A User's Guide to Health Insurance Marketplaces

What is Health Insurance?

At some point in life, everyone is a patient. We all get sick and will eventually require assistance from the health care system. Health insurance, unlike other insurance products, does not penalize you each time you use it. In fact, it is to your advantage to use as many of your benefits that are needed each year, including preventative screenings. This may be in the form of a doctor's visit, a hospital stay, or an emergency situation. However, medical care is often very expensive and can quickly become thousands of dollars a day, especially if you are expected to pay the whole amount. This is the reason health insurance exists. Health insurance is a service in which you and/or an employer on your behalf pay a monthly sum, known as a premium in exchange for sharing the costs of an agreed upon set of medical services. Insurance companies offer different plans that cost different amounts and in return pay for different services. When you get sick or need medical attention, the insurance company works with you to either pay or reduce the costs of any services that it has indicated will be covered under the plan you selected.

Where Can I Get Health Insurance?

Health insurance can be acquired in many ways. Some people are eligible for government insurance programs. If you are age 65 or older, or are deemed to have a disability, you may be eligible for a federal government insurance program called Medicare. If you are a low-income individual, you may be eligible for a government insurance program called Medicaid. Others receive coverage through the military, TRICARE, or the Department of Veterans Affairs.

Many get commercial health insurance coverage through their employer, which often requires the individual to pay some or all of the monthly premium through paycheck withholding. Others still will purchase health insurance directly from an insurance company that is active in their state.

The Health Insurance Marketplace offers direct access to individual health insurance and provides a location where you can view, compare, and enroll in a plan online, similar to the experience of shopping at a typical web-based retail store.

Details on Medicare insurance can be found at www.medicare.gov. Details on Medicaid can be found at www.medicaid.gov.

Five Reasons You Need Health Insurance

Every citizen should have health insurance.

1. Even if you are generally healthy, it's impossible to anticipate every health event, illness or accident.
2. Payments from insurance companies and negotiated discounts for medical bills will help offset the costs when you get sick or injured, reducing the amount you have to pay.
3. If you have coverage you are more likely to seek preventive care, keeping you healthy and helping to avoid expensive acute care or hospitalizations.
4. Health care is expensive and insurance can take a tremendous burden off of you by sharing the costs.
5. Medical costs for those without health insurance raise prices for everyone in society. More people with coverage results in decreased costs for society at large.

Patient Advocate Foundation
patientadvocate.org
(800) 532-5274

What are Health Insurance Marketplaces?

A Health Insurance Marketplace is a website that acts as a virtual store for insurance where you can compare selected health insurance plans offered in your state. These virtual Marketplaces are comparable to websites consumers currently use to search for airline flights, such as Orbitz or Travelocity, in which an individual can look at different options at different costs. However, instead of airline flights, the products offered will be health insurance products called 'Qualified Health Plans,' or QHPs. These QHPs have been deemed qualified to be posted on each state's website, because they meet the basic requirements for coverage outlined in the Affordable Care Act (ACA). Coverage under these insurance plans will be presented in plain language so you can understand the difference between plans when it comes to costs, quality, and benefits covered.

When and How do I Enroll?

There will be a period of time each year, termed an 'annual open enrollment period' in which you can enroll in a health plan for the first time or change health plans through the Marketplace. For federal Marketplaces, annual open enrollment periods have shortened and are now only 45 days between November 1-December 15. Each state has options to extend these days when operating their own exchange.

During this time, enrollment can be performed through a single streamlined application that will determine eligibility not only for Marketplace plans, but state Medicaid and Children's Health Insurance Programs (CHIP), financial assistance with cost-sharing, and premium tax credit as well. In addition to being able to access this information and apply directly through the Marketplace website www.healthcare.gov there is also a national toll-free hotline available for enrollment and questions at (800) 318-2596.

