Frequently Asked Questions about Healthcare Reform

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PURPOSE

This document is designed for state insurance departments to use as they give answers to frequently asked questions (FAQs) and guide consumers about their healthcare choices. This document reflects regulations and guidance received from the federal government as of July 2014 and is subject to change.

States will need to modify this document to include state-specific information and terminology. Much of the information that will vary by state is bracketed. While every effort has been made to use plain language in this FAQ, this document isn’t intended to be given directly to consumers. While some sections may be useful for direct-to-consumer communications, the document’s primary purpose is to give insurance department staff accurate and understandable information to use when they respond to consumer questions about healthcare reform.

Note that the ACA and related regulations refer to “exchanges” that operate in the states, while federal guidance documents refer to those exchanges as “marketplaces.” This document uses the term “exchanges.” However, some states may decide to follow federal guidance and use the term “marketplaces.”

Note, also, that states will need to modify this FAQ if the state has combined the exchange for individuals and families with the small business health options program (SHOP) exchange.

HEALTH CARE REFORM OVERVIEW

Health care has changed in many ways as a result of the passage and implementation of the Patient Protection and Affordable Care Act, Public Law 111-148 (PPACA), and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152. These two laws are collectively known as the federal Affordable Care Act (ACA).

Q 1: When did the ACA take effect?

The ACA was enacted on March 23, 2010. While some reforms were made quickly, others are still being implemented. It will take five years for all of the health insurance reforms adopted as part of the ACA to be fully implemented.

Q 2: What changes have taken place?

Several changes took place prior to Jan. 1, 2014:

- Lifetime dollar limits on essential health benefits aren’t allowed. Annual dollar limits on essential health benefits were also phased out by Jan. 1, 2014.
- Insurers can’t deny coverage to children younger than 19 years old because of a pre-existing condition.
- Nearly all adult children up to age 26 are eligible to remain on a parent’s health insurance policy, regardless of the child’s marital status, financial dependency, enrollment in school, or place of residence.
- Insurers must cover certain preventive services without cost sharing. There can be no cost-sharing for preventive services (see Question 234).
- Consumers have more access to information about proposed rate changes.
- Medical loss ratio standards limit how much of premium dollars insurers can spend on administrative expenses.
- Small businesses that provide health care for employees can apply for a tax credit.
Persons with Medicare prescription drug coverage receive a rebate to help cover the cost of the “donut hole.” This “donut hole” should be totally phased out by 2020.

A number of major changes took place in the non-grandfathered individual and small group plans sold or renewed on or after Jan. 1, 2014:

- Plans must include new consumer protections. Health insurers no longer can deny or refuse to renew coverage because of a pre-existing medical condition. They also can’t charge a higher premium due to a person’s gender or health condition.
- Insurers must cover routine medical costs if a person participates in a clinical trial for cancer or other life-threatening diseases. Insurance plans also can’t put annual dollar limits on essential health benefits.
- Most individuals who can afford it must have basic health insurance coverage, referred to in the ACA as “minimum essential coverage.”
- Exchanges began enrollment on Oct. 1, 2013 in every state.
- Individuals and families under 400% of the federal poverty level who need help affording coverage will have access to financial assistance when they shop in the new health insurance exchanges.

[Note: 1) plans sold before March 23, 2010 that have had no significant changes are considered “grandfathered” and are not required to comply with many of these requirements – see Question (on grandfathering); 2) plans sold before January 1, 2014, may – if allowed by the state – continued to be renewed through policy years beginning on or before October 1, 2016, without coming into compliance with certain reforms – see QXX (on transition policy).]

Q 34: Where can a person find more information about the ACA, including detailed timeline information?

For more general and detailed information about the ACA and its key provisions, visit the federal government’s website at www.healthcare.gov or marketplace.cms.gov or call 1-800-318-2596 (TTY: 1-855-889-4325).

For information about implementation of the ACA in [insert name of state], contact [insert name of state exchange] at [email address] or xxx-xxx-xxxxx

There are also a number of other helpful sites and resources for more information about the ACA, including: Kaiser Family Foundation (www.kff.org); Commonwealth Fund (www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx); and The Robert Wood Johnson Foundation (www.rwjf.org); and the Georgetown center on Health Insurance Reforms (http://chir.georgetown.edu/projects-pubs).

EXCHANGE BASICS

Q 45: What is the [insert name of state health insurance exchange]? (For questions about the [insert name of state SHOP exchange], see Questions 3368-3449.)

The [insert name of state exchange] is the name of [insert name of state]’s health insurance exchange. The ACA created health insurance exchanges as places where individuals, families, and small employers can compare private health insurance plans and shop for coverage. Exchanges also provide access to a new type of tax credit to help lower and middle-income individuals pay for coverage (see Questions 2803-2820). Through exchanges, lower-income individuals can qualify for help to lower their out-of-pocket costs (deductibles, coinsurance, or copayments) when they receive health care services. Insurers may sell plans through the exchange as well as in the market outside the exchange. Premium tax credits and cost-sharing reductions are not available for plans outside the exchange.

Drafting Note: States that have no market will not be allowing insurers to sell plans outside the exchange should modify the previous paragraph accordingly. States should note, however, that some individuals such as incarcerated individuals and undocumented immigrants not legally present cannot be denied coverage on the basis of health status even though they will not be able to purchase coverage through the exchange (see Questions 135-145).

1 In [insert name of state], the exchange for individuals and families is called [insert name of state exchange] and the exchange for small employers is called [insert name of state small business health options program (SHOP) exchange].
To learn more, or to apply for coverage through the [insert name of state exchange], individuals and families should visit the website for the [insert name of state exchange] at [insert link to state exchange website]. For more general information about health insurance exchanges, visit the federal government’s website https://www.healthcare.gov/what-is-the-health-insurance-marketplace.

Q 56: Are there different types of health insurance exchanges?

While the basic features of exchanges are the same in all of the states, the ACA allows for differences in who operates them. Some exchange operation options include the federal government operating the exchange, the state operating the exchange, and a partnership between the federal government and state working together to operate the exchange. As the ACA continues to be finalized and implemented, variations to the operation of exchange continue to be discussed. Please contact [insert state consumer affairs contact information] for how your state’s exchange is operated.

Q 62: What is the Multi-State Plan Program?

Under the ACA, there is a program called the Multi-State Plan Program (MSP) Program is administered by the U.S. Office of Personnel Management (OPM). The MSP program is designed to increase the plan choices available through the [insert name of state exchange]. Multi-State Plan options may not be available through the exchange in every state, yet within four years there will be at least two in every state. Now, in 2015, there are [insert number] MSP options available through the [insert name of state exchange]. OPM, which also administers the program that provides health insurance to Federal government employees, retirees, and their dependents, will contract with private insurance companies to offer MSP options on the state exchanges. MSP options are generally subject to all state and federal laws, and may also be required to comply with additional OPM requirements. More information about the MSP Program is available on OPM’s website: http://www.opm.gov/healthcare-insurance/multi-state-plan-program/

Drafting Note: States phasing in MSP options will need to modify this answer accordingly.

