



The Health Insurance Marketplace 101 provides a high-level overview of the Affordable Care Act, and the new Health Insurance Marketplace.

The Centers for Medicare & Medicaid Services (CMS) developed and approved this training module. CMS is the Federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Federally Facilitated Health Insurance Marketplace. Information in this module was correct as of March 2014.

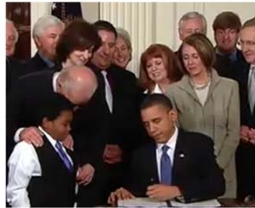
To check for an updated version of this training module, visit marketplace.cms.gov/training/get-training.html

To check for updates on the health care law, visit hhs.gov/healthcare.

This set of CMS National Training Program materials isn't a legal document. Official program provisions are contained in the relevant statutes, regulations, and rulings.

The Health Care Law

- In March 2010, President Obama signed the Affordable Care Act into law generally requiring



- Young adults up to age 26 to stay on their parents' plan
- Additional drug coverage for people with Medicare
- More preventive services with no cost-sharing
- Lifetime limits removed from essential health benefits

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That's why Congress passed and the President signed the Affordable Care Act in March 2010. So young adults can stay on their parents' plan, if it offers dependent coverage of children, until age 26. Also, the 50 million Americans with Medicare have access to new benefits like preventive care with no cost sharing and savings on prescription drugs when they hit the coverage gap known as the donut hole.

About 71 million people with private insurance can also get recommended preventive care without paying any copay or deductible. The law also prohibited lifetime limits on essential health benefits. The Affordable Care Act provides for additional improvements on health care coverage that starts on or after January 1, 2014.

What Changed on January 1, 2014?

- Discrimination due to pre-existing conditions or gender is generally prohibited
- Annual limits on insurance coverage of essential health benefits were eliminated for most plans
- Advance payments of the premium tax credit are available
- The small business health care tax credit increases
- More people are eligible for Medicaid (in some states)
- **Coverage through the Health Insurance Marketplace began**

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Some of the improvements brought about by the Affordable Care Act that were effective as early as January 1, 2014 include the following.

- Discrimination due to pre-existing conditions or gender is generally prohibited
- Annual Limits on Insurance Coverage of essential health benefits are eliminated for most plans
- Advance Payments of the Premium Tax Credit available
- The Small Business Health Care Tax Credit increased
- More people are eligible for Medicaid
- Consumers started to shop for qualified health plans on October 1, 2013. Their coverage could have begun as early as January 1, 2014

What Is the Health Insurance Marketplace?

- Part of the Affordable Care Act
- Where qualified individuals and families directly compare private health insurance options
 - Known as qualified health plans (QHPs)
 - Can directly compare on the basis of price, benefits, quality, and other factors
- Also known as Exchanges
- Small Business Health Options Program (SHOP)
 - Marketplace for small employers
 - Provides coverage for their employees

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The Health Insurance Marketplace is designed to help you find and buy health insurance that fits your budget.

Health insurance plans in the Marketplace offers comprehensive coverage, from doctors to medications to hospital visits, or provide only dental benefits. Marketplace plans are called qualified health plans (QHPs). You can compare all your insurance options based on price, benefits, quality, and other features that may be important to you, in plain language that makes sense.

The Marketplace is sometimes referred to as Exchanges.

You'll know you're getting a quality health plan at a reasonable price, because the coverage and benefits information, and premium rates are readily available.

There is a Marketplace for small employers too. It is called the Small Business Health Options Program, or SHOP. We will briefly talk about SHOP later. This session focuses on the Individual Marketplace.

The Marketplace...

- It's a way to shop for health coverage
 - An individual or family can explore every qualified health plan in the area
 - With one application you can learn all the programs for which you qualify
- Most people receive help paying premiums
 - 90% of people who were uninsured will qualify for savings on health insurance
- It offers clear options with apples-to-apples comparisons
 - All health insurance plans in the Marketplace present their price and benefit information in plain language

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About 90% of the people who didn't have health insurance will qualify to get a break on their costs. This includes coverage by Medicaid, the Children's Health Insurance Program (CHIP), and cost savings in the Marketplace. Thanks to new rules and expanded programs, even working families are able to get help through the Health Insurance Marketplace. More people than ever before qualify for free or low-cost health insurance programs.

Even if you think your income is too high to get help you should apply. One application lets you see all the programs for which you qualify.

Marketplace Establishment

- Each state can decide to
 - Create and run its own Marketplace
 - Engage actively with the federal government in operating certain Marketplace functions
 - Have a Marketplace established and operated by the federal government

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A state has substantial flexibility in establishing a Marketplace that meets the needs of its citizens. States across the country received grants to establish Marketplaces. Some states are operating their own Marketplaces. A state may apply at any time to run its own Marketplace.

A state may also decide (elect) to have the federal government operate its Marketplace. The Federal Government is operating a Marketplace in those states that didn't establish their own. In states where the Federal Government is operating a Marketplace, the state can opt to partner with the Federal Government. A Partnership Marketplace allows states to make recommendations for key decisions and help tailor a Marketplace to local needs and market conditions. States may also establish and operate only a Small Business Health Options Program (SHOP), while the federal government establishes the individual Marketplace in that state.

U.S. territories can decide whether to create their own Marketplace or expand Medicaid coverage. Residents of a U.S. territory aren't eligible to apply for health insurance using the Federal or state Marketplace; you must be a resident of the state in which a Marketplace is operating to be eligible to enroll in coverage through the Marketplace. Check with your territory's government offices to learn about these options.

Qualified Health Plans Cover Essential Health Benefits

- Essential health benefits include at least these 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
 - Pediatric services, including oral and vision care (pediatric oral services may be provided by stand-alone plan)



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The Affordable Care Act provides for the establishment of an Essential Health Benefit (EHB) package that generally includes coverage of EHBs (as defined by the Secretary of the Department of Health and Human Services (the Secretary)). The law directs that EHBs be equal in scope to the benefits covered by a typical employer plan and cover at least the following 10 general categories:

1. Ambulatory patient services (outpatient care you get without being admitted to a hospital)
2. Emergency services
3. Hospitalization (such as surgery)
4. Maternity and newborn care (care before and after your baby is born)
5. Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
6. Prescription drugs
7. Rehabilitative and habilitative services and devices (health care services that help you keep, learn, or improve skills and functioning for daily living.)
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care (pediatric oral services may be provided by stand-alone plan).

