes	Yes	No	No	No
Dependent Coverage To Age 26 Health Plans Must Allow Adult Children up to Age 26 to Remain on the Family Plan.	Yes	Yes	Yes	Yes	Yes
Out-Of-Pocket Maximums Plans Must Cap Out-Of-Pocket Costs Annually at $6,350 for Individual Coverage, $12,700 for Family Coverage.	Yes	Yes	Yes	Yes	No
Preventive Services Plans Must Cover Recommended Preventive Services at No Cost-Sharing.	Yes	Yes	Yes	Yes	No
Annual And Lifetime Limits Plans Cannot Impose Annual or Lifetime Limits on Benefits.	Yes	Yes	Yes	Yes	Lifetime Limits: Yes Annual Limits: Yes, Except For Grandfathered Individual Coverage

APPENDIX C

Where to Go for Help When You Have a Problem With Your Private Health Insurance

When to go to your state regulators for help: States are responsible for enforcing standards that apply to fully insured health plans, including those sold to individuals and small employers. The exception to this is in states that fail to enforce the standards and the U.S. Department of Health and Human Services is responsible for enforcement. See Table 1 for contact information for state departments of insurance.

When to go to federal regulators: A federal law known as ERISA governs employer-sponsored coverage, whether fully insured or self-insured, and enforcement of these rules is carried out by the U. S. Department of Labor. You can contact the DOL's Employee Benefits Security Administration at http://www.dol.gov/ebsa/contactEBSA/consumerassistance.html

To find an EBSA contact for your state, call 1-866-444-3272

Table 1: State Department of Insurance Websites

State	Department Of Insurance Website
Alabama	http://www.aldoi.gov/
Alaska	http://www.dced.state.ak.us/ins/
Arizona	http://www.id.state.az.us/
Arkansas	http://www.insurance.arkansas.gov/
California	http://www.insurance.ca.gov/
Colorado	http://cdn.colorado.gov/cs/Satellite/DORA-HealthIns/CBON/DORA/1251615908885
Connecticut	http://www.ct.gov/cid/site/default.asp
Delaware	http://www.delawareinsurance.gov/
DC	http://disb.dc.gov/page/insurance
Florida	http://www.floir.com/
Georgia	http://www.oci.ga.gov/
Hawaii	http://hawaii.gov/dcca/ins/
Idaho	http://www.doi.idaho.gov/
Illinois	http://insurance.illinois.gov/
Indiana	http://www.in.gov/idoi/
Iowa	http://www.iid.state.ia.us/
Kansas	http://www.ksinsurance.org/

Kentucky	http://insurance.ky.gov/
Louisiana	http://www.ldi.louisiana.gov/
Maine	http://www.maine.gov/pfr/insurance/
Maryland	http://www.mdinsurance.state.md.us/sa/jsp/Mia.jsp
Massachusetts	http://www.mass.gov/ocabr/government/oca-agencies/doi-lp/
Michigan	http://www.michigan.gov/difs/
Minnesota	http://mn.gov/commerce/insurance/
Mississippi	http://www.mid.ms.gov/
Missouri	http://insurance.mo.gov/
Montana	http://www.csi.mt.gov/
Nebraska	http://www.doi.nebraska.gov/
Nevada	http://doi.nv.gov/
New Hampshire	http://www.nh.gov/insurance/
New Jersey	http://www.state.nj.us/dobi/index.html
New Mexico	http://www.osi.state.nm.us/
New York	http://www.dfs.ny.gov/
North Carolina	http://www.ncdoi.com/
North Dakota	http://www.nd.gov/ndins/
Ohio	http://www.insurance.ohio.gov/Pages/default.aspx
Oklahoma	http://www.ok.gov/oid/
Oregon	http://www.cbs.state.or.us/external/ins/index.html
Pennsylvania	http://www.insurance.pa.gov/portal/server.pt/community/insurance_pa_gov/4679
Rhode Island	http://www.dbr.state.ri.us/divisions/insurance/
South Carolina	http://www.doi.sc.gov/
South Dakota	http://dlr.sd.gov/insurance/
Tennessee	http://tn.gov/commerce/
Texas	http://www.tdi.texas.gov/
Utah	https://insurance.utah.gov/
Vermont	http://www.dfr.vermont.gov/
Virginia	http://www.scc.virginia.gov/boi/
Washington	http://www.insurance.wa.gov/
West Virginia	http://www.wvinsurance.gov/
Wisconsin	http://oci.wi.gov/
Wyoming	http://doi.wyo.gov