2015 Guide to the Affordable Care Act

Adapted from the "Individual Marketplace Course, Plan Year 2015" from the Department of Health & Human Services

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Terms of Use*: The various elements of this guide were adapted either wholly or in part from the "Individual Marketplace Course, Plan Year 2015" from the Department of Health & Human Services, https://marketplace.medicarelearningnetworklms.com. Some additional references have been included to further assist Ohio residents. Ohio does not have a state-based ACA Marketplace or "exchange" and utilizes the Federally Facilitated Marketplace at: Healthcare.gov. This guide is for information purposes only and was believed to be accurate at the time of publication. Visit Healthcare.gov for the timeliest updates. This guide is not a substitute for legal or tax advice. If legal or tax advice is needed, the services of a competent legal or tax advisor should be sought.*

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2015 Open Enrollment Period

The annual open enrollment period for plan year 2015 is between November 15, 2014 and February 15, 2015.

Shared Responsibility Amounts for 2014

The annual individual shared responsibility payment for 2014 is the greater of 1% of the taxpayer's household income that is above the tax return filing threshold for the taxpayer's filing status, or the taxpayer's flat dollar amount, which is $95 per adult and $47.50 per child, limited to a family maximum of $285.

The total payment amount is capped at the cost of the national average premium for a Bronze level health plan available through the Marketplaces in 2014.

Shared Responsibility Amounts for 2015

The annual individual responsibility payment for 2015 is the greater of 2% of the taxpayer's household income that is above the tax return filing threshold for the taxpayer's filing status, or the taxpayer's flat dollar amount, which is $325 per adult and $162.50 per child, limited to a family maximum of $975.

The total payment amount is capped at the cost of the national average premium for a Bronze level health plan available through the Marketplaces in 2015.

Part 1: Key Provisions of the Affordable Care Act

The healthcare law passed in 2010 known as the Affordable Care Act was intended to assist consumers in accessing health insurance as well as helping consumers control their healthcare costs.

Here are some of the key provisions of the law that are directed at consumers:

- Doing away with lifetime coverage limitations.
- Instituting guaranteed issue requirements so health insurance providers make individual and group policies available to all eligible individuals without regard to health status.
- Making coverage available to young adults through their parents' plans up to age 26 (Ohio has extended this provision to age 28. See, http://www.insurance.ohio.gov/Consumer/Pages/DependentAgeCoverageExpansion.aspx).
- Instituting a Medical Loss Ratio (or "MLR") requirement that requires 80% of health insurance premiums paid to insurers is utilized for healthcare expenses.
- Requiring that insurers may not charge higher rates to insureds due to gender or health status.
- Prohibiting limitations on coverage due to pre-existing health conditions.
- Prohibition on preventing an eligible person from participating in approved clinical trial or engaging in discrimination against an individual were they to participate in such a trial.

Shared Responsibility Payments

The Affordable Care Act makes the requirement that citizens either keep in force "minimum essential coverage," be qualified to be exempt from minimal essential coverage, or make a "shared responsibility payment."

Minimum essential coverage is the level of coverage an individual must have in place in order to meet his or her individual responsibility requirement. Here are some examples of coverage that qualify an individual to meet the individual responsibility requirement:

- Coverage that is purchased through the individual insurance market including the Marketplaces or exchanges (i.e. Healthcare.gov or a state based exchanges).
- Medicare, Medicaid, Children's Health Insurance Program (CHIP), and TRICARE (from the Department of Defense Healthcare Program).
- Employer-sponsored plan coverage.
- Any other coverage that may be determined to be acceptable by the Department of Health and Human Services.

If a person does not have coverage that meets the individual responsibility requirement, he or she will be required to make a shared responsibility payment. The shared responsibility amount goes up between the years of 2014 and 2015.

Calculating the Shared Responsibility Payment for 2014 and 2015 Tax Years

Shared Responsibility Amounts for 2014

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Shared Responsibility Amounts for 2015

- The annual individual responsibility payment for 2015 is the greater of 2% of the taxpayer's household income that is above the tax return filing threshold for the taxpayer's filing status, or the taxpayer's flat dollar amount, which is $325 per adult and $162.50 per child, limited to a family maximum of $975.
- The total payment amount is capped at the cost of the national average premium for a Bronze level health plan available through the Marketplaces in 2015.

These calculations display the payment amount for going without qualifying health insurance coverage for the course of a full year. Individuals would be responsible for 1/12th of the yearly payment for every month they (or their dependents) went without qualifying overage and were not exempt.

The method for calculating shared responsibility payments is similar in 2016 and later years. For 2016, the shared responsibility payment is 2.5% of income over the filing threshold or $695 per person (i.e. $347.50 per child under 18), whichever is greater. Beyond 2016, the shared responsibility payment becomes adjusted for inflation. For detailed information on shared responsibility payments from the Internal Revenue Service, visit:
http://www.irs.gov/uac/Newsroom/The-Individual-Shared-Responsibility-Payment-An-Overview

Exemptions from the Individual Responsibility Requirement

Under certain circumstances, an individual may be exempt from the individual responsibility requirement. These circumstances include the following:

- The individual is uninsured for less than three months of the year.
- The lowest-priced coverage available to the consumer would cost more than 8% of the consumer's household income.
- The individual does not have to file a tax return because his or her income is too low.
- The individual is a member of a federally recognized tribe or eligible for services through an Indian health care provider.
- The individual is a member of a health care sharing ministry.

- The individual is a member of a recognized religious sect with religious objections to insurance, including Social Security and Medicare.
- The individual is incarcerated, and is not awaiting the disposition of charges.
- The individual is not lawfully present in the United States.
- The individual has experienced a hardship (hardship exemptions will be covered later in this topic).

Some types of exemptions are available only through the tax filing process; some are only available through a Marketplace; and some are available through either channel. See HealthCare.gov for more details.

Hardship Exemptions

There are certain circumstances that affect an individual's ability to purchase health insurance coverage and which may qualify an individual for a hardship exemption. To make the determination, the Marketplace considers whether an individual has experienced one of the following events:

- Becomes homeless.
- Has been evicted in the past six months, or is facing eviction or foreclosure.
- Has received a shut-off notice from a utility company.
- Recently experienced domestic violence.
- Recently experienced the death of a close family member.
- Recently experienced a fire, flood, or other natural or human-caused disaster resulting in substantial damage to individual property.
- Filed for bankruptcy in the last six months.
- Incurred medical expenses in the last 24 months that resulted in substantial debt.
- Experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member.
- Expects to claim a child as a tax dependent who has been denied coverage in Medicaid and CHIP, and another person is required by court order to give medical support to the child. In this case, the individual would not have to make a payment for the child.
- As a result of an eligibility appeals decision, is determined eligible for enrollment in a QHP through a Marketplace, the premium tax credit, or cost-sharing reductions for a period of time during which he or she was not enrolled in a QHP through a Marketplace.
- Was determined ineligible for Medicaid because his or her state did not expand eligibility for Medicaid under the Affordable Care Act.
- Lost insurance coverage because his or her individual plan was cancelled and believes other available coverage options are unaffordable.
- Experiences another hardship in obtaining health insurance.

Only individuals under age 30 and individuals with hardship exemptions may purchase a catastrophic plan. Catastrophic plans typically have high deductibles, and mainly protect individuals from very high medical costs.

Pre-Existing Condition Coverage

For all health insurance plans with effective dates or plan years starting on or after January 1, 2014, the Affordable Care Act no longer allows health insurers to limit or exclude coverage for pre-existing health conditions. This is true regardless of the age of any covered individual. For insureds under the age of 19, this stipulation became effective for policies becoming effective on or after September 23, 2010.

- In general terms, a pre-existing condition may be defined as a medical condition or illness that existed prior to the effective date of coverage.
- This is true whether or not medical consultation or treatment was received or recommended to an individual.