NOTE: The Marketplace only offers QHPs, including stand-alone dental QHPs that cover pediatric dental essential health benefits. Each state has a benchmark plan that is the basis for what services a QHP must cover as essential health benefits. If a state's base-benchmark plan lacks pediatric dental or vision coverage it must be supplemented with the FEDVIP pediatric vision/dental plan; or the state's separate CHIP plan benefit if one exists. Pediatric services must be covered for individuals under age 19, but states have the flexibility extend pediatric coverage beyond age 19.

How Qualified Health Plans Can Vary

- Some plans may cover additional benefits
- You may have to see certain providers or use certain hospitals (networks)
- The premiums, copays, and coinsurance are different
- Quality of care data will be available
- The coverage level can vary within each plan
- Some special types of plans are structured differently
 - Like high-deductible (catastrophic) plans

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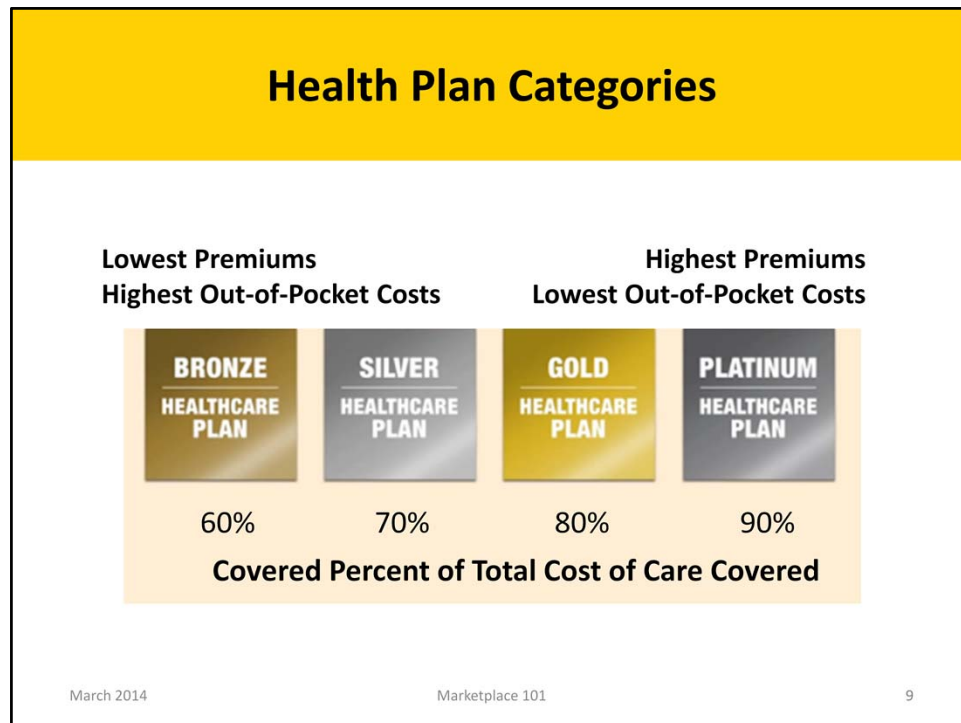
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Qualified health plans in the Marketplace can vary, for instance:

- Some plans may cover additional benefits
- You may have to see certain providers or use certain hospitals
- The premiums, copays, and coinsurance are different in different plans
- The quality of care can vary, but quality data will be made available to facilitate the consumer shopping experience
- The coverage level can vary within each plan (see next slide)
- Some plans are structured differently, like high-deductible (catastrophic) plans

Remember, all plans must cover the essential health benefits, except for pediatric dental coverage, which is not required if available from a stand-alone plan. The Marketplace lets you compare, choose and enroll.

Out-of-pocket costs include deductibles, which is the amount you pay for your covered health care services before your plan starts to pay. You also pay copayments. For instance, you may have to pay \$20 each time you see your doctor. You may also have to pay coinsurance for certain services. For instance, if the coinsurance is 30% and the covered service costs \$100, you would pay \$30 and the plan would pay \$70.



Plans in the Marketplace are primarily separated into 4 health plan categories — Bronze, Silver, Gold, and Platinum — based on the percentage the plan pays of the average overall cost of providing essential health benefits to members. The plan category you choose affects the total amount you'll likely spend for essential health benefits (EHBs) during the year.

The plan categories are each associated with an actuarial value, or AV, which, in the aggregate for a standard population, can be considered a general summary measure of health plan generosity. AV represents the percentage of the total allowed costs of benefits paid by the plan, based on the provision of EHBs. For example, if a plan has an AV of 70%, on average, you would be responsible for 30% of the costs of all covered benefits.

The health plan categories are as follows:

- Bronze level - a health plan that has an AV of 60%.
- Silver level - a health plan that has an AV of 70%.
- Gold level - a health plan that has an AV of 80%.
- Platinum level - a health plan that has an AV of 90%.

However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy. While premiums are not taken into account to calculate the AV, generally plans with a higher AV and more generous cost sharing tend to have higher premiums.

Catastrophic Health Plans

- What is catastrophic coverage?
 - Plans with high deductibles and lower premiums
 - You pay all medical costs up to a certain amount
 - Includes 3 primary care visits per year and preventive services with no out-of-pocket costs
 - Protects you from high out-of-pocket costs
- Who is eligible?
 - Young adults under 30
 - Those who qualify for a hardship exemption
 - Those whose plan was cancelled and believe Marketplace plans are unaffordable



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A catastrophic plan generally requires you pay all of your medical costs up to a certain amount, usually several thousand dollars. Costs for essential health benefits over that amount are generally paid by the insurance company. Catastrophic plans generally have lower premiums, protect against high out-of-pocket costs, and cover 3 annual primary care visits and preventive services at no cost. They're available only to people under 30 and to people who have received a "hardship" exemption because the Marketplace determined they couldn't afford health coverage. Each member of a family must meet the eligibility requirements to purchase a catastrophic plan.