BENEFITS COMPARISON	MARKETPLACE PLANS	NON-MARKETPLACE PLANS
Ambulatory Patient Services	✓	?
Emergency Services	✓	?
Hospitalization	✓	?
Maternity and Newborn Care	✓	?
Mental Health and Substance Use Disorder Services	✓	?
Behavioral Health Treatment	✓	?
Prescription Drugs	✓	?
Rehabilitative and Habilitative Services and Devices	✓	?
Laboratory Services	✓	?
Preventive Care, Wellness Services	✓	?
Chronic Disease Management	✓	?
Pediatric Services, Including Oral and Vision Care	✓	?
	Guaranteed	Unsure

Will Marketplace Plans Cover What I Need?

Health insurance plans sold within these Marketplaces are considered **comprehensive plans** and must offer a certain minimum level of coverage. This minimum level of coverage consists of benefits, termed the 'Essential Health Benefits,' that include services in all of the following ten coverage 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 care, wellness services and chronic disease managemen
- Pediatric services, including oral and vision care

Requiring coverage in these ten categories ensures that many services important to your care are covered. Specific services offered within these ten categories will vary from plan to plan to offer flexibility and diversity that will suit the needs of different people. If there is a specific service you anticipate needing over the course of a plan year, be sure to pay extra attention to these benefits when shopping for coverage.

How Do I Determine Which Plan is Best for Me?

Selecting an appropriate health insurance plan is an important task that requires some preparation on your part.

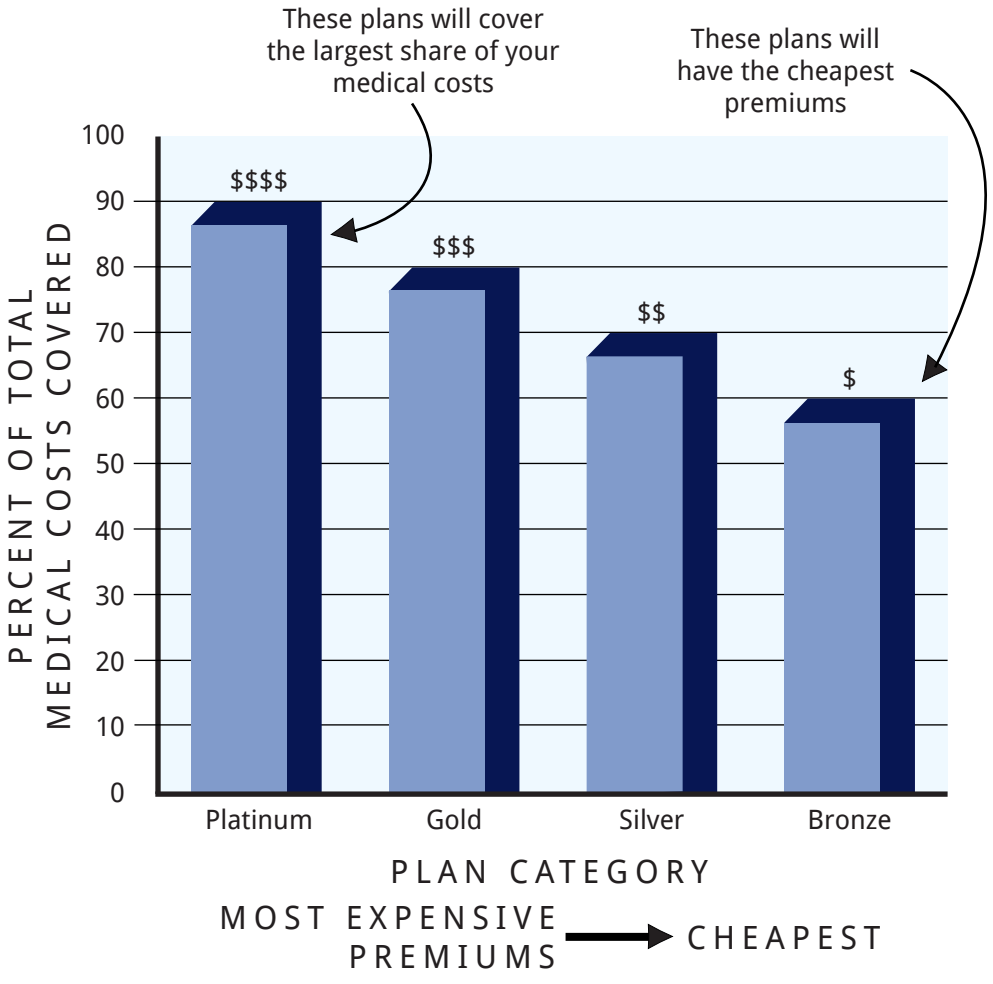
- First, it will be important to **evaluate your family health history** and any potential health concerns you may need addressed, including any doctors you need to visit and medications you need to take. This will help you determine which services you want to ensure are covered.