Nondiscrimination Regarding Clinical Trial Participation

The Affordable Care Act prohibits health insurance issuers from:

- Precluding participation of qualified individuals in an approved clinical trial.
- Denying, limiting, or placing additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in an approved clinical trial.
- Discriminating against qualified individuals on the basis of their participation in an approved clinical trial.

Guaranteed Issue and Guaranteed Renewable

Health insurance issuers by law must make available all individual and group market plans to any applicant in a given state. Insurers must accept individuals who apply for these policies provided that the persons applying agree to the terms and conditions of the policy. The stipulation to mandating the acceptance of these applicants is known as "**guaranteed issue**." Part of terms and conditions with which applicants must agree is to pay the plan premiums. Coverage offered inside and outside of the Marketplaces may limit guaranteed issued coverage to defined enrollment periods.

The law also requires insurers to renew or continue to keep in force coverage at the discretion of the person holding the policy. This provision is known as "**guaranteed renewable**."

Coverage for Young Adults

Under the healthcare law, health insurance plans covering children must continue to offer coverage to children until the age of 26 (Ohio has extended this provision to age 28: http://www.insurance.ohio.gov/Consumer/Pages/DependentAgeCoverageExpansion.aspx.)

Such young adults are permitted to join or stay on a parent's health plan whether or not they are:

- Married (coverage does not extend to married child's spouse).
- Not residing with a parent.
- Not attending school.

- Not a financial dependent of a parent.
- Currently eligible to be enrolled in their employer's health plan

Medical Loss Ratio Guidelines

The Affordable Care Act places limits on the ratio of premiums a health insurance provider can allot toward expenses beyond the provision of health insurance coverage and improving the healthcare quality of individuals enrolled in their plans.

Medical Loss Ratio or MLR is a financial metric that determines the amount of premium dollars a health insurer allocates to healthcare expenses versus profits and other expenses for administration. Starting in 2011, if a health insurer fails to allocate enough premiums to healthcare services, it must provide a rebate to policyholders and/or insureds.

- In general terms, when an insurer spends an average of 80 cents per dollar of premium to pay claims for customer's medical expenses and engage in improving the quality of healthcare, the issuer is said to have an MLR of 80%.
- MLR is not calculated person by person. Instead, it is calculated on a statewide basis for each provider. Separate calculations are made for large group, small group, and for individual markets.
- With an MLR of 80%, health insurance providers are using the 20% leftover from each dollar of premium to fund administration costs such as employee salaries and other overhead as well as to generate profits.

The ACA establishes base MLR standards depending on various markets, as is the case with some state laws.

Definition of a Qualified Health Plan

All plans offered through the insurance Marketplace are certified to be Qualified Health Plans or QHPs. These plans require licensing and must comply with certain requirements for transparency.

For a plan to be certified as a QHP it must meet a minimum set of standards that include,

- Coverage, at a minimum, of a comprehensive package of benefits, known as essential health benefits (EHB).
- Benefit design standards, including non-discrimination requirements and limits on cost-sharing.
- Network adequacy standards.

Insurers offering QHPs in a Marketplace must make available a Silver and a Gold level QHP. This stipulation became effective January 1, 2014. (See "Benefit Levels and Actuarial Values" below.)

A plan must have an adequate network of providers in order to qualify as a QHP. A qualified provider network must,

- Have a sufficient number of providers, including mental health and substance abuse providers, to ensure access to all services without unreasonable delay.
- Have a sufficient number and geographic distribution of essential community providers to enable reasonable and timely access to care for low-income and medically underserved populations in the QHP's service area.

Essential Health Benefits

Per the Affordable Care Act, health plans made available in the individual and small group markets must offer a comprehensive package of services. These services are known as "essential health benefits" or EHB.

There are ten benefit categories that make up the EHB. EHB must,

- Reflect appropriate balance between the 10 EHB categories.
- Not discriminate based on age, disability, or expected length of life.
- Account for the healthcare needs of diverse segments of the population.

Healthcare benefits can vary from state to state. There can even be minimal differences between health insurance plans in the same state. A consumer completing an application and comparing plans will be able to see small differences in benefits offered by each plan.

Minimally, EHB includes services and items within these ten categories.

- Ambulatory patient services, such as doctor visits.
- Emergency services.
- Hospitalization.
- Laboratory services.
- Maternity and newborn care.
- Mental health and substance use disorder services, including behavioral health treatment.
- Pediatric Services (pediatric oral care may be included or offered as part of a stand-alone plan).
- Prescription drugs.
- Preventive and wellness services and chronic disease management.
- Rehabilitative and habilitative services and devices.

Benefit Levels and Actuarial Value (AV)

Insurers offering coverage through an insurance Marketplace must cover EHB, limit cost sharing (including maximums that limit out of pocket costs), and provide coverage that meets certain benefit levels.

Benefit levels are designated by "metal levels," namely **Bronze**, **Silver**, **Gold**, and **Platinum** in ascending order of coverage level. Health insurance issuers are not required to offer plans at every coverage level.

Coverage levels are established by the actuarial value (AV) of the plan design. Plans cover each of the 10 EHB categories differently, but AV is calculated based on the average of all EHB estimated to be paid by the health insurance plan for a standard population.

The AV calculation is reflected in percentages. Generally, the higher the AV, the more the enrollee pays in monthly premiums and the less he or she may pay in out-of-pocket costs. Because the AV of a plan design is calculated based on a standard population, it may not exactly reflect every individual's experience.

Here are the percentages of AV for each "metal" level:

- **Bronze** - 60% AV (the health insurance plan pays approximately 60% of the average cost of all EHB for an average person)
- **Silver** - 70% AV (the health insurance plan pays approximately 70% of the average cost of all EHB for an average person)
- **Gold** - 80% AV (the health insurance plan pays approximately 80% of the average cost of all EHB for an average person)
- **Platinum** - 90% AV (the health insurance plan pays, approximately 90% of the average cost of all EHB for an average person)

Out of Pocket Limits

Under the Affordable Care Act, all health plans are required to limit cost sharing for enrollees via the following:

- Deductibles and copayments cannot be applied to certain recommended preventive services.
- Annual cost-sharing limits cannot exceed the limits for certain high deductible health plans including catastrophic plans. (For 2015, the limits are $6,600 for an individual and $13,200 for families enrolled in individual market plans.)
- No annual or lifetime dollar limits are allowed on EHB as of January 1, 2014.

Catastrophic Plans

In addition to offering metal level plans (Bronze, Silver, Gold, and Platinum), insurers may also offer catastrophic plans. Catastrophic plans have limited eligibility.

The availability of catastrophic plans is limited to:

- Individuals under age 30.
- Individuals who otherwise do not have an affordable coverage option or who otherwise qualify for a hardship exemption to the minimum essential coverage requirement.

If a person qualifies to enroll in catastrophic coverage, the plan is considered to have met the minimum essential coverage requirement. Catastrophic plans do not have a fixed actuarial value (AV). Those

enrolling in catastrophic plans will have higher deductible limits than those who enroll in metal level plans.

Still, there are several benefits included in catastrophic plans:

- Catastrophic plans offer lower premiums on average than Bronze, Silver, Gold, or Platinum plans.
- Protect enrollees with a maximum out-of-pocket cost limit (the limit changes annually; for 2015, the maximum out-of-pocket cost limit is $6,600 for an individual and $13,200 for a family).
- Cover recommended preventive services without cost sharing.

Rating Standards

The Affordable Care Act provides many stipulations relating to rating standards

Age Rating Standards:

- Health insurers may not charge older adults more than three times the rate of a 21 year old.
- States are permitted to set up their own age curve or set a default to the federal age curve.