NOTE: People who enroll in catastrophic health plans aren't eligible for premium tax credits to lower their monthly premiums.

Small Business Health Options Program (SHOP) Marketplace

- A streamlined way for small employers to offer health insurance
- A Marketplace for small employers
- Offers access to qualified health plans
- Works with new insurance reforms and tax credits to lower barriers to offering health insurance
- SHOP Marketplace Help Desk for **employers**
 - 1-800-706-7893 (TTY 1-800-706-7915)

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Small employers have access to a new way to offer health insurance to their employees for 2014 and future years. It's called the Small Business Health Options Program, or the SHOP Marketplace. It's open to employers with 50 or fewer employees in 2014. In 2016, the program will be open to businesses with 100 or fewer employees in all states, and a few states could choose to expand eligibility to such businesses before then. The SHOP Marketplace is part of the Health Insurance Marketplace. It gives small businesses and their employees access to qualified health plans that must include a package of essential health benefits, like coverage for doctor visits, preventive care, hospitalization and prescriptions.

Small employers—including non-profit and religious organizations—can participate in the SHOP Marketplace. Small employers will also be able to enroll and offer coverage to their employees any time. There is no requirement under the new Health Care Law for small employers with fewer than 50 employees to offer health insurance, nor is there any fee for those small employers who do not offer employee health insurance. Instead, the law offers small employers a range of new options, tools and protections, and for many, tax credits, to help those would like to or already offer employee health coverage.

Call us right now to get your SHOP and small business questions answered by a customer service representative at 1-800-706-7893 or (TTY: 1-800-706-7915). The call center is open Monday through Friday, 9 a.m. to 7 p.m. EST. Employees should call 1-800-318-2596 or (TTY: 1-855-889-4325) available 24/7 except on certain holidays. More information about the SHOP Marketplace is available at <http://marketplace.cms.gov/training/get-training.html> under *Overview of the SHOP Marketplace*.

Eligibility in the Individual Marketplace

- Marketplace eligibility requires you to
 - Live in its state or service area, and
 - Be a U.S. citizen or national, or
 - Be a non-citizen who is lawfully present in the U.S. for the entire period for which enrollment is sought
 - Not be incarcerated
 - Can apply for Marketplace coverage if pending disposition of charge
 - Can apply for Medicaid/CHIP at any time

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To be eligible to enroll in a Marketplace, you must live in its service area. You must also be a U.S. citizen or national, or be a non-citizen who is lawfully present in the U.S. for the entire period for which enrollment is sought. (For more information visit <https://www.healthcare.gov/immigration-status-and-the-marketplace/>.)

You also cannot be incarcerated*, unless you are pending disposition of charges. However, like others, those who are incarcerated can apply for Medicaid or CHIP at any time.

*Not be incarcerated, other than incarceration pending the disposition of charges. It's important to note that if someone is incarcerated, they can still apply for Medicaid or the Children's Health Insurance Program (CHIP) at any time. For purposes of the Marketplace, "incarcerated" means serving a term in prison or jail. Incarceration doesn't mean living at home or in a residential facility under supervision of the criminal justice system, or living there voluntarily. In other words, incarceration doesn't include being on probation, parole, or home confinement. You're not considered incarcerated if you're in jail or prison pending disposition of charges—in other words, being held but not convicted of a crime.

Lower Premium Costs

- The premium tax credit may be taken as advance payments to lower monthly premium costs, or as a refundable credit on the tax return you file
- Eligibility is based on
 - Household income and family size
 - Household income between 100% to 400% FPL
 - \$23,550 – \$94,200 for a family of 4 in 2013
 - Obtaining health insurance through the Marketplace
 - Ineligibility for government-sponsored coverage, affordable employer-sponsored insurance, or certain other minimum essential coverage

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When you use the Marketplace you may be eligible to receive advance premium tax credits that may be used to lower your monthly premiums, and cost-sharing reductions that lower your out-of-pocket costs. The premium tax credit is generally available to individuals and families with household incomes between 100% and 400% of the Federal poverty level (\$23,550 – \$94,200 for a family of four in 2013, \$23,850 – \$95,400 for a family of four in 2014 which will be used to determine eligibility for 2015 Marketplace coverage (higher in Alaska and Hawaii)) who don't have access to certain other types of minimum essential coverage, which makes coverage much more affordable for the middle class.

Remember, minimum essential coverage includes government-sponsored coverage (like Medicare, Medicaid, CHIP, some VA coverage, and TRICARE), affordable employer-sponsored insurance (meaning the cost for the employed individual is no more than 9.5% of their income), and certain other coverage.

A tax filer on whose behalf advance payments are made is required to file a tax return for the coverage year to reconcile any advance payment of the premium tax credit with the premium tax credit allowed on the return. Thus, if the premium tax credit allowed on the return is more than the amount of the advance payment of the premium tax credit, the individual may receive the excess amount as a tax credit. On the other hand, if the amount of the premium tax credit on the tax return, determined based on annual household income and family size, is less than the amount of the advance payment of the premium tax credit, the individual will be responsible for repayment of the excess amount via the tax return, subject to a statutory cap.

The Marketplaces will provide documentation to the tax filer and to the IRS that will support the reconciliation process, in the same way that an employer or bank provides a Form W-2 or Form 1099. The advance payments of the premium tax credit available through the Marketplace lets you reduce your monthly premiums when premiums are due. There are special rules that apply in case of divorce. If you get married, the savings amount is prorated by month. The Congressional Budget Office estimates that when the Affordable Care Act is fully phased in, the PTC will help 20 million Americans afford health insurance.