Q 78: What is a CO-OP plan?

CO-OP stands for Consumer Operated and Oriented Plan, which is a new type of health insurer. The ACA gave low interest loans to private organizations to create a new type of non-profit insurer designed to increase the plan choices available through the state exchanges. Any profits earned by CO-OPs must be applied to either lower premiums or expand benefits for customers. The federal Center for Insurance Information and Insurance Oversight (CCIIO) in the U.S. Department of Health and Human Services (HHS) maintains oversight of the CO-OPs. CO-OPs also must be governed by their members (or customers) and are required to offer plans through their respective states’ exchanges.

In [insert name of state], the [insert name of CO-OP] is the CO-OP available through the [insert name of state exchange].

To find out more about the CO-OP program, please visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Insurance-Programs/Consumer-Operated-and-Oriented-Plan-Program.html.

Drafting Note: States should modify or eliminate this question if there are not any CO-OPs in the state.

Q 89: If a person lives in one state but works in another, to which state’s exchange should they apply?

If a consumer doesn’t have access to coverage through their employer (or their spouse’s employer), they should apply for coverage in the state where they live.

Q 910: Who can buy a plan through the [insert name of state exchange]?

In [insert name of state], any individual or family who wants may buy coverage through the [insert name of state exchange]. The only people who can’t are people not legally in the United States (see Question 123), people who are incarcerated (other than pending disposition of charges) (see Question 124) and people on Medicare (see Question 851).

Small employers (employers with fewer than [XX] employees) may buy health insurance for their employees through the [insert name of state SHOP Exchange] (For more information about the [insert name of state SHOP exchange], see Questions 3473-3479).
Q 101: When are consumers able to enroll in plans through the [insert name of state exchange]?

In [insert name of state], open enrollment in [insert name of state exchange] for 2015 coverage for individuals and families begins Nov. 15, 2014 and continues through Feb. 15, 2015. Coverage will be effective on either the first day of the following month – if a consumer enrolls by the 15th of the month - or the first day of the second following month, if a consumer enrolls after the 15th of the month. During open enrollment, consumers will be able to change plans, change insurance companies or stay with the plan they have, if it’s still available.

Consumers who miss open enrollment may be eligible to enroll in coverage at times other than during the open enrollment period. There are special enrollment periods for individuals or families if they experience a “triggering event.” Some examples of triggering events include: (1) loss of minimum essential coverage for an individual or their dependent; (2) gaining or becoming a dependent; (3) newly gaining citizenship; and (4) being enrolled in a plan through the exchange without tax credits and then becoming newly eligible for tax credits (see Questions 79-80). The federal website https://www.healthcare.gov/how-can-i-get-coverage-outside-of-open-enrollment/#part=1 lists possible options for consumers to obtain coverage outside an open enrollment period.

Consumers can apply for coverage through [insert name of state exchange] any time during the year, regardless of whether it’s an enrollment period or not. The [insert name of state exchange] will process the application and tell the consumer whether or not they can enroll or must wait until the next open enrollment period. Contact the [insert name of state exchange] at [insert website] or [insert phone number] for information about whether a consumer might be eligible to enroll in coverage through the [insert name of state exchange] during a special enrollment period. People who are eligible for Medicaid and CHIP can apply and enroll in [insert name of state Medicaid agency] at any time.

Q 121: How can a consumer prepare to enroll in a plan through the [insert name of state exchange]?

The federal website https://www.healthcare.gov/how-can-i-get-ready-to-enroll-in-the-marketplace has suggestions for things consumers should be thinking about to prepare to enroll in a plan through the exchange. The [insert name of state department of insurance] website at [insert website] has helpful information for consumers who are thinking about enrolling in a plan through the [insert name of state exchange].

Consumers can start gathering basic information about household income, such as their most recent tax return if they filed one, or other income information. Many people will qualify for financial help to make insurance affordable, and consumers will need income information to find out how much help they are eligible for. Consumers can find more information about how to save money on coverage at https://www.healthcare.gov/how-can-i-save-money-on-marketplace-coverage/.

SHOPPING FOR HEALTH INSURANCE COVERAGE: WHAT IS COVERED?

Q 123: What types of plans will be available through the [insert name of state exchange]?

Health plans sold through the [insert name of state exchange] will be required to meet comprehensive standards for items and services that must be covered (see Question 16). To help consumers compare costs, plans available through the [insert name of state exchange] will be organized in four tiers, or four levels of generosity of the plans’ cost-sharing:

- **Bronze level** – The plan must cover 60% of expected costs across a standard population. This is the lowest level of coverage.
- **Silver level** – The plan must cover 70% of expected costs across a standard population.
- **Gold level** – The plan must cover 80% of expected costs across a standard population.
- **Platinum level** – The plan must cover 90% of expected costs across a standard population. This is the highest level of coverage.

In addition, a **catastrophic plan** will be offered, and will cover the same services but its coverage will be slightly less generous than the Bronze level plans. Also, beginning in 2015, catastrophic plans cannot be used with Health Savings Accounts. A catastrophic plan may be a less expensive option for those who are eligible: only **young-adult individuals** under...
age 30 and individuals who have a hardship exemption from the individual mandate or cannot afford other coverage are allowed to buy catastrophic plans. If a person has their plan cancelled and can’t afford replacement coverage, they may apply for a hardship exemption and buy a catastrophic plan. Premium tax credits and cost-sharing reductions aren’t available for catastrophic plans.

Stand-alone dental plans are available through the [insert name of state exchange] (see Question 25).

Q 143: How do the tiers (bronze, silver, gold and platinum) help consumers compare plans?

The tiers are a way to categorize plans based on “actuarial value.” Plans within each tier have a similar actuarial value, even if they cover different benefits or have different types of cost-sharing. While all plans in a tier must cover essential health benefits (see Question 145), the details of their coverage (such as how many physical therapy visits are covered or which prescription drugs are covered) may be different. Not all plans in the same tier have the same benefits or cost-sharing requirements. Some plans may offer benefits in addition to the essential health benefits.

Q 145: What is actuarial value?

Actuarial value measures the percentage of total overall health care costs for the essential health benefits covered by a plan. This is the average share of medical spending that the plan pays, measured across a standard population. The percentage of total average costs the plan pays depends on the cost-sharing details – how much out-of-pocket the consumer pays for deductibles, coinsurance, and copayments and the out-of-pocket limits.

Actuarial value is calculated for a standard population and doesn’t mean that the plan will pay that percentage of a given person’s actual costs. For instance, a silver tier plan will pay more than 70% of covered medical expenses for some people and less than 70% for other people.