Federal Age Bands:

- 0-20
- One-year bands between 21-63
- 64 and older

Family Rating Standards

Family members included in rating,

- One or two parents.
- Up to three family members under the age of 21
- Dependent children 21 and older
- Family premiums are formulated on the premiums for individual family members as well as each family member's age and use of tobacco.
- A total family premium is derived by factoring the premiums for up to three children below the age of 21 and per-member rates for dependent children 21 and older.

Geographic Rating Standards

Premiums may reflect geographic rating areas in a state. Rating areas are,

- A person's home address for individual coverage.
- For small group coverage, an employer's primary business location in a state

Tobacco Rating Standards

- Health insurers are not permitted to charge a tobacco user more than 1.5 times the rate of a non-tobacco user.
- Tobacco user rate may vary based on the age of the insured. For example, 1.2: 1 for those under the age of 35.
- Tobacco users insured by small employer plans can avoid the tobacco surcharge by participating in a "wellness program" such as a tobacco cessation program.

Differences in rates stemming from tobacco use are only applied to the premium of the individual family member that uses tobacco. If only one person in the family smokes, any surcharge would apply to that one individual only.

Part 2: Premium Subsidy Programs

Insurance Affordability Programs

Individuals who enroll in a QHP through an Individual Marketplace may be eligible for the premium tax credit, which reduces the cost of premiums for themselves and their tax dependents. An individual can choose to apply the tax credit towards QHP premium costs on an advance basis – with reconciliation at the end of the year – or to receive the credit on his or her federal tax return filed for the plan 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 plan year.
- Individuals who are married at the end of the plan year are required to file a tax return and may not use the "Married Filing Separately" filing status on the tax return to receive a premium tax credit.
- Eligibility for the premium tax credit is based on household income, family size, and access to other minimum essential coverage.

As a result of the Defense of Marriage Act (DOMA) ruling in 2013, the eligibility rules with respect to the premium tax credit treat same-sex spouses in the same manner as opposite-sex spouses, so long as the taxpayer and his or her spouse do not file a tax return with a filling status of "Married Filing Separately" for the taxable year.

Cost-sharing reductions limit the out-of-pocket costs for essential health benefits (EHB) covered by QHPs. There are several categories of cost-sharing reductions that are based on annual household income and family size. Each QHP issuer implements these differently, based on its specific plan design. When an individual is determined eligible for a category of cost-sharing reduction, the plan comparison pages reflect adjusted cost-sharing requirements of each plan.

2014 Federal Poverty Level Chart*

The Department of Health & Human Services (HHS) issues poverty guidelines that are often referred to as the "federal poverty level" (FPL). Federally Facilitated Marketplaces will use the 2014 guidelines when making calculations for the insurance affordability programs starting November 15, 2014.

Household Size	100%	138%**	150%**	200%**	250%**	300%**	400%**
1	$11,670	$16,105	$17,505	$23,340	$29,175	$35,010	$46,680
2	15,730	21,707	23,595	31,460	39,325	47,190	62,920
3	19,790	27,310	29,685	39,580	49,475	59,370	79,160
4	23,850	32,913	35,775	47,700	59,625	71,550	95,400
5	27,910	38,516	41,865	55,820	69,775	83,730	111,640
6	31,970	44,119	47,955	63,940	79,925	95,910	127,880
7	36,030	49,721	54,045	72,060	90,075	108,090	144,120
8	40,090	55,324	60,135	80,180	100,225	120,270	160,360

*Chart is for 48 contiguous states and the District of Columbia; for Hawaii and Alaska please visit the website of the HHS Assistant Secretary for Planning and Evaluation (ASPE): http://aspe.hhs.gov/poverty/14poverty.cfm.

**Dollar amounts are calculated based on 100% column; rounding rules may vary across federal, state, and local programs.

Affordability Measures: Premium Tax Credits, Cost Sharing Reductions

Under the Affordable Care Act, millions of Americans are eligible to purchase health coverage through Marketplaces. The Act also provides the opportunity for eligible individuals to reduce their cost for health insurance coverage through,

- The premium tax credit,
- And, to reduce out-of-pocket expenses through cost-sharing reductions.

Eligible individuals may elect to reduce their monthly premiums by having the premium tax credit paid on an advance basis directly to insurance companies on their behalf.

The Marketplace application process allows individuals and the agents and brokers who assist them, to determine if they are eligible for the premium tax credit or cost-sharing reductions, Medicaid, and CHIP.

The Premium Tax Credit

The premium tax credit helps individuals and families afford health insurance coverage purchased through a Marketplace.

- An individual may choose to apply some or all of the tax credit towards qualified health plan (QHP) premium costs on an advance basis (called advance payments of the premium tax credit or APTC), to reduce monthly premiums, with reconciliation at the end of the year.
- Alternatively, if an individual is eligible for a premium tax credit and does not elect to have advance payments made during the year, he or she may claim the credit on his or her federal tax return filed for the plan year.
- Advance payments of the premium tax credit are paid on a monthly basis directly to the insurance company offering the QHP.

The premium tax credit is NOT available for coverage purchased outside of the Marketplaces.

How to Calculate a Premium Tax Credit

The premium tax credit is based on projected annual household income, family size, and the cost of the second lowest cost Silver level (AV 70%) benchmark plan for that individual or family. The Marketplace uses this information to compute a maximum premium tax credit, which can then be applied in part, or in full, to reduce the monthly premiums of one or more QHPs.

The amount of the premium tax credit depends on the QHP that the individual or family selects.

- If the monthly premium for the selected QHP is greater than the monthly advance payments of the maximum premium tax credit, the individual or family will pay the difference in the monthly premium cost.
- If the premium for the selected QHP is less than the maximum advance payments, the individual or family may elect to receive the maximum advance payments of the premium tax credit, and have no additional monthly premium cost.

Example 1: Family A is eligible for a maximum of $800/month for advance payments of the premium tax credit. Family A selects a QHP that costs $1,000/month. If they elect to receive the full amount of the premium tax credit as advance payments, $800/month will be paid directly to the QHP issuer, and Family A will pay the issuer the remaining $200/month premium.

Example 2: Individual B is eligible for a maximum of $400/month for advance payments of the premium tax credit. Individual B selects a QHP that costs $350/month. If he or she elects to receive the full amount of the premium tax credit as advance payments, $350/month will be paid directly to the QHP issuer, and Individual B will not have a monthly premium payment.

To learn more about Affordable Care Act tax provisions, visit the IRS' Affordable Care Act Tax Provision website: http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions-Home

How the Premium Tax Credit is Reconciled

The income tax return for the plan year will reconcile any advance payments of the premium tax credit with the premium tax credit allowed on the return.

- The Marketplace provides documentation to the tax filer and to the Internal Revenue Service (IRS) that supports the reconciliation process in the same way that an employer or bank provides a Form W-2 or Form 1099.
- The amount of the premium tax credit or an individual's change in circumstances may impact the individual's refund or tax liability:

If the actual premium tax credit amount is *greater* than the total advance payments made to the QHP issuer, either a refund is increased or a tax liability is reduced.

If the actual premium tax credit amount is *less* than the total advance credit payments made to the QHP issuer, either a refund is reduced or a tax liability is increased.

Changes in circumstances (e.g., income, family size) must be reported to the Marketplace in order to avoid the payment of excess advance payments of the premium tax credit that will need to be repaid with the tax return.

Cost-sharing Reductions

Cost-sharing reductions reduce out-of-pocket costs such as,

- Deductibles
- Co-insurance
- Co-pays

Eligibility for cost-sharing reductions is based on household income and requires the individual or family to enroll in a Silver level plan. Members of federally recognized Indian tribes may qualify for additional cost-sharing benefits.

Cost-sharing reductions are NOT available for coverage that is purchased outside of the Marketplaces.

Individuals and families with household incomes up to 250% of the FPL may be eligible to receive cost-sharing reductions. Household income is determined by calculating their modified adjusted gross income (MAGI).