Ways to Use a Premium Tax Credit

Choose to Get It Now:

Advance Payments of the Premium Tax Credit

- All or some of the premium tax credit is paid directly to your plan on a monthly basis
- You pay the difference between the monthly premium and advance payment
- You reconcile when you file your tax return for the coverage year*

Choose to Get It Later

- Don't request any advance payments
- You pay the entire monthly plan premium
- Claim the full amount on the tax return you file for the coverage year

*You should report all changes in the information you provided on your application to avoid owing money after reconciliation on your tax return.

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If you enroll through an Individual Marketplace you may be eligible to receive premium tax credits which can be used to reduce the cost of monthly premiums for yourself and for any tax dependents. You can choose to receive a portion of the credit each month as an advance payment of the premium tax credit – with reconciliation at the end of the year – or to receive the tax credit on your federal tax return filed for the coverage year. Advance payments are paid directly to QHP issuers on a monthly basis.

Individuals eligible for a premium tax credit who do not receive an advance payment of the premium tax credit may claim the credit on their income tax return filed for the coverage year. Individuals who are married at the end of the coverage year are required to file a joint return to receive a premium tax credit.

A tax filer on whose behalf advance payments are made is required to file a tax return for the coverage year to reconcile any advance payments of the premium tax credit with the premium tax credit allowed on the return. Thus, if the premium tax credit allowed on the return is more than the amount of the advance payment of the premium tax credit, the individual may receive the excess amount as a tax credit. On the other hand, if the amount of the premium tax credit determined based on annual household income and family size on the tax return is less than the amount of the advance payment of the premium tax credit, the individual will be responsible for repayment of the excess amount via the tax return, subject to statutory caps.

The Marketplace will provide documentation to the tax filer and to the IRS that will support the reconciliation process, in the same way that an employer or bank provides a Form W-2 or Form 1099. You should report all changes to the information in your application (such as marriage, divorce, birth, eligibility for affordable employer coverage, and increases and decreases in household income) as soon as possible to avoid owing money after reconciliation on your tax return.

Who is Eligible for Cost-Sharing Reductions?

- Lower costs on deductibles, copayments, and coinsurance
- To be eligible, you must
 - Have income at or below 250% FPL
 - \$58,875 annually for a family of 4 in 2013
 - \$59,625 annually for a family of 4 in 2014
 - Receive the premium tax credit
 - Enroll in a Marketplace Silver-level plan
- Members of federally recognized Indian tribes
 - Don't have to pay cost-sharing if household income is at or below 300% of the Federal poverty level (FPL)
 - Up to around \$70,650 for a family of 4 (\$88,320 in Alaska) in 2013
 - Up to around \$71,550 for a family of 4 (\$89,460 in Alaska) in 2014

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Cost-sharing reductions are available to help reduce your out-of-pocket expenses, including deductibles, copayments, and coinsurance.

To be eligible for a cost-sharing reduction, you must have a household income that is less than or equal to 250% of the Federal poverty level (FPL) which is \$58,875 annually for a family of four in 2013 (\$59,625 annually for a family of 4 in 2014); meet the requirements to enroll in a qualified health plan through the Marketplace; receive the premium tax credit; and enroll in a Silver-level plan through the Marketplace.

There are 3 levels of cost-sharing reductions:

- If your income is between 100% and 150% FPL (\$23,850-\$35,775* for a family of 4 in 2013), the actuarial value (AV) of your Silver-level plan is approximately 94% (you pay 6% for covered services).
- If your income is between 150% and 200% FPL (\$35,775-\$47,700* for a family of 4 in 2013), the AV of your Silver-level plan is approximately 87% (you pay 13% for covered services).
- If your income is between 200% and 250% FPL (\$47,700-\$59,655* for a family of 4 in 2013), the AV of your Silver-level plan is approximately 73% (you pay 27% for covered services).

Members of federally recognized tribes, shareholders of Alaska Native regional and village corporations, California Indians, and persons of Indian descent who are eligible for services from the Indian Health Service, tribal programs, or urban Indian health programs, who purchase health insurance through the Marketplace (regardless of plan category like Bronze or Silver) are exempt from premiums and cost-sharing if their income is under 300% FPL, which is roughly \$70,650 for a family of four in 2013 (\$88,320 in Alaska), or \$71,550 for a family of 4 in 2014 (\$89,460 in Alaska and \$82,290 in Hawaii).

*Higher in Hawaii and Alaska.

Medicaid Eligibility in 2014

- The health care law offers a new opportunity for states to expand Medicaid to
 - Adults ages 19 – 64 with incomes up to 133% FPL
 - \$15,282 per year for individual (\$15,521 in 2014)
 - \$31,322 per year for family of 4 (\$31,720 in 2014)
- The law ensures Medicaid coverage for children in families with household incomes up to 133% FPL
- A new simplified way of calculating income to determine Medicaid/CHIP eligibility
 - Known as Modified Adjusted Gross Income (MAGI)-based method

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The health care law provides states with additional federal funding to expand their Medicaid programs to cover adults under 65 who make up to 133% of the Federal poverty level (FPL). (Because of the way this is calculated, it is effectively 138% FPL.) Children (18 and under) are eligible up to that income level or higher in all states. If your state is expanding Medicaid, you'll probably qualify if you make up to about \$15,800 a year for 1 person (\$32,500 for a family of 4). (In 2014 up to \$16,521 for an individual and \$32,220 for a family of 4 plus a 5% income disregard).

Children in families with household incomes up to 133% of the FPL (plus a 5% income disregard) are eligible for Medicaid. Those states that previously covered these children through the CHIP program continue to receive the enhanced CHIP matching rate.

When you apply through the Marketplace, the information you provide is “data matched” against the information the IRS and SSA have in their systems.

In states that don't implement Medicaid expansion, people between the state's Medicaid ceiling (it varies by state) and 100% of the FPL are not eligible for Medicaid or the new premium tax credit. However, these individuals are not subject to a fee if they do not obtain coverage through the Marketplace. Otherwise eligible applicants with income above 100% of the FPL can receive a premium tax credit to help lower the cost of monthly premiums.

In addition, the rules for counting income for purposes of determining Medicaid and CHIP eligibility are much simpler and easier for families to understand.