- Second, it will be important to look at your personal finances and **establish a budget** for health care-related costs. Determine how much you are willing to dedicate each month towards health care needs, factoring in any eligible discounts or financial assistance. Also consider potential co-payments, deductibles, and co-insurance you may incur when visiting physicians, hospitals, and other medical facilities and paying for any medication you take.

- Finally, examine the plans on the health Marketplace website. Evaluate each plan against what you have determined are important medical services to be covered, and your budget. **Note any special restrictions on coverage or exclusions that a plan** may have and whether they may interfere with you or your family's potential care. Research consumer and professional rankings of the insurance companies that offer top-rated plans to get a better understanding of the quality of these companies. Also confirm that these plans cover services from your preferred provider.

The Four Plan Tiers in the Marketplace

All of the insurance products offered in a Marketplace will be categorized in four 'tiers' indicated by the metals 'bronze,' 'silver,' 'gold,' and 'platinum.' While the bronze plan will most often be the cheapest in terms of monthly payment or **premium** required (by the consumer), it is designed to only cover approximately **60 percent** of covered medical expenses up to an established out-of-pocket maximum. The silver plan will cover approximately **70 percent** of covered medical expenses, gold will cover approximately **80 percent** of covered medical expenses, and platinum will cover approximately **90 percent** and above of covered medical expenses up to an established out-of-pocket maximum, with higher monthly premiums as the amount of coverage increases. After you reach your plan's established out-of-pocket maximum, all plans will pay 100 percent of all covered medical care.



Who Runs These Marketplaces and Does it Matter?

The Affordable Care Act gave each state the option of setting up a Marketplace itself, allowing the Federal Government to set up a Marketplace in the state, or partnering with the Federal Government as a joint effort. Each Marketplace has a wide variety of insurance options available regardless of who is running it.

What's the Difference Between a Plan on the Marketplace and Other Commercial Plans?

Plans purchased through the official Marketplace at healthcare.gov must offer protections provided under the Affordable Care Act. Other plans available in the individual or small group market including those purchased directly from insurance companies may not always provide the same protections; for instance, official Marketplace plans on the exchange may not charge you more, refuse to cover you if you have a pre-existing condition, or must cover the ten essentials health benefits.

However, the only way you may receive federal assistance such as tax credits or subsidies to get lower costs for your premium based on income is by purchasing your insurance through the Marketplace. Your eligibility for and level of assistance is determined during the enrollment process within the Marketplace.

Will I Be Penalized For Not Buying Health Insurance?

The Affordable Care Act contains a provision for maintaining minimum essential health coverage referred to as an individual mandate. If you did not have qualifying insurance, you were subject to a financial penalty for months you were without coverage. However, the tax penalty is no longer in effect. The individual mandate still applies, so there is still a rule that says you must have coverage, but there will no longer be a penalty enforced for people who do not comply with the mandate.

Can I Keep My Current Doctor?