How Cost Sharing Reductions are Calculated

Cost-sharing reductions limit the out-of-pocket costs for essential health benefits (EHB) for individuals and families with MAGI between 100-250% of the federal poverty level, and certain American Indians/Alaska Natives enrolled in a Silver level QHP through the Individual Marketplaces.

Federal regulations set the reduced maximum annual limitation on cost sharing for individuals and families eligible for cost-sharing reductions based on income, however, reductions on cost-sharing for specific benefits and services may vary based on a QHP issuer's specific plan design.

Under federal regulations, a family can only enroll in the most generous plan for which all members of the family are eligible. For families that want to maximize each family member's ability to access cost-sharing reductions, the Marketplace provides separate initial enrollment groups for each family member(s) eligible for different levels of cost-sharing reduction.

Reduction in Maximum Annual Limitation on Cost Sharing for 2015

Plan Variation (from 70% AV Silver Plan)	Income Range for Individual*	Individual Out-of-Pocket Maximum (standard 2015 limit: $6,600)	Income Range for Family of Three*	Family Out-of-Pocket Maximum (standard 2015 limit: $13,200)
94% AV Silver Plan Variation (for households with a MAGI between 100-150% of FPL)	$11,670- $17,505	$2,250	$19,790- $29,685	$4,500
87% AV Silver Plan Variation (for households with a MAGI between 150-200% of FPL)	$17,505- $23,340	$2,250	$29,685- $39,580	$4,500
73% AV Silver Plan Variation (for households with a MAGI between 200-250% of FPL)	$23,340- $29,175	$5,200	$39,580- $49,475	$10,400

American Indians/Alaska Natives with MAGI below 300% of FPL enrolled in a zero cost sharing plan variation have all cost sharing eliminated for EHB. American Indians/Alaska Natives with MAGI above 300% of FPL enrolled in a limited cost sharing plan variation have cost sharing eliminated for any EHB item or service that is furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, Urban Indian Organization, or through referral under contract health services.

*Please review the 2014 Federal Poverty Chart to find dollar ranges for the different percentages of FPL.

Medicaid and Children's Health Insurance Program (CHIP)

Medicaid and CHIP are federal and state partnership programs designed to provide coverage to lower income individuals and children. These programs provide safety net coverage for the country's lowest income populations. These programs vary by state.

A person who is eligible for Medicaid or CHIP is NOT eligible for the premium tax credit or cost-sharing reductions for coverage purchased through the Individual Marketplaces.

Medicaid

Medicaid is a federal and state partnership to provide coverage for some people with,

- Lower incomes.
- Older people.
- People with disabilities.
- And, some families and children.

To qualify for Medicaid, an individual must be part of a covered group – children, pregnant women, parents or caretaker relatives, the elderly, the disabled, or other non-elderly adults who are not eligible for or enrolled in Medicare – and must meet financial eligibility requirements. To be eligible for Medicaid, individuals need to satisfy federal and state requirements regarding residency, citizenship or immigration status, household income and, in some cases, financial resources.

Medicaid is jointly funded through federal and state dollars, but administered at the state level. All Medicaid programs must cover the 10 categories of essential health benefits.

CHIP

CHIP provides no-cost or low-cost health insurance coverage to children up to age 19 in families that have too much income to qualify for Medicaid coverage. It also covers pregnant women in some states. Like Medicaid, the costs for CHIP are shared by the federal government and state governments, but the program is administered at the state level. CHIP provides comprehensive benefits, often through private insurance companies.

To find CHIP information by state, visit InsureKidsNow.gov

Medicaid, CHIP, and the Affordable Care Act

The Affordable Care Act streamlines the eligibility standards and enrollment processes for Medicaid. It allows states to voluntarily expand Medicaid to all adults ages 19 – 64 with household MAGI at or below 138% of the FPL. This is known as “Medicaid expansion.”

- Participation in Medicaid expansion is optional for states (i.e. Ohio has chosen to participate in Medicaid expansion).
- Through Medicaid expansion, the Affordable Care Act provides opportunities for adults to be covered by Medicaid.
- Even if a state did not expand Medicaid, it will still cover pregnant women and children above the poverty level – and in some cases, will cover children through CHIP with income at several times the poverty level.

When an individual indicates on his or her application that he or she is interested in help paying for health insurance, the Marketplace conducts an eligibility assessment or determination for Medicaid and CHIP for each family member that the applicant indicates needs health insurance coverage.

Certain family members may qualify for Medicaid, even if other family members do not and will need to purchase health insurance coverage through a Marketplace. For instance, if a couple has an eligible child who files his or her own tax return, that child may be eligible for Medicaid even if his or her parents are not. Additionally, a family member may qualify for Medicaid due to a disability, while the rest of the family purchases health insurance through the Marketplace.

Similarly, there may be instances where the parent(s) of a family may obtain health insurance through the Marketplaces, while their child does not enroll in the family's QHP because he or she is determined to be eligible for CHIP coverage. Parents can only receive the cost-sharing reductions and the premium tax credit that they are determined to be eligible for by enrolling in a QHP through a Marketplace. These affordability programs are not available for those who are determined to be eligible for minimum essential coverage through Medicaid or CHIP.

Part 3: Who is Eligible?

Eligibility in the Federally Facilitated Marketplace (FFM)

Individuals can use the Individual Marketplaces to explore their health insurance coverage options, even if they already have insurance (i.e. through employer-sponsored coverage). To be eligible to obtain insurance through a Marketplace, an individual must:

- Be a resident of the state where he/she will apply for coverage and enroll in a QHP.
- Be a United States citizen or national, or a lawfully present non-citizen.
- Not be incarcerated, other than incarceration pending the disposition of charges.

While any eligible individual may apply for QHP coverage through the Marketplace, QHPs are generally not intended for individuals who are eligible for or enrolled in other types of minimum essential coverage—such as employer-based coverage, Medicaid, CHIP, TRICARE (the Department of Defense heath care program), and certain other types of coverage.

Immigrant Families and the Marketplace

Immigrant families have important Marketplace eligibility details to consider.

In order to buy private health insurance through the Marketplace, a person must be a U.S. citizen or be lawfully present in the United States. The term "lawfully present" includes immigrants who have:

- "Qualified non-citizen" immigration status, regardless of whether they have a waiting period.
- Humanitarian statuses or circumstances (including Temporary Protected Status, Special Juvenile Status, asylum applicants, Convention Against Torture, victims of trafficking).
- Valid non-immigrant visas.

- Legal status conferred by other laws (temporary resident status, LIFE Act, Family Unity individuals).

Lawfully present immigrants may be eligible for the premium tax credit and cost-sharing reductions if they meet the other eligibility criteria for these programs.

Many immigrant families are of “mixed immigration status,” with members having different immigration and citizenship statuses. Some families may have taxpaying members who cannot buy health insurance coverage through the Marketplaces, alongside other family members who are eligible to use the Marketplaces as citizens or lawfully present immigrants.

The same situation could apply in a family that has some members who are not eligible for full Medicaid, and others who are eligible for Medicaid or CHIP.

“Mixed immigration status” families can apply for the premium tax credit or cost-sharing reductions for private insurance for their family members who are eligible for coverage in the Marketplace, or for Medicaid and CHIP coverage. For more information about immigrant families and the Marketplace, please visit HealthCare.gov.

Individual Eligibility

To enroll in a qualified health plan (QHP) through the Individual Marketplaces, an individual must:

- Be a resident of the state where he or she will apply for coverage and enroll in a QHP.
- Be a United States citizen or national (or a lawfully present non-citizen).
- Not be incarcerated, other than incarceration pending the disposition of charges.