Starting in 2014, Everyone Must:		
<p>1. Have minimum essential coverage</p>  <p>They're already covered and don't need to do anything.</p> <p><small>March 2014</small></p>	<p>OR</p> <p>2. Have an exemption from the shared responsibility payment (fee)</p> <div style="border: 1px solid black; padding: 5px; text-align: center; width: fit-content; margin: 10px auto;">EXEMPT</div> <p>They don't have to get coverage and won't have to pay a fee for not having coverage.</p> <p><small>Marketplace 101</small></p>	<p>OR</p> <p>3. Pay a fee (shared responsibility payment)</p>  <p>They should consider getting coverage. If they don't, they'll pay a fee.</p> <p><small>17</small></p>

The health care law requires all people who can afford it to take responsibility for their own health insurance by getting coverage or paying a fee (shared responsibility payment).

Starting in 2014, everyone must have minimum essential coverage, have an exemption from the shared responsibility payment (fee), or pay a fee.

If you have minimum essential coverage, you don't have to do anything. You're already covered. If you qualify for an exemption, you won't have to pay the fee even if you don't have coverage. But, if you don't have coverage, and don't qualify for an exemption, you have to pay a fee. Let's look at what all this means.

1. What is Minimum Essential Coverage?

- If you have coverage from any of the following, you're covered and **don't have to do anything**
 - Employer-sponsored coverage, including COBRA and retiree
 - Individual coverage (outside the Marketplace)
 - Marketplace coverage
 - Medicare (Part A) and Medicare Advantage plans
 - Most Medicaid coverage
 - Children's Health Insurance Program (CHIP)
 - Certain Veterans health coverage (from the VA)

About 85% of Americans already have minimum essential coverage.

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Minimum essential coverage is coverage that meets a standard that provides essential health benefits. The following provides minimum essential coverage. If you have it you don't have to do anything. About 85% of Americans have minimum essential coverage.

- Employer-sponsored coverage, including self-insured plans, COBRA coverage and retiree coverage
- Coverage purchased in the individual market, including a qualified health plan offered by the Health Insurance Marketplace
- Medicare (Part A) coverage and Medicare Advantage Plans
- Most Medicaid coverage
- Children's Health Insurance Program (CHIP) coverage
- Certain types of Veterans health coverage administered by the Veterans Administration

What is Minimum Essential Coverage? Continued

- If you have coverage from any of the following, you're covered and **don't have to do anything**
 - Most types of TRICARE coverage
 - Coverage provided to Peace Corp volunteers
 - Coverage under the Nonappropriated Fund Health Benefit Program
 - Refugee Medical Assistance (ACF)
 - Self-funded health coverage offered to students by universities
 - State high risk pools
 - Other coverage recognized by the Secretary of HHS

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Minimum essential coverage is coverage that meets a standard that provides essential health benefits. The following provides minimum essential coverage. If you have it you don't have to do anything. About 85% of Americans have minimum essential coverage.

- Most types of TRICARE coverage under chapter 55 of title 10 of the United States Code
- Coverage provided to Peace Corps volunteers
- Coverage under the Nonappropriated Fund Health Benefit Program
- Refugee Medical Assistance supported by the Administration for Children and Families
- Self-funded health coverage offered to students by universities for plan or policy years that begin on or before December 31, 2014 (for later plan or policy years, sponsors of these programs may apply to HHS to be recognized as minimum essential coverage); and
- State high risk pools for plan or policy years that begin on or before December 31, 2014 (for later plan or policy years, sponsors of these program may apply to HHS to be recognized as minimum essential coverage)
- Other coverage recognized by the Secretary of HHS as minimum essential coverage

Minimum essential coverage does not include coverage providing only limited benefits, such as coverage only for vision care or dental care; and Medicaid covering only certain benefits such as family planning; workers' compensation; or disability policies.

NOTE: For 2014 only – Medicaid covering only family planning, pregnancy-related Medicaid, Tuberculosis-related services Medicaid, emergency medical conditions Medicaid, certain Section 1115 demonstration projects, coverage for medically needy individuals, space available care, or under TRICARE receiving line-of-duty care, or space available care will not be subject to the fee

2. Who is Eligible for an Exemption?

- You may get a coverage exemption if you
 - Are conscientiously opposed (religious conscience)
 - Are a member of a recognized health care sharing ministry
 - Are a member of a federally recognized Indian tribe
 - Don't make the minimum income required to file taxes
 - Have a short coverage gap (less than 3 consecutive months)
 - Suffered a hardship
 - Didn't have access to affordable coverage (cost of available coverage greater than 8% of household income)
 - Were incarcerated (unless pending disposition of charges)
 - Weren't lawfully present
 - Your health plan was cancelled and there is no affordable option in the Marketplace

EXEMPT

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If you don't have minimum essential coverage, you may have to pay a fee. We will discuss that next. You may be exempted from the fee for one of these reasons: religious conscience; membership in a recognized health care sharing ministry; membership in a Federally recognized Indian tribe; you have no tax filing requirement (household income below minimum threshold); if you have a short coverage gap* (<3 consecutive months); you suffered a hardship (a circumstance that affects your ability to purchase health insurance coverage, like being homeless, or recently experiencing domestic violence); you have unaffordable coverage options (minimum amount you must pay for premiums is more than 8% of your household income), you are incarcerated; or if you are not lawfully present (neither a U.S. citizen, a U.S. national, nor an alien lawfully present in the U.S.), or your health plan was cancelled and there is no affordable coverage option in the Marketplace.

To apply for an exemption based on coverage being unaffordable; membership in a health care sharing ministry; an Indian, as defined by section 4(d) of the Indian Self-Determination and Education Assistance Act, with membership in a Federally-recognized tribe, including shareholders of Alaska Native regional or village corporations; or being incarcerated, you have two options - you can claim these exemptions when you fill out your 2014 Federal tax return, which is due in April 2015, or you can apply for the exemptions in the Marketplace.