Actuarial value only reflects differences in cost-sharing. It doesn’t give any other information about a plan that may be important to a particular person or affect their costs. It doesn’t tell you how broad or narrow a plan’s provider network is, the quality of the provider network, about the plan’s customer service and support, how broad or narrow the drug formulary is, or the premium levels. All of this information is important for consumers to consider when they choose a plan.

See https://www.healthcare.gov/how-do-i-choose-marketplace-insurance/#part=1 for more consumer information for consumers about choosing a plan.

Q 156: What services/benefits must plans cover? What are essential health benefits?

After Jan. 1, 2014, almost all plans sold in the individual and small group market, including those sold through the [insert name of state exchange] and [insert name of state SHOP exchange], as well as plans sold in the market outside the exchange, must cover, at a minimum, a comprehensive set of benefits known as essential health benefits. These essential health benefits include the following:

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

“Grandfathered” and “transitional” plans sold in the individual and small group markets before January 1, 2014, may are not required to include Essential Health Benefits and may still be considered Minimum Essential Coverage that meets the individual mandate. For more information on these plans see Questions 29 and 31.
Q 162: What insurance companies will offer coverage through the [insert name of state exchange]? How can I get a list of companies and plans available?

There are listings of the health plans available through the [insert name of state exchange] and the [insert name of state SHOP exchange] on their websites: [Insert links to state exchange website and state SHOP exchange website]. People without access to the Internet can call the customer service line for the [insert name of state exchange] at [insert phone number], and for the [insert name of state SHOP exchange] at [insert phone number], or get help from an agent, broker, or other type of assistor (see Question §261).

Q 178: How can a consumer find out the details about what a particular plan covers?

All individual and small group plans offered after Jan. 1, 2014, will cover essential health benefits (see Question 15), except grandfathered and transitional plans. (see Questions §629-31).

To learn if a specific benefit is covered, and at what level, check a plan’s Summary of Benefits and Coverage (SBC). An SBC is a uniform document that includes details about what a plan does and doesn’t cover. It also includes information about what kinds of costs a consumer can expect to pay out-of-pocket, such as copayments, coinsurance, and deductibles. An SBC comes with plans offered through the exchange and in the market outside the exchange. It gives information in the same way for every plan to make it easier to compare plans. The SBC forms are on the federal government’s website at www.healthcare.gov, the [insert name of state exchange] website at [insert link], or from an agent or broker for plans offered in the market outside the exchange.

It should be noted, the SBC provides a summary of the benefits. More detailed information may be available through the insurer or an insurance agent or broker.

The [insert name of state exchange] website at [insert link] includes information about what each plan covers and links to the insurer’s plan brochures.


Q 189: How can consumers compare benefits and understand what a plan covers?

In addition to getting an SBC (see Question §548) consumers can get information about the health plan options available in their state online at the [insert name of state exchange] website at [insert link], through the [insert name of state exchange]’s toll-free telephone number, or from navigators or consumer assistants. To find those that can assist you in your area, you can go to “Find Local Help” at: https://localhelp.healthcare.gov/

Q 192: How can consumers see and compare prices for plans?

The [insert name of state exchange] is set up to let consumers compare policies on the basis of price, provider network, actuarial value, and other factors. In addition to premium costs, consumers should look at all the benefits and cost-sharing provisions when choosing a plan since, in addition to the premium costs, plans with the lowest premium often have the highest out of pocket costs.

Consumers can get this information from the [insert name of state exchange] website at [insert link] or call center at [insert phone number]. Also, navigators, certified application counselors, insurance agents or brokers, or other assistants, should be able to help consumers compare plans.
Consumers won’t be able to see the cost of a specific service or benefit unless a stand-alone plan provides that service or benefit. An example of a stand-alone plan is an adult dental plan. Check the [insert name of state exchange] website at [insert link] for additional information.

Drafting Note: States that allow stand-alone vision plans to be sold through the exchange should modify this answer to include stand-alone vision plans.

Q 204: Can a person take benefits out of a plan? What if a consumer doesn’t need all of the benefits in a plan?

No, consumers can’t take benefits out of a plan, but they may be able to add extra coverage. At a minimum, every health plan on the [insert name of state exchange] must provide coverage for all of the essential health benefits the ACA requires (see Question 1435). Even though a person may not need every benefit in a plan, plans must cover all of the essential benefits to share risk across a broad pool of consumers and be sure all benefits are available for everyone. This also helps to protect people from risks they can’t always predict across their lifetimes.

There may be short-term plans or limited benefit plans available, but they do not provide “minimum essential coverage” required to meet the individual mandate. Consumers who don’t have a plan that provides minimum essential coverage may have to pay a penalty when they file their income taxes. (See Question 2453.)

Q 212: Can a person’s health condition affect their coverage?

No. Under the ACA, health insurance companies no longer can limit coverage based on a person’s health condition, often called “pre-existing condition exclusions.” Nor can they charge a higher premium because of a person’s health condition. These protections apply whether a person buys coverage through the exchange or outside the exchange.

Q 223: Can an insurance company charge smokers tobacco users more than non-smokers tobacco users?

Under the ACA, health insurance companies in the individual and small group markets can charge consumers who use tobacco products a higher premium (within a ratio of 1.5:1). Consumers in group plans may not have to pay this extra charge if they complete a tobacco cessation program.

Drafting note: States that don’t allow the tobacco surcharge should replace the previous paragraph with the following one: in [insert name of state], health insurance companies can’t charge consumers a higher premium for being a tobacco user.

Q 243: What are preventive benefits and how are they covered?

Preventive benefits are designed to keep people healthy by providing screening for early detection of certain health conditions or to help prevent illnesses. The ACA requires that plans cover many preventive services with no out-of-pocket costs (meaning no deductibles, co-payments, and coinsurance) for all new plans beginning Sept. 23, 2010. Some of these covered preventive services are:

- Colorectal cancer screenings, including polyp removal for individuals over age 50
- Immunizations and vaccines for adults and children
- Counseling to help adults stop smoking
- Well-woman checkups, as well as mammograms and cervical cancer screenings
- Well-baby and well-child exams for children

Unless an insurer doesn’t have an in-network provider to do a particular preventive service, plans can charge for these preventive services when done by an out-of-network provider.

For more detailed information about covered preventive services, visit the federal government’s website at: https://www.healthcare.gov/what-are-my-preventive-care-benefits.

Q 254: Are dental or vision benefits available through the [insert name of state exchange]?
The ACA requires plans sold through the [insert name of state exchange] to include vision coverage for children, but there’s no process to offer a stand-alone vision plan through the [insert name of state exchange]. Dental benefits are treated differently. The ACA lets insurance companies offer health plans through the [insert name of state exchange] that don’t include children’s dental benefits, so long as the [insert name of state exchange] offers a stand-alone dental plan that includes a pediatric dental benefit.

Plans offered through the [insert name of state exchange] aren’t required to include dental or vision coverage for adults, but a plan can choose to include these benefits as part of their coverage. Check a plan’s SBC to learn if the plan includes dental or vision coverage for adults.