While any eligible individual may apply for QHP coverage through the Marketplace, QHPs are generally not intended for individuals who are eligible for or enrolled in other types of minimum essential coverage—such as employer-based coverage, Medicaid, the Children’s Health Insurance Program (CHIP), the Department of Defense TRICARE Program, and certain other types of coverage.

As mentioned above, certain individuals may be able to qualify for insurance affordability programs, such as the premium tax credit or cost-sharing reductions to help lower their costs.

Small Business Eligibility and SHOP

In 2015, small businesses that offer coverage through the Federally Facilitated SHOP (FF-SHOP) may be able to offer employees a choice of QHPs and qualified dental plans (QDP) within a given metal level or issuer, or a single QHP or QDP.

To qualify for an FF-SHOP, a business must:

- Be located in an FF-SHOP's service area (generally a state).
- Have at least one eligible employee on payroll.

- Have 50 or fewer full-time equivalent (FTE) employees on payroll. This methodology includes part-time employees, but not seasonal employees (those working fewer than 120 days per year).
- Offer coverage to all full-time employees (those working an average of 30 or more hours per week)

Additional Requirements for the SHOP Marketplaces

Employers and employees are assured that the QHPs offered meet network adequacy and benefit design standards of the SHOP. The FF-SHOPs provide flexibility in the amount that members of the small group contribute towards the total premium. Employers may also choose to offer coverage to employees' dependents. Premiums for the employers and employees are not based on their health or medical history, but can only vary based on age, family composition, geographic area, and tobacco use.

Premium tax credit and cost-sharing reductions are not available through the SHOP Marketplace. However, employers meeting certain size and average wage requirements may receive a small business health care tax credit on their tax returns of up to 50 percent of the employer's contribution to health insurance premiums. Generally, this credit is only available for coverage provided through a SHOP.

How the Individual Marketplaces Determine Eligibility

Consumers apply for coverage using a single, streamlined application that determines eligibility for the Individual Marketplaces and insurance affordability programs. Agents and brokers can assist consumers in completing applications, which may be submitted either online, by mail, in person, or by calling the Marketplace Call Center.

The Marketplace verifies data for individuals seeking coverage through the Marketplace, including verification of:

- Social Security Number (SSN) (if applicant has an SSN).
- Citizenship or lawful presence.
- Incarceration status.
- Membership in a federally recognized Indian tribe or status as a shareholder in an Alaska Native Corporation (if applicable).
- Household income for consumers seeking eligibility for insurance affordability programs.
- Annual household income for premium tax credit/cost-sharing reduction eligibility.
- Current monthly household income for Medicaid/CHIP eligibility.
- Access to minimum essential coverage.

The Marketplace must provide the applicant with timely written notice of an eligibility determination. Notification occurs immediately if the application was submitted electronically, and indicates if additional information is needed. Notices include information regarding the right to appeal eligibility findings.

The Marketplace must transfer any applicant assessed or determined eligible for Medicaid or CHIP to the applicable state Medicaid or CHIP agency, which will follow up for either the completion of the eligibility process (in states where the state Medicaid and CHIP agencies make the final eligibility determination) or plan/delivery system selection (in states where the Marketplace makes the final determination of eligibility for Medicaid or CHIP).

Determining Eligibility for Tax Credits and Cost Sharing Reductions

The Marketplace uses Modified Adjusted Gross Income (MAGI) to determine a consumer's eligibility for advance payments of the premium tax credit and cost-sharing reductions. Additionally, the Affordable Care Act requires all states to determine eligibility for Medicaid and CHIP for the majority of individuals (essentially, all non-disabled, non-elderly individuals) based on their MAGI.

- The MAGI calculation for advance payments of the premium tax credit and cost-sharing reductions equals *adjusted gross income as defined by the Internal Revenue Service (IRS), plus any excluded foreign income, tax-exempt interest received or accrued during the taxable year, and non-taxable Social Security benefits.*
- Assets are not considered in determining eligibility. This income methodology is the same for determining eligibility for advance payments of the premium tax credit and cost-sharing reductions, and determining eligibility for Medicaid and CHIP, with the following exceptions:

Due to variances in the way states and the federal government determine eligibility based on immigration status and other non-financial factors, certain individuals may qualify for advance payments of the premium tax credit or cost sharing reductions, but may not be eligible to apply for Medicaid or CHIP regardless of their income. Medicaid and CHIP disregard certain rare types of income.

Medicaid and CHIP eligibility is primarily based on current monthly income, while eligibility for advance payments of the premium tax credit and cost-sharing reductions is based on projected annual household income.

Eligibility for Affordability Programs

As noted earlier, some individuals who are eligible to enroll in a QHP are eligible for financial support to make their health insurance coverage more affordable. As part of the application process, the Marketplace assesses eligibility for advance payments of the premium tax credit and cost-sharing reductions based on household income relative to the federal poverty level (FPL).

Advance Payments of the Premium Tax Credit

The following are eligibility criteria for advance payments of the premium tax credit,

- Meets the eligibility criteria for enrollment in a QHP (and ultimately enrolls in a QHP offered through the Marketplace).

- Has an annual household income between 100% and 400% of the FPL (or between 0% and 400% FPL if a lawfully present non-citizen who is ineligible for Medicaid by reason of immigration status).
- Be a part of a tax household that will file a tax return for the plan year, and does not use the "Married Filing Separately" filing status on the tax return.
- Is not eligible for minimum essential coverage (including employer-sponsored coverage that meets affordability and minimum value standards, Medicaid, CHIP, Medicare, and other forms of coverage), other than through the Individual Marketplaces.

As a result of the Defense of Marriage Act (DOMA) ruling in 2013, the eligibility rules with respect to advance payments of the premium tax credit treat same-sex spouses in the same manner as opposite-sex spouses, so long as the taxpayer and his or her spouse do not file a tax return with a filling status of "Married Filing Separately" for the taxable year.

Advance payments of the premium tax credit are NOT available for the purchase of catastrophic coverage.

Cost-Sharing Reductions

The following are eligibility criteria for cost-sharing reductions.

- Meets the eligibility criteria for enrollment in a QHP and for advance payments of the premium tax credit.
- Has an annual household income between 100% and 250% of the FPL, OR an annual household income at or below 300% of the FPL for members of federally-recognized Indian tribes or shareholders of Alaska Native corporations.
- Is not enrolled or eligible for government-sponsored coverage, employer-sponsored coverage that meets affordability and minimum value standards, or another type of minimum essential coverage.
- Is enrolled in a Silver level plan through a Marketplace.

A consumer's "Summary of Benefits and Coverage" summarizes the QHP's benefits before taking into account financial assistance the consumer may receive in the form of cost-sharing reductions. If a consumer is eligible for cost-sharing reductions, the cost sharing may be lower than what the consumer sees on his or her summary of benefits and coverage. Consumers who are eligible for cost-sharing reductions can review the cost-sharing information available at HealthCare.gov or in the QHP's documents to see what their cost sharing might be.

Determining Eligibility for Medicaid

To learn more about a state Medicaid or CHIP program and other available options, use the insurance and coverage finder at HealthCare.gov or visit Medicaid.gov or InsureKidsNow.gov.

For Ohio residents: http://medicaid.ohio.gov/ or http://www.insurekidsnow.gov/state/ohio/

Eligibility for Medicaid Based on Non-Financial Factors

The Marketplace also does a quick screening of anyone who is listed on an application that requests help paying for health insurance coverage to assess if the individual might be eligible for Medicaid based on factors other than MAGI, such as being age 65+, disabled, or needing long-term care services.

If an individual indicates on the application that he or she is age 65+, disabled, or needing long-term care services, or if the Social Security Administration indicates that the individual is disabled, then a Marketplace will complete a regular eligibility determination, but also send the application to the state Medicaid agency to follow up with the individual to see if he or she is interested in pursuing eligibility for non-MAGI Medicaid.