Most health insurance plans have a network that includes a specific set of hospitals, doctors, specialists, pharmacies, and other health care providers that they contract with to provide services to people enrolled in their plans. If you would like to keep your current doctor, you will need to research the network of any plan you are interested in to ensure that your current doctor is covered.

When comparing plans in the Marketplace, you will have the opportunity to view a list of providers in each plan's network. You may also reach out to the plan's customer service team to make sure your doctor is covered in the network of the plan you are considering.

Can I Get Dental Coverage?

In the Health Insurance Marketplace, you may get dental coverage as part of a health plan or by itself through a separate, stand-alone dental plan. Dental coverage is available two ways:

- Health plans that include dental coverage. In the Marketplace, dental coverage will be included in some of the available health plans. You'll be able to see which plans include dental coverage when you compare them. You'll also see explanation of the specific dental benefits within each plan. If a health plan includes dental coverage, the premium shown for the plan includes both health and dental coverage.

- Separate, stand-alone dental plans. In some cases separate, stand-alone plans will be offered. You may want to choose this option if the health coverage you plan to enroll in doesn't include dental coverage or if you want different dental coverage. If you choose a separate dental plan, you'll pay an additional premium for the dental plan.

Under the Affordable Care Act, dental insurance is treated differently for adults and children 18 and under. Dental coverage for children is an Essential Health Benefit, and thus must be made available in either stand-alone plans or included within plans that cover children.

However, dental coverage is not considered an Essential Health Benefit for adults, and is an optional benefit that adults may select if they desire. Insurance companies do not have to offer adult dental coverage, however you are likely to see plans in your Marketplace that do offer dental plans for adults either included or as stand-alone policies.

What About Vision Coverage?

At this time, any separate vision plans available on the Marketplace would be at the discretion of the insurance company offering coverage. If you are seeking additional coverage related to your eye health (commonly including eye exams, contacts, eyeglasses, etc), we encourage you to look specifically at the Marketplace within your state to find out what is available, or ask your current eye care provider for information on the vision networks in your area. As with dental coverage, the Affordable Care Act treats vision coverage differently for adults and children 18 and under. Vision coverage for children is an Essential Health Benefit, so it must be made available in either stand-alone plans or included within plans that cover children.

What Do I Need to Have to Start an Enrollment Application?

You can research and review available plan details on the Marketplace website beginning on the first day of open enrollment. When ready to begin an enrollment application you should gather the following information in order to accurately answer questions along the way:

- Social Security Numbers (or document numbers for legal immigrants) for all individuals seeking insurance.
- If you are employed, you will need employer contact information and wage information for each household member. You will also need to include information about any additional sources of income you may have, if any.
- Information about any current health insurance you may have.
- Information about your children or other family members who will be covered.

Can I Buy a Short-Term Health Plan in the Marketplace?

Short-term health insurance plans are not sold through the Health Insurance Marketplace but are available on the private market. Short-Term health plans do not cover the minimum essential health benefits and are intended to be temporary gap coverage while waiting for other, more comprehensive coverage to begin. These plans are designed to have very limited benefits and will often exclude coverage to people with pre-existing conditions since these plans are not governed under the ACA.

Am I Buying Government Health Insurance Through the Marketplace?

Every health insurance plan purchased through a Marketplace is provided by a private insurance company - not the government. The premiums will be paid directly to the insurance company that issues the plan. If you are eligible, the Federal Government may provide you with financial assistance to help pay these premiums, in the form of Premium Tax Credits.

If you are deemed eligible for your state's Medicaid insurance or CHIP program, the Marketplace will connect you to that program's office to finish enrollment.

What if I Still Cannot Afford Coverage?

During enrollment the Marketplace will inform you of any financial assistance available to help reduce your medical costs. One example of such financial assistance will be the Premium Tax Credits, available to individuals between 100-400 percent of the Federal Poverty Level. In addition, extra savings known as cost-sharing assistance is available to individuals enrolling in a Silver plan, with annual incomes at or below 250 percent of the Federal Poverty Level.