Some insurance companies may offer stand-alone dental plans through the [insert name of state exchange]. Check the [insert name of state exchange] website at [insert link] for more information. As long as a consumer has minimum essential health coverage, that consumer isn’t required to buy health insurance coverage from a company if he or she simply wants to buy a stand-alone dental plan.

**Drafting Note:** States where consumers will need to purchase health coverage before progressing to the dental section should modify the preceding sentence as appropriate.

Check the federal website www.healthcare.gov for more information about dental benefits.

**Drafting Note:** States that allow people with Medicare to buy dental plans through the exchange should include this information in this answer.

**Drafting Note:** States that allow stand-alone vision plans to be sold through the exchange should modify the answer to this question as appropriate.

Q265: How does a consumer find out what drugs a plan covers?

Health insurers keep lists of which drugs are covered and which are covered at the lowest cost for each of their plans. These lists are called formularies. Drug cost-sharing is often “tiered,” that is, consumers pay less for a generic drug, more for a brand name drug, and sometimes even more for a non-preferred brand name drug. Consumers should request formularies from insurers and review the formularies in any plan they are considering to be sure the plan meets their prescription drug needs and to know what cost sharing is required for any given drug. For plans that use formularies, the SBC includes an internet address (or similar contact information) to obtain information about the plan’s drug coverage. Consumers also can call their health insurer for help.

Formulary information is also available on [insert name of state exchange] website.

**Drafting Note:** States should include their rules regarding whether the insurance company can change the formulary or tiering after the consumer has purchased the plan.

Q267: What are out-of-network services and do consumers have any coverage for them?

Services are considered out-of-network if they’re from a doctor, hospital, or other provider that doesn’t have a contractual relationship with a particular health plan. Not all plans cover out-of-network services, but when they do, a consumer’s share of the cost is usually a lot higher than for an in-network service (see Question 2423 regarding preventive services and Question 2228 regarding emergency services). Consumers may want to find out whether a provider is in-network before they receive services. Consumers also may want to find out if their regular or desired health care providers are in-network before they buy a plan. Additionally, different plans offered by the same insurer may have different provider networks, so consumers should be careful to look at the network for their specific plan.

Though the ACA limits how much money a person is required to spend each year on his or her family’s health care, health insurers are not required by federal law to count cost of out-of-network services towards these limits, although health plans insurers are permitted to count out-of-network costs towards the out-of-pocket costs.

A plan’s SBC will include information about coverage for out-of-network services.
Q 278: How do consumers determine if their doctor or dentist is in the network?

The [insert name of state exchange] and the [insert name of state SHOP exchange] websites (at [insert websites]) let consumers look up whether or not their doctor is in the network plan. For plans with a provider network, the SBC includes an internet address or (similar contact information) for getting a list of network providers. Because plan networks may change regularly, it’s always a good idea to also check with the doctor or dentist before you schedule an appointment to learn if the information on the website is up to date.

Q 298: Do consumers have access to emergency care out-of-network?

Yes, the ACA requires any health plan that provides benefits for emergency services to cover them regardless of whether the provider is in or out of the network. Under the ACA, health plans aren’t allowed to charge a higher copayment or coinsurance for out of network services received in an emergency. In addition, [Insert name of state] prohibits balance billing for emergency care received out-of-network, meaning only in-network rates will apply for all emergency care.

Drafting Note: States that allow health care providers to balance bill for emergency care received out-of-network should replace the previous paragraph with the following:

Yes, the ACA requires any health plan that provides benefits for emergency services to cover them whether the provider is in or out of the network. While health plans aren’t allowed to charge a higher copayment or coinsurance for out-of-network services received in an emergency, [Insert state name] allows health care providers to bill consumers for the difference between the cost of emergency care received out-of-network and what the cost of that emergency care would have been in-network, amount the plan allows. For more information about [insert name of state]’s rules on balance billing, please contact [insert specific state contact information].

Q 2930: What is a “grandfathered” health plan?

A grandfathered health plan is a plan that has existed continuously since before March 23, 2010 without and that has not made certain significant changes in the plan. Grandfathered plans aren’t subject to many of the ACA requirements, such as the requirement that plans cover essential health benefits (see Question 16), but are considered to provide minimum essential coverage under the ACA (see Question 56).

Grandfathered plans that make certain changes, such as major increases in their cost-sharing, (such as coinsurance, deductibles, copayments) or eliminating benefits to diagnose or treat a particular condition may lose grandfathered status and then would have to follow the applicable ACA requirements. Employer-sponsored plans that significantly raise the employee share of the premium also could lose grandfathered status.

In the individual market, a consumer cannot enroll in a grandfathered plan with a new enrollment. Only consumers that were enrolled in an individual plan as of March 23, 2010 can re-enroll into that grandfathered plan.

A plan must indicate in the plan materials if it’s a grandfathered plan. Also, consumers can check with their insurance company or employer.

Q 30XX: My plan is not grandfathered but it does not comply with the ACA’s requirements. Can I still keep it?

It depends. In Nov. 2013, the Obama Administration announced a transitional policy that would permit certain policyholders to keep their 2013 coverage for another year even if the plan did not comply with certain ACA reforms. In March 2014, the Administration extended this transitional policy for two years, until policy years beginning on or before Oct. 1, 2016. These transitional plans may not be sold on or off the Exchange to new customers after January 1, 2014 and are not eligible for subsidies. Plans that provide this option will provide notice to affected individuals and small businesses. Check with your insurance carrier to see if they will be renewing these plans and what changes, if any, they will be making to the plans.

Q: 31XX: Can I keep my fixed indemnity plan?
Maybe. Fixed indemnity plans are plans that pay a flat dollar amount for services regardless of the cost of the service. These plans are not considered minimum essential coverage and, beginning January 1, 2015, anyone purchasing fixed indemnity coverage must attest during the application process that they have another source of minimum essential coverage. Those who purchased plans before January 1, 2015, must make a one-time attestation that they have another source of minimum essential coverage when the plan is first renewed after October 1, 2016.

EMPLOYER-SPONSORED COVERAGE

Q 312: Is employer-based coverage required to cover dependents (spouses and children)?

Under the ACA, if an employer with 50 or more employees doesn’t offer coverage that meets minimum standards to employees and their dependents and employees access premium tax credits through the exchange, the employer may have to pay a tax penalty (see Questions 49 and 50). However, for purposes of this penalty, the IRS has interpreted the phrase “and their dependents” to mean children under age 26, but not spouses. For more information, see http://www.irs.gov/uac/Newroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act Small employers with fewer than 50 employees aren’t required to offer coverage to employees or their dependents (see Question 4851). Also, if employer-based coverage includes children, the ACA requires the employer to let children up to age 26 stay on their parent’s policy. Adult children up to age 26 can stay on their parent’s policy whether or not they live in the parent’s home, are married, or the parent no longer claims them as a dependent on their tax return. The employee can be required to pay for this coverage, however.