This referral does not affect eligibility for a QHP, the premium tax credit, or cost-sharing reductions. If an individual then is contacted by the state, decides to pursue non-MAGI Medicaid, and is found eligible, advance payments of the premium tax credit or cost-sharing reductions will end because the individual will be enrolled in comprehensive benefits through Medicaid.

The Affordable Care Act, through Medicaid expansion, provides new opportunities for adults in some states (i.e. like Ohio) to be covered by Medicaid. The Affordable Care Act specifies that, as of January 1, 2014, Medicaid may cover all non-elderly, non-pregnant individuals who are ineligible for Medicare and have household income at or below 138% of the FPL.

Regardless of whether a state chooses to expand its Medicaid eligibility, as of January 1, 2014, all state Medicaid programs:

- Use MAGI as the income methodology for the majority of applicants (generally, all non-elderly, non-disabled populations).
- Do not consider assets in determining eligibility for individuals whose financial eligibility is based on MAGI.
- Streamline income-based rules, systems, and verification procedures.

How the Marketplace Determines Eligibility

After an individual submits an application for coverage to a Marketplace, if no additional verification is required, the Marketplace provides an immediate eligibility determination. If there are inconsistencies and additional verification is required, the Marketplace provides a notice that includes information about next steps, including an identification of the inconsistencies that need to be resolved and instructions for how to resolve them.

- Electronically submitted applications generally are processed immediately upon submission.
- Mailed applications take longer to process.

If an individual is determined eligible for enrollment in a QHP through the Marketplace, he or she then may select a QHP to initiate enrollment. If an individual is assessed as potentially eligible or determined eligible for Medicaid or CHIP, the Marketplace provides a notification, and transfers his or her information to the state Medicaid or CHIP agency for follow-up. Please note that families may be covered by different plans if certain family members qualify for Medicaid or CHIP. For instance, parents that qualify for an insurance affordability program such as the premium tax credit or a cost-sharing reduction may be on different plan from their children if the children qualify for CHIP.

Individuals who are determined eligible for Medicaid are eligible for benefits on or before the date of application. Individuals who are determined eligible for CHIP will generally be eligible for benefits on the first of the following month.

Individuals Who are Eligible for Government-Sponsored Coverage

An individual who completes an application by visiting HealthCare.gov may learn that he or she is eligible for other government-sponsored coverage such as Medicaid/CHIP, Medicare, or TRICARE.

Medicaid/CHIP

If an individual is determined to be eligible for Medicaid or CHIP, that individual should contact his or her state Medicaid/CHIP office. While individuals who are eligible for Medicaid and CHIP may enroll in a QHP available through a Marketplace, it is likely not in the person's financial best interests to do so since they would not be eligible to receive either the premium tax credit or cost-sharing reductions and would be required to pay full premiums.

Note: The Marketplaces do NOT determine eligibility for Medicare or TRICARE.

Medicare

Medicare is a health insurance program for,

- People age 65 or older.
- People under age 65 with certain disabilities.
- People of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).
- Medicare-eligible individuals should visit: http://www.medicare.gov/ for more information about this program.

TRICARE

- TRICARE is a health care program serving Uniformed Service members, retirees and their families worldwide. For more information about this program individuals should visit: http://www.tricare.mil/.

How the Individual Marketplaces Determine Eligibility

The following phases illustrate the process of how the Marketplace will determine eligibility.

- Application - Single Streamlined Application. Agents and brokers may assist consumers in submitting online applications.
- Eligibility Determination - For QHP alone or QHP and insurance affordability programs
- Verification - Assurance of Correct Data
- Notification - Notify Applicant and Transmit Information. The Marketplace must transfer any applicant assessed or determined eligible for Medicaid or CHIP to the applicable state Medicaid or CHIP agency. The agency will follow up for plan/delivery system selection (in a determination state) or with final eligibility results (in an assessment state).

Appealing an Eligibility Decision

If an individual disagrees with the eligibility determination, he or she may appeal the decision. Individuals can appeal any aspect of an eligibility decision, including

- Eligibility for Marketplace coverage.
- Eligibility to enroll in a Marketplace QHP outside the open enrollment period.
- Eligibility for insurance affordability programs and the amount of advance payments of the premium tax credit or level of cost-sharing reductions.
- Eligibility for Medicaid or CHIP.
- Eligibility for an exemption for the individual shared responsibility payment.

If a consumer wishes to file an appeal, he or she can do that by logging into his or her account at HealthCare.gov or by mailing in the appropriate appeal request form, which can be found at HealthCare.gov.

Also, if an individual in a determination state (i.e. a state where the Marketplace makes final eligibility determinations for Medicaid and CHIP) is not assessed as potentially eligible for Medicaid or CHIP and would like reconsideration, he or she can also ask for a “full determination” from the state agency. The option to select this is on the Eligibility Results page on HealthCare.gov. If an individual selects this option, his or her application will be transferred to the state for a final decision. If the Marketplace said that he or she was eligible for enrollment in a QHP through the Marketplace and advance payments of the premium tax credit or cost-sharing reductions, he or she can enroll in a Marketplace plan with advance payments of the premium tax credit or cost-sharing reductions pending the state’s decision.

Part 4: 2015 Enrollment Periods

Enrollment Periods

After their eligibility has been determined, individuals may enroll in a QHP during two timeframes throughout the year: the **open enrollment period**, and **special enrollment periods** (SEP).

- The annual open enrollment period for plan year 2015 is between November 15, 2014 and February 15, 2015.
- SEPs occur throughout the year, based on individuals' special circumstances.

The Marketplaces send an annual open enrollment notice to each enrollee during the fall to inform enrollees of the upcoming open enrollment period.

Open Enrollment and Renewing Coverage

Open Enrollment Renewal

As of January 1, 2014, the Marketplaces must annually re-determine the eligibility of each qualified individual who was previously determined eligible for enrollment in a QHP. This eligibility redetermination occurs in advance of the open enrollment period.

Please refer to 45 CFR § 155.335 for details regarding the annual redetermination process. http://www.gpo.gov/fdsys/pkg/FR-2013-01-22/pdf/2013-00659.pdf

Special Enrollment Periods & Triggering Events

Under certain circumstances, individuals may enroll in a QHP or change QHPs outside of the annual open enrollment period. These SEPs are based on certain triggering events or special circumstances.

Events that permit an SEP include:

- Gaining or becoming a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care.
- Gaining status as a citizen, national, or lawfully present individual.
- Loss of coverage (e.g., loss of Medicaid eligibility, QHP no longer available), except if enrollment is terminated based on failure to pay premiums, fraud, or enrollee initiated termination.
- Determination that an individual is newly eligible or ineligible for advance payments of the premium tax credit or a change in eligibility for cost-sharing reductions.
- Permanent move to an area where different QHPs are available.
- American Indian or Alaskan Native status.
- Misconduct of a Navigator, consumer assister, agent or broker, or insurer customer service representative, or misconduct of a QHP while conducting direct enrollment.
- Errors, contract violations, or other exceptional circumstances identified by the Marketplace.

Most SEPs extend for 60 days from the date of the triggering event. The Marketplace permits consumers to access the SEP for loss of coverage up to 60 days before the anticipated loss date.

In order to apply for an SEP, individuals use the same Marketplace application as for the open enrollment period.

Triggering Events

A number of triggering events allow people to enroll in or switch their Marketplace coverage during an SEP outside the open enrollment period.

For example, people who lose employer-sponsored insurance, or lose Medicaid coverage, can enroll in a QHP through the Marketplaces. Other triggering events include,

- Marriage and the birth or adoption of a child.
- Gaining lawfully present status
- Newly eligible or ineligible for premium tax credit
- Change in eligibility for cost-sharing reductions
- Permanent move
- Native American status (“Indian Rule”)—Individual unable to change plans more than once in a month.