Your eligibility for financial assistance is determined when you fill out your application during open enrollment and is based on both income and the size of your family. Once you complete your application, you should be informed about the amount you would be able to receive in assistance immediately.

Unlike other tax credits, you do not have to wait until you file your taxes to receive the Premium Tax Credit. The tax credit is provided as an advanced payment at the beginning of your coverage and is sent directly to your insurance plan to help reduce your monthly premium. If your income increases drastically during the year, you may have to pay all or a portion of the credit back. Always alert the Marketplace of changes in your household income or size.

What if I Need Something That is Not Covered?

If your health plan is unable to cover everything you need, you have multiple options. You can pay for the non-covered services out-of-pocket, you can purchase supplemental health insurance through the commercial market to cover any gaps in your health plan's coverage, or you can appeal the decision to not cover a service. Specific appeals instructions will vary by state and information can be found on your state's Marketplace website.

What Options Will I Have?

When you apply for Marketplace coverage you will report your Modified Adjusted Gross Income from your most recent tax return and estimate your income for the upcoming year. Based on household income and size, unemployed or low-income individuals may qualify for any of the following:

- **Medicaid** provides coverage to millions of children, pregnant women, parents of Medicaid-eligible children who meet certain income requirements, and low-income seniors and disabled adults. Each state's Medicaid eligibility requirements are different. Many states have expanded Medicaid through the health care law to cover childless adults with incomes up to 133 percent of the Federal Poverty Level.

- **Children's Health Insurance Program (CHIP)** provides coverage for children, and in some states pregnant women, within families with incomes too high for Medicaid but too low to afford private insurance.

- **Commercial Plans Sold by Private Insurers** If your income is higher than your state eligibility for Medicaid or CHIP, you will be provided a variety of options for individual and family plans, sorted by bronze, silver, gold, or platinum benefit levels.

What if I Am Unemployed?

You can still enroll in a health plan through a Marketplace. In addition, you may also qualify for Medicaid, the Children's Health Insurance Program (CHIP), the Premium Tax Credit and/or lower cost-sharing related to a plan purchased through a Marketplace based on your household income and size. Your eligibility for these programs will be determined during the enrollment process.

What are Catastrophic Plans? Do I Qualify?

Catastrophic plans are Qualified Health Plans sold through the Marketplace that are similar to High Deductible Health Plans. Catastrophic plans do not cover any benefits other than three primary care visits per year before you meet the plan's deductible. The premium amount you pay each month for health care is generally lower than for other plans, but the initial out-of-pocket costs are generally higher.

To qualify for a catastrophic plan, you must be under 30 years old or obtain a 'hardship exemption' because the Marketplace determined that you are unable to afford other health coverage. Only those that meet these eligibility options will be offered catastrophic plans to choose from. If you enroll in a catastrophic plan, you will not be eligible for Premium Tax Credits or cost-sharing assistance regardless of your household income.

What Types of Situations Allow Enrollment Into a Marketplace Plan Outside of the Open Enrollment Periods?

Most people will need to complete the enrollment process during the annual open enrollment period each fall. However, in certain circumstances you may be eligible to enroll at other times throughout the year. Common situations that allow consumers to be eligible for a Special Enrollment Period (SEP) are:

- Immediately following a marriage, birth, or adoption
- When you gain citizenship or qualifying immigration status
- If you lose minimum essential coverage, such as through loss of employer-based coverage or turning 26 and coming off your parents' plan
- If you gain or lose eligibility for Premium Tax Credits or assistance with cost-sharing
- If you move your permanent residence to a new state
- Other exceptional circumstances

A person already enrolled in Marketplace coverage can only use a SEP to change plans within the same metal level as his or her current plan. The only exception is if there are no other plans available within the same metal level — in that case, a person will be allowed to enroll in an adjacent metal level plan.