Q 323: What can a consumer do when employer-based health coverage ends?

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), a federal health law since 1986, when an employee and his or her dependents lose employer-based coverage they’re still eligible to stay on their employer’s group health plan, even though that coverage would otherwise end. COBRA doesn’t apply to employers with fewer than 20 employees [insert state mini-COBRA law information if applicable].

However, COBRA coverage can be expensive, since the former employer isn’t required to pay any part of the premium. Those who have lost employer-based health coverage may be eligible to access new tax credits to buy a more affordable individual or family policy through the [insert name of state exchange] even if the loss of coverage occurs outside of the open enrollment period. Consumers enrolled in COBRA cannot qualify for advance premium tax credits. Dropping COBRA coverage outside of an open enrollment period will not qualify as a special enrollment opportunity.

Q 34XX: Must a consumer exhaust all available COBRA coverage before purchasing coverage on through the Exchange with subsidies?

No. COBRA allows group health plan participants and beneficiaries to continue coverage under their group health plan for a limited period of time after certain events cause a loss of coverage, such as voluntary or involuntary job loss, reduction in the number of hours worked, transition between jobs, death, and divorce. If an individual loses eligibility for minimum essential coverage, including employment-based coverage, he or she will be eligible for a special enrollment period during which he or she can purchase coverage on the [insert name of state exchange] or in the individual market outside of it. At this time, the individual may also apply for advance premium tax credits and cost-sharing reductions through [insert name of state exchange] to see if he or she is eligible to receive them. However, if an individual has already enrolled in COBRA coverage, however, he or she must wait until the next open enrollment period or until that COBRA coverage has been exhausted before enrolling in an individual market plan.

Q 353: If a consumer has access to employer-based coverage, can an employer make the consumer wait before becoming eligible for benefits?

Yes, employers may require a waiting period before individuals become eligible for benefits. Under the ACA, this waiting period can’t be longer than 90 days. In addition, employers also may impose an additional one-month orientation period before the waiting period begins. For more information, contact your employer’s human resources department or review the health plan’s SBC.
Q 364: Can a consumer with access to employer-based coverage get a tax credit to buy a plan through the [insert name of state exchange]?

A consumer who has access to employer-based coverage is free to buy a plan through the [insert name of state exchange]. But tax credits to buy the coverage are available only if the employer’s plan isn’t affordable or doesn’t provide minimum value. If a consumer has access to employer-sponsored coverage that is affordable and provides minimum value, the consumer will not be able to get tax credits and cost-sharing reductions.

Coverage isn’t affordable if the cost of employee-only coverage under the employer plan costs the employee more than 9.56% of the employee’s annual household income. The plan doesn’t provide minimum value if it pays for less than 60% of medical costs that the plan covers. HHS and IRS have developed a minimum value calculator at www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mv-calculator-final-4-11-2013.xlsm.

An employer must provide a consumer with a minimum value notice stating whether the plan is above or below the 60% threshold. Consumers will receive this information from their employer together with the SBC document when you’re shopping for coverage through the [insert name of state exchange].


Q 375: If a consumer has employer-based coverage, can that consumer’s spouse get a tax credit to buy coverage through the exchange?

If the spouse can enroll in the consumer’s employer-based plan, and the plan meets the standards for adequacy (including that the premium to cover only the employee is less than or equal to 9.56% of household income), the spouse isn’t eligible for the tax credit (see Question 34). Contact the [insert name of state exchange] to learn more.

Q 386: What is the [insert name of state SHOP Exchange]?

Under the ACA, states may create Small Business Health Options Program (SHOP) exchanges, where small employers who want to offer coverage to their employees can shop for plans. In [insert name of state], the SHOP exchange is called the [insert name of state SHOP exchange]. In 2014, under the [insert name of state SHOP exchange], employers decided the plan or plans from which employees chose their coverage.

The ACA calls for “employee choice” in the SHOP exchanges. Under this provision, small employers may choose to give their employees a choice of health plans from multiple insurers on the SHOP exchange. However, employee choice will be phased in gradually, and in 2015 the range of employee choice will vary from state to state. When employee choice is available on [insert date], employers will get a single aggregated bill for all their employees regardless of how many different insurers’ plans employees choose. In [insert name of state], employee choice will be/will not be implemented in 2015.

There’s more information about the [insert name of state SHOP exchange] at [insert link to state SHOP exchange website]. There are resources for information about small employer issues and the ACA on the following websites:

http://healthcare.gov/small-businesses

IRS Affordable Care Act News Releases, Multimedia and Legal Guidance

U.S. Department of Labor Patient Protection and Affordable Care Act Information
http://www.dol.gov/ebsa/healthreform/

U.S. Small Business Administration Health Care Reform Page
http://www.sba.gov/healthcare

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Q 397: Is there a cost to participate in [insert name of state SHOP exchange]?

There’s no fee for small employers or their employees to use SHOP. Some employers may be eligible for a tax credit of up to 50% of the cost of the premium.

Q 4038: Can insurers charge more (or less) for policies sold through [insert name of state SHOP exchange]?

No, insurers must charge the same for similar plans whether they’re sold through the [insert name of state SHOP exchange] or in the market outside of the [insert name of state SHOP exchange].

Q 4139: What happens if an employer’s staff increases to more than 50 employees after the employer bought coverage through the SHOP?

The small employer still will be eligible to buy health insurance through the [insert name of state SHOP exchange] because the employer had 50 or fewer employees at the time they first bought coverage through [insert name of state SHOP exchange].

Drafting Note: States should modify this paragraph in accordance with the state definition of small employer.

Q 420: How will employers with fewer than 100 employees, but more than 50, be affected in 2016 when the definition of small group increases to 100?

Beginning in 2016, employers with up to 100 employees will be eligible to buy small group health insurance coverage through the [insert name of state SHOP exchange].

Drafting Note: States should modify this paragraph in accordance with the state definition of small employer.

Q 413: How are small employers defined?

The definition of a small employer currently varies by state and by the purpose for using the term. To be eligible for the [insert name of state SHOP exchange] and certain ACA requirements that apply to small employers, as of 2016, a small employer will be defined as an employer with 100 or fewer employees. Before then, in [insert name of state], to determine if an employer is required to provide health insurance to his or her employees or pay a penalty, a small employer is defined as an employer with fewer than 50 full-time employees (including FTEs) on average during the previous calendar year.

Drafting Note: States should modify this paragraph in accordance with the state definition of small employer.

Q 424: How do employers with full-time and part-time employees know whether they’re required to offer health insurance?

All employers will want to assess whether they’ll be considered to have at least 50 full-time equivalent employees. Penalties will be assessed starting Jan. 1, 2016 against employers with 50 full-time equivalent employees not offering health coverage in 2015 if an employee gets the premium tax credit (see Questions 4952- and 5053).

Below are links to the IRS Questions and Answers about the requirements and delayed implementation: http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act

Q 435: Are health insurers required to sell their plans through the federal SHOP Exchange?