When Coverage Begins for Special Enrollments

In general,

- If plan selection is made before or on the day of the loss of coverage, the coverage effective date is the first day of the month following the loss of coverage.
- If plan selection is made after the day of the loss of coverage, the coverage effective date is the first day of the month following plan selection.
- The coverage effective date is the first day of the month following plan selection.
- The coverage effective date is the date of birth, adoption, placement for adoption, or placement in foster care. The Marketplace may allow the individual or family to choose an effective date of the first day of the month following the date of birth, adoption, placement for adoption, or placement in foster care.
- If event is between the 1st and 15th day of the month, the coverage effective date is the first day of the following month.
- If the event is between the 16th and the last day of the month, the coverage effective date is the first day of the second following month.
- If event is between the 1st and 15th day of the month, the coverage effective date is the first day of the following month.
- If the event is between the 16th and the last day of the month, the coverage effective date is the first day of the second following month.

Special Enrollment Period for Marriage

An SEP exists for marriage. This means that if a qualified individual gets married, the applicant has the chance to either enroll in a QHP for the first time, or make changes to an existing QHP enrollment without waiting for the open enrollment period.

- For marriage, Individual Marketplace coverage begins the 1st of the month following the consumer's QHP selection (e.g., coverage effective date of July 1st if plan selection occurred June 28th).
- The Individual Marketplace would need to be notified and plan selection needs to occur within 60 days of a marriage to enroll or change plans. If the 60-day deadline is missed, applicants must wait until the next open enrollment period, or another SEP, to enroll or change plans.

Special Enrollment Period for Birth or Adoption

An SEP exists for the birth, adoption, placement for adoption, or placement in foster care of a child.

- The effective date of coverage can be the date of the birth, adoption, placement for adoption, or placement in foster care as long as the Individual Marketplace is notified in a timely manner.
- The Individual Marketplace would need to be notified within 60 days of a birth, adoption, placement for adoption, or placement in foster care to enroll applicants or change plans. If the 60-day deadline is missed, applicants must wait until the next open enrollment period, or another SEP, to enroll or change plans.

Determining When Coverage Begins

When enrollments take effect during the Initial Open Enrollment Period, the date that an individual's QHP health insurance coverage takes effect is based on the date the Marketplace receives his or her enrollment selection. The effectuation standards for the open enrollment period are as follows:

- When Enrollment Selection is received - November 15, 2014 to December 15, 2014 the date health insurance coverage begins - January 1, 2015.
- When Enrollment Selection is received - December 16, 2014 to January 15, 2015 the date health insurance coverage begins - February 1, 2015.
- When Enrollment Selection is received - January 16, 2015 to February 15, 2015 the date health insurance coverage begins - March 1, 2015.
- When Enrollment Selection is received on the 1st-15th calendar day of a given month, health insurance coverage begins on the 1st day of the following month.
- When Enrollment Selection is received on the 16th-31st calendar day of a given month, health insurance coverage begins on the 1st day of the second following month.

Consumers can select a later effective date if they want coverage to begin in a later month.

Note that Medicaid and CHIP do not limit the time periods during which an individual can enroll.

Making Changes after Enrollment

Changes Prior to Effective Date

If a qualified individual makes a QHP selection but later selects a new QHP before the coverage effective date, without making any application changes, the Marketplace will automatically cancel the initial QHP

selection as part of the transmission of updated enrollment information to QHP issuers. If any premiums were paid to the initial QHP, the QHP issuer would be responsible for refunding the premium.

- For example, if Jane chooses a QHP by January 15th, her coverage becomes effective on February 1st. She would have until January 31st to change her QHP selection. If she changes her QHP between January 16th and the end of the month, her coverage would then become effective on March 1st.

As the above example shows, consumers generally need to select a QHP by the 15th of the month if they want their coverage to start by the 1st of the following month. If a person enrolls or changes his or her QHP between the 16th and the last day of the month, his or her coverage starts the first day of the second following month.

Making Changes after Enrollment

Changes During the Year

A Marketplace must re-determine a qualified individual's eligibility if it receives and verifies new information (e.g., change of state of residence, death of a covered family member), either from the qualified individual or other sources used for periodic data matching, that affect an individual's eligibility. Qualified individuals must report any changes with respect to eligibility within 30 days, so their eligibility for enrollment in coverage and for insurance affordability programs, if applicable, remains accurate.

There are two ways an individual can report changes that impact his or her eligibility:

- **Online**. The individual can log in to his or her HealthCare.gov account (or create an account). Select application, then select "Report a life change" from the menu on the left.
- **By phone**. The individual can contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

Termination by Enrollee

Enrollees may terminate QHP coverage on their own accord at any time of the year, including as the result of obtaining other minimum essential coverage (e.g., Medicaid, employer-sponsored insurance coverage), after giving appropriate notice to the Marketplace. **However, if a consumer voluntarily terminates QHP coverage outside of an open enrollment period, the consumer may have to wait until the next open enrollment period to choose a new plan, unless he or she qualifies for an SEP.**

When an individual selects a different QHP during an applicable enrollment period, previous QHP coverage ends automatically on the date that new QHP coverage takes effect.

Termination by a Marketplace or QHP

The Marketplaces and QHPs may terminate an enrollee's coverage if the individual:

- Is no longer eligible for coverage in a QHP through a Marketplace.
- Fails to pay premiums, consistent with the three-month minimum grace period requirement.
- Is enrolled in a QHP that is being terminated or decertified and does not select a different QHP during an applicable enrollment period.
- Has obtained coverage based on fraud or an intentional misrepresentation of material fact.

Part 5: Applying for Coverage

How to Apply

The main steps of the Marketplace eligibility and enrollment process are as follows:

1. Individual submits the single, streamlined application.
2. Marketplace verifies information needed to determine eligibility.
3. Marketplace determines eligibility and notifies individual.
4. Eligible individual completes the QHP comparison, selection, and enrollment process.

Agents and brokers may assist consumers throughout the eligibility and enrollment process, including assisting with the application process.

In the Marketplaces, individuals are able to complete a single, web-based, streamlined application to receive an eligibility determination for health insurance coverage and insurance affordability programs (i.e., Medicaid, CHIP, the premium tax credit, and cost-sharing reductions).

There are several ways that a consumer may submit an eligibility application in the Federally-facilitated Marketplaces. When completing the eligibility application and enrolling in health care insurance coverage online at HealthCare.gov, a consumer may use one of two pathways:

- **The Marketplace Pathway**
- **The Direct Enrollment Pathway**

When initiated online, the eligibility and enrollment process should be seamless for consumers. That is, once an eligibility determination is made (regardless of the pathway selected), an eligible consumer will immediately be able to begin shopping online for health insurance coverage during open enrollment or a special enrollment period.

The online version of this application features a dynamic, “smart” process that is tailored based on the applicant’s circumstances, and only asks questions that are relevant to that applicant.

Two other methods that applications may be submitted are by **phone** and **mail.**

- Paper applications, which an individual may submit via mail. Note, however, that agents and brokers may not submit paper applications on behalf of an individual, but an individual may submit a paper application on his or her own behalf. Visit HealthCare.gov to download a paper application and instructions.

- Phone applications, which may be submitted through the Federally Facilitated Marketplace toll-free call center (1-800-318-2596 TTY: 1-855-889-4325). Services are available in 150 languages. In the event that they encounter technical problems when using HealthCare.gov, agents and brokers may conduct a three-way call with the consumer and the call center.

Applications may also be submitted through the state Medicaid or the CHIP portals or call centers.

The Marketplace or Exchange

The major functions of a Marketplace include:

- Certifying health plans to participate in a Marketplace as QHPs.
- Determining individuals' eligibility for enrollment in a QHP.
- Determining individuals' eligibility for the premium tax credit and cost-sharing reductions.
- Determining or assessing individuals' eligibility for enrollment in Medicaid and/or the Children's Health Insurance Program (CHIP).
- Facilitating individuals' enrollment in a QHP.
- Carrying out certain plan oversight functions, including monitoring QHP issuers for continuing compliance with certification requirements.
- Facilitating employers' applications and employee enrollments in coverage through SHOP.