To apply for an exemption based on membership in a recognized religious sect whose members object to insurance; are a member of a federally recognized Indian tribe or you're eligible for services through an Indian health care provider; or one of the hardships described above, you fill out an exemption application in the Marketplace.

If your income is low enough that you are not required to file taxes, you don't need to apply for an exemption. This is true even if you file a return in order to get a refund of money withheld from your paycheck. You won't have to make the shared responsibility payment. For more information visit <http://www.irs.gov/pub/irs-pdf/p501.pdf>.

If you have a gap in coverage of less than 3 months, or you are not lawfully present in the U.S., you don't need to apply for an exemption. This will be handled when you file your taxes.

* If you have two short gaps in coverage during a year, this exemption only applies to the first gap.

3. You May Pay a fee (Shared Responsibility Payment)

- You may pay a fee when you file your 2014 Federal tax return in 2015 (and thereafter)
 - If you don't have minimum essential coverage, and
 - You don't qualify for an exemption
- Paying the fee doesn't provide health coverage



Less than 2% of Americans are expected to have to pay the fee.

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When an uninsured person requires urgent—often expensive—medical care but doesn't pay the bill, everyone else ends up paying the price. That's why the Health Care Law requires all people who can afford it to take responsibility for their own health insurance by getting coverage or paying a fee (shared responsibility payment). People who choose not to obtain health coverage will also have to pay the entire cost of all their medical care. They won't be protected from the kind of very high medical bills that can sometimes lead to bankruptcy.

The fee in 2014 is \$95 per adult and \$47.50 per child (up to \$285 for a family), or 1% of yearly income, whichever is greater. The fee cannot be more than the national average price for a Bronze-level plan in the Marketplace. Amounts go up after 2014. But it's important to remember that someone who pays the fee won't get any health insurance coverage.

After open enrollment ends on March 31, 2014, people won't be able to get health coverage through the Individual Marketplace until the next Annual Enrollment Period unless they have a qualifying life event that provides for a Special Enrollment Period. You can apply for Medicaid or CHIP at any time.

According to the Congressional Budget Office, less than two percent of Americans are expected to choose to go without coverage and will owe a shared responsibility payment.

If you sign up for Marketplace coverage by March 31, 2014, you will not have to pay a fee for a gap in coverage for 2014. For more information visit <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/enrollment-period-faq-10-28-2013.pdf>.

How much is the fee?

In 2014, you pay the <i>greater</i> amount of	1% of your annual household income	or	\$95 per adult, and \$47.50 per child under 18
In 2015, you pay the <i>greater</i> amount of	2% of your annual household income	or	\$325 per adult, and \$162.50 per child under 18
In 2016*, you pay the <i>greater</i> amount of	2.5% of your annual household income	or	\$695 per adult, and \$347.50 per child under 18

*After 2016 - Plus an increase based on cost of living.

Penalty for noncompliance can't exceed the national average premium for a bronze level Marketplace QHP (for the relevant family size).

The total family penalty is capped at 300% of the annual flat dollar amount.

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The penalty in 2014 is calculated one of 2 ways. You'll pay whichever of these amounts is higher:

- **1% of your yearly household income.** The maximum penalty is the national average yearly premium for a bronze plan.
- **\$95 per person for the year (\$47.50 per child under 18).** The maximum penalty per family using this method is \$285.

The fee in 2014 is \$95 per adult and \$47.50 per child (up to \$285 for a family), or 1.0% of yearly income, whichever is greater. The fee cannot be more than the national average price for a Bronze level plan in the Marketplace for the relevant family size. The total family penalty is capped at 300% of the annual flat dollar amount. Amounts go up after 2014. But it's important to remember that someone who pays the fee won't get any health insurance coverage.

You pay the fee when you file your 2014 Federal income tax return in 2015, and thereafter. The IRS routinely works with taxpayers who owe amounts they cannot afford to pay. The law prohibits the IRS from using liens or levies to collect any payment you owe related to the individual responsibility requirement (also known as the individual shared responsibility payment), if you, your spouse or a dependent included on your tax return does not have minimum essential coverage.

Any penalty that taxpayers are required to pay for themselves or their dependents must be included in their return for the taxable year. Those individuals who file joint returns are jointly liable for the penalty.

For coverage in 2014, although not considered minimum essential coverage, those with Medicaid covering only family planning, pregnancy-related Medicaid, Tuberculosis-related services Medicaid, emergency medical conditions Medicaid, certain Section 1115 demonstration projects, coverage for medically needed individuals, space available care, or under TRICARE receiving line-of-duty care, or space available care, will not be subject to the fee.

When You Can Enroll in the Individual Market

- Marketplace initial open enrollment period
 - October 1, 2013 – March 31, 2014
- Annual open enrollment periods
 - November 15 – February 15
- Special enrollment periods
 - Available in certain circumstances during the year

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The Marketplace may only permit a qualified individual to enroll in a qualified health plan (QHP) or an enrollee to change QHPs during the Initial Open Enrollment Period (October 1, 2013 – March 31, 2014), the Annual Open Enrollment Period (for 2015 coverage it will run from November 15, 2014 – February 15, 2015), or a Special Enrollment Period for which the qualified individual has been determined eligible (such as a qualified individual or dependent loses minimum essential coverage; gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption; or an individual, who was not previously a citizen, national, or lawfully present individual gains such status).

In subsequent years, the Open Enrollment Period (OEP) dates are proposed. To look at the proposed rule visit <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/proposed-2015-payment-notice.html>

The Marketplace may automatically enroll qualified individuals, at such time and in such manner as HHS may specify, and subject to the Marketplace demonstrating to HHS that it has good cause to perform such automatic enrollments.

Starting in 2014, the Marketplace must provide a written Annual Open Enrollment notification to each enrollee from September 1 - September 30.

NOTE: You can apply for Medicaid and the Children's Health Insurance Program (CHIP) at any time.



There are four steps to using the Marketplace.