It’s expected that only some insurers currently offering small group health insurance plans will choose to sell their plans through [insert name of state SHOP exchange]. If they choose to, they must at least offer one plan in the silver metal tier and one in the gold. They may offer plans in the other metal tiers, but they might choose to offer those plans only in the market outside the [insert name of state exchange]. That’s another reason to compare exchange plans with those in the market outside the exchange. If an insurer sells individual market health insurance plans through the [insert name of state exchange] has (or is affiliated with an insurer that has) a small group market share of at least 20%, they (or their affiliate if they aren’t
active in the small group market) also must offer coverage through the [insert name of state SHOP exchange]. It’s important for small employers to understand all of their options. Small employers may ask a navigator, or licensed agent or broker for information about what’s available.

Drafting Note: HHS places the 20% market share requirement on federally facilitated and partnership exchanges. States with state-based exchanges without this requirement should modify this answer.

Q 464: Are small employers required to buy a health plan for their employees through [insert name of state SHOP exchange]?

No, small employers may buy health insurance for employees through the [insert name of state SHOP exchange] or in the market outside the exchange. However, to receive the small group tax credit (see Q 51XX), the coverage must be purchased on the SHOP exchange. It will be important for small employers to understand and compare all options available to them. State licensed health insurance agents and brokers are available to help small employers compare options and determine which plan best meets their needs.

[States that require small employers choosing to buy health insurance for their employees to do so through the exchange should modify this answer as appropriate]

Q 475: Will consumers be better off with individual coverage through the [insert name of state exchange] rather than small employer coverage?

Maybe. It depends on many variables, such as the employees’ out-of-pocket expenses under the small group plan offered, the consumers’ personal circumstances, and the premiums of the plans available through the exchange. Small employer sponsored coverage could cost less than individual coverage through the federal exchange, even with premium tax credits.

In November 2014October 2013, rates were made available for plans offered through the [insert name of state exchange] and for plans in the market outside the [insert name of state exchange].

Q 486: Are there participation rates that insurers can require employers to meet to be eligible to buy small group coverage through the [insert name of state SHOP exchange] or in the market outside the [insert name of state SHOP exchange]?

Insurers offering coverage in the small group market through the [insert name of state exchange] or outside the [insert name of state exchange] may impose participation rates consistent with [insert name of state] law. However, a small employer that can’t meet minimum participation rates must be allowed to buy coverage during an annual enrollment period that begins Nov. 15 and extends through Dec. 15 of each year.

[Insert name of state] law doesn’t allow a small employer insurer to impose more stringent requirements than the following:

- [insert participation limits consistent with state law]

Drafting Note: States with state-based exchanges may impose minimum participation rates as a condition of participation in a state SHOP exchange. In states with a federally-facilitated exchange, the SHOP has a default minimum participation rate of 70% for QHPs and will be adjusted higher or lower depending on state law or general insurer practice.

Q 492: Can small employers who are the sole employees of their business buy small group coverage either through the [insert name of state exchange] or the outside market?

Neither federal nor state law lets insurers sell small group health insurance plans to self-employed individuals with no common law employees through the SHOP. In the state of [insert state name], however, self-employed individuals with no common law employees can buy coverage in the small group market outside of the SHOP.

Contact the [insert name of state exchange] at [insert link] or [phone number], or a licensed agent or broker for help.
Q 50XX: How does rating work in the small group market?

Under the ACA, there is community rating in the small group market. This means that the rates each employer pays for their health insurance depends on the claims experience of the entire small group market in [insert name of state], rather than the claims experience of that employer’s any single small group.

The ACA offers states the option of combining the individual and small group markets together. By combining the markets, risk gets pooled among a larger number of policyholders. A larger risk pool increases rate stability, however, initially premiums for individuals are likely to be lower on average, while premiums for small employers are likely to be higher. This difference is likely to decrease over time as the ACA’s insurance reforms and tax subsidies are implemented.

Q 5148: Do small employers have to offer health care insurance coverage to their employees?

The ACA doesn’t require small employers (defined as employers with fewer than 50 employees) to offer health insurance coverage to their employees. Small employers who want to provide coverage may be eligible for a tax credit to help make insurance more affordable.

If the employer does offer coverage, however, the coverage must meet ACA’s minimum standards for all-small group insurance plans, as well as specific requirements that apply to the small group market, such as coverage of the essential health benefits and the prohibition on discrimination based on health status.

In [insert name of state], the [insert name of state SHOP exchange] is a place where small employers who want to offer coverage to their employees can shop. There’s more information about the [insert name of state SHOP exchange] at [insert link to state SHOP exchange website].

Q 5249: Do large employers have to offer health care insurance coverage to their employees? What about seasonal employees?

Under the ACA, if a large employer doesn’t offer affordable coverage that provides minimum value to full-time employees (and their dependents2), and an employee gets a premium tax credit, the employer has to pay a penalty. For employer-based coverage to be considered affordable, the premiums for the plan’s employee-only option must be less than 9.56% of his or her annual household income. To offer minimum value, the plan must pay at least 60% of the medical costs for services the plan covers. HHS and IRS have developed a minimum value calculator at [insert link to minimum value calculator], where consumers can enter information and get an estimate of whether a plan provides minimum value.

Large employers are employers with 50 or more full time employees, including full-time equivalent (FTE) employees. Full-time employees are employees with 30 hours or more of service in a week. The number of full-time equivalent (FTE) employees is determined by adding the number of hours of service in a month for all part-time workers and dividing by 120 hours per month. Penalties will be assessed starting Jan. 1, 2016 against employers with 50 full-time equivalent employees not offering health coverage in 2015 if an employee gets the premium tax credit.

Below are links to the IRS Questions and Answers about the requirements and delayed implementation:

Employers with a large seasonal workforce (such as agricultural workers hired for the harvest season or retail clerks hired for the holiday season) are given leeway under the ACA not to count seasonal employees to decide if they meet the definition of

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a large employer. If the employer has more than 50 full-time or FTE employees only during 120 or fewer days per year, the employer doesn’t have to count those employees for those months.

For more information, go to IRS Questions and Answers about the shared responsibility for employer requirements: http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act

Q 530: What are the penalties if large employers don’t provide coverage?

Large employers may have to pay a tax penalty if they don’t offer affordable coverage that provides minimum value for at least 95% of their full-time employees and their dependents, or all but 5 full-time employees, whichever is greater, and at least one of their employees gets premium tax credits through the [insert name of state exchange]. The penalty will be imposed starting Jan. 1, 2016 for coverage not offered in 2015.

The penalty for a large employer that doesn’t offer coverage to full-time employees and their dependents is $2,000 multiplied by the number of full-time employees, if at least one full-time employee has received a tax credit from the [insert name of state exchange]. The first 30 employees are exempted in the count.