Note: Outside of the open enrollment period, you cannot enroll in a QHP through a Marketplace unless you meet one of these situations. In order to qualify under any of these scenarios, you will need to provide documentation to show that you meet the above listed exceptions allowed for special enrollment.

Can I Add a Family Member to My Policy After Enrollment?

Once a Special Enrollment Period is triggered, generally all family members are eligible to enroll in coverage or to change plans. You can add a new dependent to your current plan or enroll the dependent in a separate plan up to 60 days AFTER birth, adoption, foster care placement, or child support court order. If you'd like to enroll an existing dependent in a Marketplace plan outside of a SEP, you can do so through the 45 day annual open enrollment period.

What if I Have a Pre-Existing Medical Condition?

As a result of health care reform, comprehensive health insurance plans now cannot refuse to cover you or charge you more just because you have a pre-existing health condition when purchasing in a Marketplace. Additionally, a plan cannot impose any waiting periods before they cover treatment for a pre-existing condition. This is true even if you have been turned down or refused coverage due to a pre-existing condition in the past.

What if I Need Help with the Application Process?

Recognizing that selecting a health insurance plan can be overwhelming, the ACA created the 'navigator program,' to help you search for the health plan that is best for you. These Navigators will inform you of coverage options (but not select one for you), help facilitate enrollment in a plan and help you understand your rights and responsibilities. If you are in need of assistance from a Navigator, you can locate one by going to **www.healthcare.gov**. *In addition, if you need assistance with the application process, Marketplaces have 'certified application counselors' that can provide you with direct assistance online, by phone, or in person with completing the application process. Navigators and Certified Application Counselors are not associated with any insurance company or plan and cannot receive payment for recommending one plan over another.*

Q&A Special Situations

What are my options as a non-citizen lawful US resident?

You are eligible to participate in the Marketplace, as well as receive Premium Tax Credit assistance.

Is there an age limit for those who can purchase insurance in the Marketplaces?

No. Insurance products will be available on Marketplaces for people of all ages.

However, if you are over 65 and already enrolled into a Medicare plan or are Medicare-eligible, there is no need for you to utilize the Marketplace for your insurance needs. Rather, you can apply and enroll in Medicare at www.medicare.gov. Marketplaces are useful for seniors who are NOT Medicare eligible and are seeking insurance coverage (for example, older adults that have not worked for at least 10 years in Medicare-covered employment are not Medicare-eligible). For minors, income documentation from parents will be used to determined eligibility for reduced costs in the Marketplace or Medicaid.

What if I currently have COBRA insurance?

If you currently have or are eligible for COBRA continuation health coverage, you can choose to enroll in a Marketplace plan if you prefer under these circumstances:

- During the annual open enrollment period; or
- If your employer discontinues their group health plans, affecting your COBRA and making you eligible for a Special Enrollment Period
- If COBRA coverage expires, making you eligible for a Special Enrollment Period

Note: You are **not** eligible for a SEP if **you** decide to end COBRA coverage early or if coverage is terminated due to a failure to pay premiums.

Can those living in US territories access a Marketplace?

Marketplaces are only available to residents of the fifty states and the District of Columbia. If you live in any of the U.S. territories, including the Virgin Islands, Guam, Puerto Rico, American Samoa, or the Northern Mariana Islands, you are not eligible to use the Marketplace to apply for health insurance. Check with your territory's government offices to learn more about health coverage options available to you.

I am self-employed. Can I enroll through a Marketplace?

Yes, if you are self-employed and have no employees, you may buy insurance through the Marketplace.

I'm currently enrolled in a plan from my employer, but it is not meeting the needs of my family (or budget). Can I enroll in a plan from the Marketplace and forgo my employer's plan?

Yes, you may purchase health insurance through a Marketplace instead of through your employer. However, you will no longer receive employer contributions toward your health insurance premiums and you will not be eligible for the Premium Tax Credit nor for assistance with your cost-sharing obligations if the health insurance offered through your employer is deemed 'affordable' (less than 9.86 percent of your annual household income) and provides minimum value.