1. **Create an account.** First provide some basic information. Then choose a user name, password, and security questions for added protection.
2. **Apply.** Next you'll enter information about you and your family, including your income, household size, other coverage you're eligible for, and more. Visit HealthCare.gov to get a checklist to help you gather the information you'll need.
3. **Pick a plan.** Next you'll see the plans and programs you're eligible for and compare them side-by-side. You'll also find out if you can get lower costs on monthly premiums and out-of-pocket costs.
4. **Enroll.** Choose a plan that meets your needs and enroll.

If you have any questions, there's plenty of live and online help along the way.

Applying for affordability programs is optional. However, your eligibility information will still be verified against data sources even if you don't apply for lower premiums.

4 Ways to Get Marketplace Coverage

<h3 style="margin: 0;">Over the phone</h3> <p>Call the Marketplace Call Center at 1-800-318-2596. TTY users should call 1-855-889-4325. A customer service representative can help you apply and enroll over the phone.</p> 	<h3 style="margin: 0;">Online</h3> <p>Visit HealthCare.gov to apply and enroll on the web.</p> 
<h3 style="margin: 0;">In-person help</h3> <p>Get help from people in your community trained and certified to help you apply and enroll in the Marketplace. Visit Localhelp.HealthCare.gov, or call the Marketplace Call Center.</p> 	<h3 style="margin: 0;">Paper application</h3> <p>If you don't have a computer or time to apply and enroll over the phone, you can fill out a paper application. Call the Marketplace Call Center to get an application or download a copy from HealthCare.gov.</p> 



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CMS Product No. 11751
October 2013

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You can apply for coverage in the Marketplace by phone, online, in person, or by mail. The number for the National Health Insurance Marketplace call center is 1-800-318-2596. TTY users should call 1-855-889-4325. Customer service representatives are available 24 hours a day, 7 days a week, including New Year's Day. The call center is closed on Thanksgiving, Christmas, Labor Day, Memorial Day, and the Fourth of July.

The call center provides objective information in English and in Spanish. It uses language lines for 150 additional languages. The customer service representatives help consumers go through the eligibility and enrollment process, and refer them to local in-person help. When you call, you are asked what state you live in. If you live in a state operating a State-Based Marketplace, you are provided with the number to that state's Marketplace call center.

HealthCare.gov can help you identify your options for health insurance. The website is also available in Spanish at CuidadoDeSalud.gov. This website is also accessible for those with visual disabilities. If your state is running its' own Marketplace (state-based Marketplace), you'll be referred to its' website.

If you click on "Preview Plans and Prices" you can see what plans are available in your area and their full cost. If you qualify for a tax credit or cost sharing reduction, you would save on these costs. Visit <https://www.healthcare.gov/find-premium-estimates/> to view the premium estimation tool.

In-person help is also available. You can find trained and certified help to apply and enroll by visiting Localhelp.HealthCare.gov, or call the Marketplace call center.

The paper application is available for download and printing on HealthCare.gov.

In-Person Assistance

- Marketplace in-person help is available
 - Navigators
 - Non-Navigator assistance personnel
 - Certified application counselors
 - Issuer application assisters
 - Enrollment assistance contractor
 - Agents and brokers
 - To find assistance in your area, go to Localhelp.HealthCare.gov



Visit Marketplace.cms.gov for information on your organization becoming a Champion for Coverage

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There are several programs to help you through the process of applying for, enrolling in, and using health insurance, including the Navigator program, non-Navigator assistance personnel, issuer application assisters, enrollment assistance contractors, agents and brokers, and certified application counselors. These programs play a large role in helping people apply for health insurance coverage.

It is important to note that some of the assistance resources (Marketplace call centers and websites, and Navigators) are required to provide unbiased and impartial advice, while others (such as agents and brokers and issuer web sites and call centers) are not.

Organizations that don't meet the requirements to become Marketplace-approved assisters are invited to become a "Champion for Coverage." They can help educate the public about the Marketplace and refer them to resources where they can find assistance. Visit Marketplace.cms.gov for more information. If you have questions, send an email to champion@cms.hhs.gov.

Marketplace and People with Medicare

- Medicare isn't part of the Marketplace. If you have Medicare,
 - You don't need to do anything related to the Marketplace
 - Your benefits don't change because of the Marketplace
- If you become eligible for Medicare after you join a Marketplace plan
 - You can cancel the Marketplace plan once your Medicare coverage starts, or
 - You may be able to keep your Marketplace plan after your Medicare coverage starts
 - Once Part A coverage starts, you lose access to any premium tax credits/reduced cost sharing through the Marketplace

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Medicare is not a part of the Health Insurance Marketplace. Medicare Part A provides minimum essential coverage. If you have Medicare, you don't have to do anything related to the Marketplace. The Marketplace doesn't change your Medicare plan choices or your benefits. Medicare plans and supplement (Medigap) policies are not available in the Marketplace. In subsequent years, the Open Enrollment Period (OEP) dates are proposed. To look at the proposed rule visit <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/proposed-2015-payment-notice.html>

If you turn 65 in 2014, you can get a Marketplace plan to cover you before your Medicare begins. You can then coordinate cancelling your Marketplace plan when your Medicare coverage starts to avoid a gap in coverage. If you enroll in Medicare after your Initial Enrollment Period ends, you may have to pay a late enrollment penalty for as long as you have Medicare. It's against the law for someone who knows that you have Medicare to sell or issue you a Marketplace policy. This is true even if you have only Medicare Part A or only Part B.

Marketplace and People with Medicare *Continued*

- **Exception – Marketplace coverage instead of Medicare**
 - If you're eligible for Medicare but haven't enrolled because you'd have to pay a premium, or because you're not collecting Social Security benefits, you may be eligible to get a Marketplace plan
 - If you're paying a premium for Part A, you can drop Part A and Part B and may be eligible to get a Marketplace plan
- **Important considerations**
 - A late enrollment penalty may apply if you decide to enroll in Medicare later, after your initial enrollment period ends
 - Generally you can enroll **only** during the Medicare general enrollment period (January 1 to March 31)
- **You can get employer coverage through SHOP**

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It's against the law for someone who knows you have Medicare to sell you a Marketplace plan policy. But there are a few situations where you can choose Marketplace coverage instead of Medicare:

- You can choose Marketplace coverage if you're eligible for Medicare but haven't enrolled in it (because you would have to pay a premium, or because you're not collecting Social Security benefits).
- If you're paying a premium for Part A, you can drop your Part A and Part B coverage and get a Marketplace plan instead.