Similarly, the penalty for a large employer that offers coverage that isn’t affordable or doesn’t give minimum value is $3,000 multiplied by the number of full-time employees who receive premium tax credits. (The maximum penalty may not be greater than $2,000 multiplied by the total number of all full-time employees.)

Medicaid-eligible employees can’t get premium tax credits, so employers will not face penalties for employees who receive Medicaid coverage or for employees’ children who receive CHIP coverage.

Q 544: How do small employers find out if they’re eligible for the small employer tax credit?

Employers who buy coverage for their employees through the [insert name of state SHOP exchange] may be eligible for small business tax credits. To qualify, the employer must: (1) have fewer than 25 full-time equivalent employees; (2) pay employees an average annual wage that’s less than $50,000, and (3) pay at least half of the insurance premiums.

In 2014 the tax credit will increase from a maximum of 35% to a maximum of 50% and will only be available to small employers buying health insurance through [insert name of state SHOP exchange]. The tax credit is worth up to 50% of an employer’s contribution toward employees’ premium costs (up to 35% for tax-exempt employers).

Contact the [insert name of state SHOP exchange] at [insert link] or [insert phone number] for more information. A competent tax advisor also should be able to advise a small employer. There’s more information on the Internal Revenue Service website at http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-Questions-and-Answers:-Calculating-the-Credit.

Q 552: What ACA requirements apply to large employers?

A number of ACA requirements apply to non-grandfathered health plans that large employers offer on either an insured or self-insured basis. The requirements include limits on out-of-pocket expenditures and waiting periods, no annual or lifetime dollar limits on coverage of essential health benefits or cost sharing for preventive services, the requirement that coverage be offered to adult children up to age 26, and the requirement of access to internal and external appeals. Also, as noted in Questions 49 and 80, large employers are required to offer affordable and adequate coverage, or face a tax penalty.
ACA REQUIREMENT TO HAVE BASIC HEALTH CARE COVERAGE (INDIVIDUAL MANDATE)

Q 563: What is the individual mandate, and does that mean consumers must buy coverage through the [insert name of state exchange]?

Under the ACA, starting Jan. 1, 2014, consumers and their dependent children are required to have “minimum essential coverage” or pay a penalty, unless they fit within an exemption (see Question 55). This requirement is commonly known as the “individual mandate.”

Consumers may buy a plan through the [insert name of state exchange] to satisfy the individual mandate, but they don’t have to. Other forms of health coverage that satisfy the requirement to have “minimum essential coverage” include grandfathered plans (see Question 30), most employer-sponsored plans, union plans, and enrollment in a government program such as Medicare, Medicaid, TRICARE or CHIP. Consumers can continue to use agents and brokers to buy insurance available in the market outside the exchange.

Some examples of health plans that do not meet the requirement of minimum essential coverage and do not satisfy the individual mandate requirement to have basic health care coverage are fixed indemnity plans and insurance coverage and discount plans that include only specialty or ancillary services (for example, hearing, chiropractic, etc.).

Check the website https://www.healthcare.gov/what-if-someone-doesnt-have-health-coverage-in-2014 for more information.

Q 547: What happens if a consumer doesn’t satisfy the individual mandate?

Those who don’t have health insurance coverage or fit within an exemption will pay a tax penalty beginning in 2014. The penalty is set to increase each year as follows:

- In 2014, it will be the greater of $95 per adult or 1% of taxable income above the filing limit.
- In 2015, it will be the greater of $325 per adult, or 2% of taxable income above the filing limit.
- In 2016, it will be the greater of $695 per adult, or 2.5% of taxable income above the filing limit.
- After 2016, the tax penalty increases annually based on a cost-of-living adjustment.

The maximum penalty is the national average premium for a bronze plan. The penalty starts after three months without coverage. Each month, the penalty due is 1/12 of the total annual penalty. The penalty for a child is half that of an adult. The total liability for a family is capped at 300% of the individual penalty. Only the first two children are counted to calculate the penalty. A maximum penalty will be calculated based on premiums for plans offered through the [insert name of state exchange].

There’s more information on the penalty at: https://www.healthcare.gov/fees-exemptions/fee-for-not-being-covered/

Q 585: Are there any exemptions to the individual mandate?

Yes. The ACA lists the following who aren’t required to pay a penalty if they don’t have health insurance coverage:

1) Individuals and families whose income is low enough that they don’t need to file federal income tax returns,
2) People who would pay 8% or more of their income for coverage, after taking premium tax credits and employer contributions into account,
3) Individuals who have been uninsured for less than three months,
4) People who are incarcerated,
5) Individuals who are not lawfully present in the country,
6) Members of federally recognized American Indian tribes and individuals who are not members of federally recognized American Indian tribes who can get services through an Indian health care provider, and
7) People who don’t have coverage because they belong to a religious group that objects to insurance coverage,
8) People who are members of a health care sharing ministry, and
9) People who experience hardship in obtaining coverage.
The Kaiser Family Foundation has put together a flowchart to help consumers understand who must have health insurance: http://healthreform.kff.org/en/the-basics/requirement-to-buy-coverage-flowchart.aspx. There’s more information about who doesn’t have to pay a penalty if they don’t have health insurance in the IRS FAQ at: http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision.

**Q59XX: How do consumers get an exemption from the individual mandate?**

The process for getting an exemption from the individual mandate depends on the consumer’s reason for getting the exemption. The federal website, www.healthcare.gov has instructions, including online forms, for consumers to use to get an exemption.

**Q 5606: What if a consumer already has health insurance coverage?**

Consumers with health insurance coverage don’t need to do anything, unless their insurance company sends them a notice that their health insurance doesn’t qualify as “Minimum Essential Coverage.” Consumers who get such a notice may have to pay a tax penalty for not having adequate health insurance coverage. To avoid this, contact the [insert name of state exchange] website or phone number, or contact an agent or broker.

In [insert name of state], insurance companies must tell their policyholders if a plan, such as a short-term policy, doesn’t qualify as minimum essential coverage by [insert date].

**ENROLLING IN HEALTH CARE COVERAGE: WHERE CAN I GET HELP?**

**Q 6157: Where do consumers go for help to choose and enroll in a plan?**

Consumers should make a list of questions before they shop for a health plan. Consumers should gather information about household income and set a budget for health insurance. Consumers should find out if they can stay with their current doctors and pharmacy, and understand how insurance works – including understanding of deductibles, out-of-pocket maximums and co-payments.

There are a number of resources from the Kaiser Family Foundation, Consumer Reports, the National Association of Insurance Commissioners, and the U.S. Department of Health and Human Services and the Department of Labor to help consumers understand how insurance works, the different insurance options, and what to consider when you buy coverage.

A new standard form called the Summary of Benefits and Coverage (SBC), and the companion set of uniform definitions, also is available for all health insurance plans. This information can help consumers compare different insurance options (see Question 18). Consumers can get the form and definitions through the [insert name of state exchange] website or phone number, or ask the plan for it. The [insert name of state exchange] also can direct consumers to more information and resources about the options that will be available starting in October.