Q&A Special Situations

I was unable to enroll in a Marketplace plan due to a technical issue.

There is a chance you may qualify for a SEP if you were not enrolled in a plan or were enrolled in the wrong plan because of an error or delay occurred that was beyond your control, including situations where:

- Misinformation, misrepresentation, misconduct, or inaction of someone working in an official capacity to help you enroll (like an insurance company, navigator, certified application counselor, agent, or broker)
- Wrong plan data (like benefit or cost-sharing information) displayed on www.HealthCare.gov at the time that you chose your health plan (with proof)
- You can prove your Marketplace plan violated a material provision of its contract
- If you or a family member applied for Medicaid or Children's Health Insurance Program (CHIP) coverage during the Marketplace Open Enrollment Period, or after a qualifying event, and your state Medicaid or CHIP agency determined you (or a member in your household) weren't eligible
- You can show you had an exceptional circumstance that kept you from enrolling in coverage for an extended length of time during enrollment, like being incapacitated or a victim of a natural disaster

What if I am Denied a Special Enrollment Period but I Think I Qualify?

If you are denied an SEP, you may be eligible to file an appeal to have your situation reviewed. Go to healthcare.gov to determine if you can file an appeal and instructions on how to do so.

What resources are available for Spanish-speakers?

Non-English Speaking people who have questions about the Marketplace can visit healthcare.gov to find resources in their language. Or, representatives are available to answer questions in Spanish and other languages through the federal marketplace toll-free hotline at (800) 318-2596.

Open Enrollment from

November 1 to December 15

www.healthcare.gov

State Health Insurance Marketplace Websites

The list below identifies each state's website that should serve as your starting point when seeking individual plans.

State	Website	State	Website
Alabama	www.HealthCare.gov	Missouri	www.HealthCare.gov
Alaska	www.HealthCare.gov	Montana	www.HealthCare.gov
Arizona	www.HealthCare.gov	Nebraska	www.HealthCare.gov
Arkansas	www.HealthCare.gov	Nevada	www.HealthCare.gov
California	www.coveredca.com	New Hampshire	www.HealthCare.gov
Colorado	www.connectforhealthco.com	New Jersey	www.HealthCare.gov
Connecticut	www.accesshealthct.com	New Mexico	www.HealthCare.gov
Delaware	www.HealthCare.gov	New York	www.nystateofhealth.ny.gov
District of Columbia	www.DChealthlink.com	North Carolina	www.HealthCare.gov
Florida	www.HealthCare.gov	North Dakota	www.HealthCare.gov
Georgia	www.HealthCare.gov	Ohio	www.HealthCare.gov
Hawaii	www.HealthCare.gov	Oklahoma	www.HealthCare.gov
Idaho	www.yourhealthidaho.org	Oregon	www.HealthCare.gov
Illinois	www.HealthCare.gov	Pennsylvania	www.HealthCare.gov
Indiana	www.HealthCare.gov	Rhode Island	www.healthsourceri.com
Iowa	www.HealthCare.gov	South Carolina	www.HealthCare.gov
Kansas	www.HealthCare.gov	South Dakota	www.HealthCare.gov
Kentucky	www.HealthCare.gov	Tennessee	www.HealthCare.gov
Louisiana	www.HealthCare.gov	Texas	www.HealthCare.gov
Maine	www.HealthCare.gov	Utah	www.HealthCare.gov
Maryland	www.marylandhealthconnection.gov	Vermont	portal.healthconnect.vermont.gov
Massachusetts	www.mahealthconnector.org	Virginia	www.HealthCare.gov
Michigan	www.HealthCare.gov	Washington	www.wahealthplanfinder.org
Minnesota	www.mnsure.org	West Virginia	www.HealthCare.gov
Mississippi	www.HealthCare.gov	Wisconsin	www.HealthCare.gov
		Wyoming	www.HealthCare.gov