Before making this choice, there are 2 important points to consider:

- If you enroll in Medicare after your initial enrollment period ends, you may have to pay a late enrollment penalty for as long as you have Medicare.
- Generally you can enroll in Medicare **only** during the Medicare general enrollment period (from January 1 to March 31). Your coverage won't begin until July of that year.

Employer coverage offered through the Small Business Health Options Program (SHOP) is treated like any other employer coverage. Medicare Secondary Payer rules apply.

For more information, view the publication *Medicare & the Health Insurance Marketplace*, CMS Product No. 11694 at www.Medicare.gov/Pubs/pdf/11694.pdf.

Marketplace and People with...

- COBRA
 - You can drop COBRA and enroll in the Marketplace
 - During the Marketplace open enrollment period
 - Within 60 days of COBRA expiring (special enrollment period)
- Pre-existing Condition Insurance Plan (PCIP)
 - Coverage in the federal PCIP program ends March 31, 2014
 - These individuals need to apply for Marketplace coverage by March 15 to avoid a break in coverage (no automatic transition)

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When you leave a job, you may be able to keep your job-based health coverage for a period, usually up to 18 months. This is called COBRA continuation coverage. You can drop COBRA coverage during Marketplace Open Enrollment (OEP) (October 1, 2013 – March 31, 2014) and get a Marketplace plan. It's important not to let your COBRA coverage end before your Marketplace coverage begins to avoid a gap in coverage. If your COBRA expires, you may be eligible to receive a Special Enrollment Period (SEP) and enroll in a Marketplace plan within 60 days. You don't get an SEP for dropping COBRA outside of the OEP.

The Affordable Care Act established the Pre-existing Condition Insurance Plan (PCIP) program in every state and the District of Columbia. PCIP provides temporary coverage to people with pre-existing conditions. The federal PCIP program was extended through March 31, 2014. If you are enrolled in a PCIP, and you want to ensure no break in coverage by enrolling in the Marketplace, you must enroll by the January 15 deadline. The PCIPs will send notices to their enrollees to make them aware and encourage them to take action. Some PCIP enrollees may be eligible for Medicaid or other sources of coverage.

Seventeen state-based PCIPs transitioned to the Federally-run PCIP on July 1: Arkansas, California, Colorado, Illinois, Iowa, Kansas, Michigan, Missouri, New Hampshire, New York, North Carolina, Ohio, Oregon, Pennsylvania, South Dakota, Utah, and Washington.

Key Points to Remember

- The Marketplace is a new way to find and buy health insurance
- Qualified individuals and families can shop for health insurance that fits their budget
- Small employers can cover their employees through the SHOP
- States have flexibility to establish their own Marketplace
- Individuals and families may be eligible for lower costs on their monthly premiums and out-of-pocket costs
- There is assistance available to help you get the best coverage for your needs

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Here are some key points to remember:

- The Marketplace is a new way to find and buy health insurance
- Individuals and families can shop for health insurance that fits their budget
- Small employers can cover their employees through the SHOP
- States have flexibility to establish their own Marketplace
- Individuals and families may be eligible for lower costs on their monthly premiums and out-of-pocket costs
- There is assistance available to help you get the best coverage for your needs

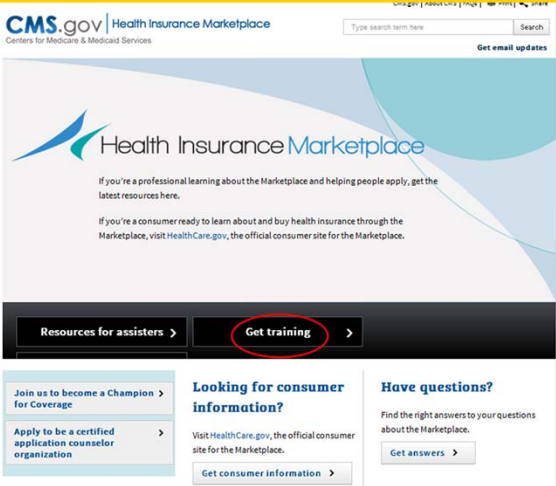
Marketplace.cms.gov

Get the latest resources to help people apply, enroll, and get coverage in 2014

Click “Get Training” for helpful videos



(an Compare (long version))



The screenshot shows the CMS.gov Health Insurance Marketplace homepage. The navigation bar includes links for 'Resources for assisters', 'Get training' (circled in red), and 'Get email updates'. Below the navigation bar, there are sections for 'Join us to become a Champion for Coverage', 'Apply to be a certified application counselor organization', 'Looking for consumer information?', and 'Have questions?'. The 'Get training' link is highlighted with a red circle.

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You can get up-to-date information to help you counsel people who may benefit from the Health Insurance Marketplace at Marketplace.cms.gov. There is access to consumer materials, training materials (including videos), research and more. You can sign up for updates as well. This is also where organizations can apply to become Certified Application Counselors and Champions for Coverage.

If you live in a state-based Marketplace you will be referred to your state's Marketplace website.

Want More Information about the Marketplace?

- Stay connected
 - Sign up to get email and text alerts at HealthCare.gov/subscribe
 - CuidadoDeSalud.gov for Spanish
 - Updates and resources for organizations are available at Marketplace.cms.gov
 - [Twitter@HealthCareGov](https://twitter.com/HealthCareGov)
 - [Facebook.com/Healthcare.gov](https://facebook.com/Healthcare.gov)

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Need more information about the Health Insurance Marketplace?

Sign up to get email and text alerts at HealthCare.gov/subscribe (CuidadoDeSalud.gov provides the HealthCare.gov information in Spanish).

Updates and resources for partner and stakeholder organizations are available at Marketplace.cms.gov.

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