Marketplace Application Checklist

When consumers apply for coverage in the Health Insurance Marketplace, they need to provide some information about their household, including income, any insurance they currently have, and some additional items.

The following checklist helps consumers gather what they need to apply for coverage:

- Social Security Numbers (or document numbers for legal immigrants).
- Employer and income information for every member of the household who needs coverage (for example, from pay stubs or W-2 forms—Wage and Tax Statements).
- Policy numbers for any current health insurance plans covering members of the household.
- Information for every job-based plan the individual or family member is eligible for, regardless of whether or not the individual or family member has chosen to enroll in a job-based plan.

Connecting to the Marketplace

As mentioned above, you can get help from an agent or broker to assist you in the Federally-facilitated Marketplace in two ways, through either the **Marketplace Pathway** or the **Direct Enrollment Pathway**.

Marketplace Pathway

An agent or broker can assist consumers directly via HealthCare.gov using the Marketplace pathway. These are the general steps for the Marketplace Pathway:

1. Consumers must first gather the appropriate documents required to complete the application. The list of information required can be found at: http://www.HealthCare.gov/downloads/MarketplaceApp_Checklist_Generic.pdf.

2. An agent or broker can assist a consumer in creating his or her Marketplace user account if needed, but the consumer or a legally authorized representative must enter his/her own information into the application. The consumer or legally authorized representative must also create his or her own Marketplace username and password and should not share this information with third parties, including agents and brokers. Agents and brokers are not permitted to log in as the consumer, using the consumer's ID and password when assisting consumers using the Marketplace pathway.

3. An agent can then help guide the consumer as he or she completes the eligibility application at HealthCare.gov.

4. In the application, the consumer is prompted to enter the agent's Federally Facilitated Marketplace user ID and NPN on the application to indicate that an agent or broker assisted him or her. Agents should provide this information to the consumer and help ensure that the consumer correctly fills in this information. **(Note: for McCarthy Stevenot Agency, Inc. customers, please call our office 513-891-9888 for this information).**

5. As a part of the process, consumers will receive an eligibility determination. A consumer should print this for his or her records.

6. If determined eligible, the consumer can use the plan-shopping feature at HealthCare.gov. Consumers can compare QHPs at HealthCare.gov and submit their selection.

Direct Enrollment Pathway

Through this pathway, an agent or broker can log onto an agents and brokers landing page available through direct enrollment at HealthCare.gov and can complete an application for the consumer.

Although agents and brokers drive the direct enrollment process to assist consumers with completing their applications, consumers have the ultimate legal responsibility for completing their applications and attesting to the accuracy of the information contained therein.

These are the general steps for the Direct Enrollment Pathway:

1. Agents can work with the consumer to determine whether he or she would like to apply for QHP coverage through the Federally Facilitated Marketplace. If necessary, an agent can visit HealthCare.gov and use the plan landscape and premium estimator to help the consumer determine which QHP would best meet the consumer's needs.

2. Agents can advise the consumer to gather the appropriate documents he or she needs to complete the application.

3. Agents can log on to the issuer's agents and brokers portal and supply agent or broker credentials as required by the issuer.

4. Agents are securely redirected from the issuer's portal to an agents and brokers landing page at HealthCare.gov where they then log into the system. Only issuers that support direct enrollment will be able to facilitate access to the agents and brokers landing page at HealthCare.gov.

5. Agents can assist the consumer in completing the consumer's eligibility application at HealthCare.gov. Please note that the consumer will not set up his/her own Health Insurance Marketplace account username and password through an agent or broker, but can return to HealthCare.gov separately to set up his/her Health Insurance Marketplace account username and password. Although an agent may enter the information on behalf of the consumer, the consumer has the ultimate legal responsibility for completing the application and attesting to the accuracy of the information contained therein.

6. Once the application is completed and the consumer has received his or her eligibility determination from HealthCare.gov, the agent will be securely redirected to the issuer's website. Once back on the issuer's site, the agent or broker can compare and select a QHP with the consumer. Through this process an agent will only be able to help the consumer choose among QHPs offered by that specific issuer.

7. If applicable, the consumer should select the amount of the advance premium tax credit that he or she would like to apply.

8. At this point, if a consumer decides to enroll, the issuer submits the enrollment information to HealthCare.gov. The agent or broker's identifying information will be included in the official Federally Facilitated Marketplace enrollment record sent to the issuer.

Acknowledgement of Qualified Health Plan Selection

When a Marketplace receives a QHP selection from an eligible individual, it promptly notifies the applicable QHP issuer of the requested enrollment and transmits the needed eligibility and enrollment information.

Once a consumer has enrolled in a QHP, he or she must pay the first premium directly to the insurance company – not to the Marketplace. The QHP issuer then provides the enrollee with an enrollment information package.

Insurance companies handle payments differently. Consumers should follow the instructions from their insurers about how and when to make a premium payment and the due date.

How the Marketplace Verifies Applicant Information

To determine eligibility, the Marketplace verifies applicant information using data from key federal agencies and other sources.

In general, the verification process involves validating an applicant's attestation by checking available electronic data from data sources approved by the Department of Health & Human Services (HHS). If there are inconsistencies between the applicant's attestation and the information contained in the approved electronic sources, the application process provides a period of time for the applicant to provide satisfactory documentation or otherwise resolve the issue. At the conclusion of the eligibility verification process, the Marketplace produces a notice that includes a list of any inconsistencies, along with instructions regarding how they can be resolved.

Depending on an individual's specific circumstances, the Marketplace may verify information from the following sources to conduct the verification process:

- Social Security Number (SSN) (Social Security Administration [SSA]). (An individual does not have to provide an SSN if he or she does not have one.)
- Citizenship status (SSA and Department of Homeland Security [DHS]).
- Immigration status (DHS).
- Household size (IRS).
- Household income (IRS, SSA, consumer reporting agency, potentially other sources).
- Access to other coverage (Medicaid, CHIP, Medicare, TRICARE, Department of Veterans Affairs, Peace Corps, other State-based Marketplaces, Small Business Health Options Program (SHOP), and potentially other sources).

If a Marketplace needs additional information regarding SSN, citizenship, or immigration status, it establishes eligibility based on the individual's attestation in those areas for a period of 90 days, during which it will use the individual's attestation to establish eligibility. If the consumer is otherwise eligible for a QHP, the premium tax credit, cost-sharing reductions, Medicaid, or CHIP, during this time, he or she can enroll and obtain coverage. The individual just needs to resolve the issue by the close of the period to continue his or her eligibility for health care coverage.

If a Marketplace needs additional information regarding a criterion of eligibility other than SSN, citizenship, or immigration status, whether it establishes eligibility for health insurance coverage while the inconsistency is resolved depends on what the information that the applicant provided indicates that he or she is eligible for. If the applicant's income and other eligibility information are consistent with eligibility for enrollment in a QHP with or without the premium tax credit, a Marketplace establishes eligibility for enrollment in a QHP, the premium tax credit, and cost-sharing reductions, as applicable, based on the applicant's attestation during the 90-day inconsistency period, as long as the applicant attests that he or she understands that advance payments of the premium tax credit are subject to tax reconciliation. If the applicant's income and other eligibility information are consistent

with eligibility for Medicaid or CHIP, the applicant will not be able to access Medicaid or CHIP until the open verification items are resolved.

The 90-day inconsistency period may be extended if the applicant demonstrates that he or she has made a good faith effort to obtain the required documentation. This can be done through the Marketplace call center. After the inconsistency period expires, the Marketplace issues a final eligibility determination.