If a consumer is eligible to buy coverage through the [insert name of state exchange], he or she can enroll through the [insert name of state exchange] website at [insert link], by phone at [insert phone number], or in person through [Insert links and contact information]. The U.S. Department of Health and Human Services (HHS) also has an online health plan-finder tool at www.healthcare.gov.

Also, there are four types of individuals trained to help consumers make decisions about health coverage.

**A. Insurance agents or brokers**

Health insurance agents and brokers sell insurance coverage from one or more insurance companies. Health insurance agents and brokers are licensed by [insert name of state] and receive continuing education related to their job. They can help educate consumers about health insurance policies, help consumers apply for coverage, and advise consumers about the type of health insurance coverage that best suits them and their family. Agents and brokers can sell consumers insurance plans in the market outside the exchange, as they always have.
Agents and brokers who want to sell policies through the [insert name of state exchange] will have had extra training from the U.S. Department of Health and Human Services (HHS) or the state-based exchange. They will have passed a test at the end of their training to sell insurance policies through the [insert name of state exchange]. [Insert name of state] requires agents and brokers to have extra state-specific training before they sell through the [insert name of state exchange]. A list of agents and brokers authorized to sell through the [insert name of state exchange] is available on the [insert name of state exchange] website at [insert link]. Consumers may want to talk with more than one agent or broker before they decide which plan to buy (see Question 71).

**Drafting Note:** States where there may not be a list of agents and brokers on the exchange may want to modify the answer accordingly.

### B. Navigators

Navigators are individuals trained to help consumers understand the insurance policies available through the [insert name of state exchange] and answer consumer questions about the [insert name of state exchange]. They also can answer questions about insurance affordability programs, including Medicaid and CHIP. Navigators also can help educate consumers about their health insurance policy options and help them apply for coverage. Navigators get grants from the [insert name of state exchange] to receive training on how to help consumers. After training, they must pass a test and be certified by [insert name of state exchange]. In [insert name of state], navigators also must have extra state-specific training before they can help consumers. Consumers can contact navigators at [insert state contact information] (see Question 65).

**Drafting Note:** States where HHS will be doing training and certification should modify the preceding paragraph accordingly. HHS will certify navigators in the federally facilitated exchanges.

### C. In-person assistance personnel

In-person assistance personnel generally do the same things as navigators. In-person assistance personnel have received and successfully completed comprehensive training. They also can help educate consumers about health insurance policies and help them apply for coverage. [Insert name of state] has set up an in-person assistance program. Consumers can contact in-person assistance personnel at [insert contact information].

**Drafting Note:** States should delete this section if they do not have in-person assistance personnel.

### D. Certified application counselors

Certified application counselors provide enrollment assistance to consumers. Certified application counselors receive and successfully complete comprehensive training. They, too, can help educate consumers about health insurance plans and help them complete an application for coverage. [Insert name of state] has examples of application counselors include staff at [insert name of local community health centers or hospitals or consumer non-profit organizations].

**Drafting Note:** States will need to customize this section depending on what type of exchange they have and what kinds of individuals will be assisting consumers. Additional customization may be necessary if the state has any licensure or certification requirements.

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**Q 6258: How are people who help consumers make decisions about health coverage paid?**

Insurance agents and brokers may have an agreement that the insurance company will pay them if they enroll consumers in a health insurance policy consistent with state law. The state-based exchange may set rules about paying health agents and brokers from the exchange or directly from insurance companies. In [insert name of state], the agent or broker will be paid an amount agreed to by the health insurance agent and the company.

In [insert name of state], navigators will get funding from [insert funding source]. They don’t get enrollment-based reimbursement from insurance companies and aren’t allowed to charge a fee.

In-person assistance personnel will be paid by [insert funding source]. They don’t get enrollment-based reimbursement from insurance companies and aren’t allowed to charge a fee.
Certified application counselors will not be paid through the [insert name of state exchange]. They don’t get enrollment-based reimbursement from insurance companies and aren’t allowed to charge a fee. They may, however, receive federal funding through other grant programs or Medicaid, or from another source.

Q 6359: How can consumers find an insurance agent or broker to help them enroll in a plan?

In [insert state name], the [insert name of state health insurance exchange] website at [insert web address] lists insurance agents and brokers authorized to enroll individuals, families, and small businesses in coverage through the [insert name of state exchange]. Consumers can contact the [insert state Insurance Department] for a list of licensed health insurance agents and brokers in their area. Some agents and brokers don’t contract with all health plans, so consumers must make sure they know the full list of plans that are available to them before they ask an agent or broker for help. Also, health insurance agents and brokers may or may not be able to help individuals complete the enrollment process for Medicaid or CHIP after they get an eligibility decision.

Drafting Note: States should modify this answer consistent with the information available in the state. In the federally-facilitated exchanges, such a listing will not be available for agents assisting consumers with individual market qualified health plans (QHPs). It has not been decided whether such a listing will be available for the federally facilitated SHOP exchange.

Q 640: What are the qualifications required for health insurance agents and brokers to participate in the [insert name of state exchange]?

In [insert name of state], health insurance agents and brokers are regulated by the [insert name of state department of insurance]. Agents and brokers receive training from the [insert name of state exchange or Department of Health and Human Services]. The insurance companies must appoint the insurance agents and brokers who sell their plans through the [insert name of state exchange]. An agent or broker selling plans through the [insert name of state exchange] must provide information on all plans that are offered on the [insert name of state exchange], even if the agent or broker isn’t authorized to sell some of those plans.

Drafting Note: States that are not requiring agents and brokers to be appointed to all the insurance companies selling through the exchange or that are not requiring agents to provide information about all plans available through the exchange, should modify the previous paragraph accordingly.

Q 654: Where should consumers go with a problem enrolling in a plan through the [insert name of state exchange]?

The [insert name of state exchange] should be able to help consumers with any problems. In particular, [insert name of state exchange] operates a call center to help answer consumer questions. The number for the call center is [insert number] and is available on the [insert name of state exchange] website at [insert link]. Insurance agents and brokers, navigators, in-person assistance personnel, and certified application counselors also should be able to help (see Question 57).

Q 626: Do consumers have to re-enroll annually?

Eligibility for premium assistance and enrollment in a health plan will be decided annually using updated income, family size, and tax information (when authorized). Each year, before the open enrollment period, the [insert name of state exchange] will check income data and send a notice to consumers who are determined eligible for enrollment in a plan through the [insert name of state exchange]. This notice explains the consumer’s eligibility for the upcoming year and tells the consumer to let the [insert name of state exchange] know of any changes. After this, there will be an annual open enrollment period for consumers to change plans or insurance companies if they want to.

All consumers are encouraged to go to the Exchange to review all of their options and to update income and other information to ensure the correct subsidy is received. If a person enrolled in a plan through the exchange in 2014 does not choose to re-enroll or enroll in a different plan by December 15, 2014, they will be automatically re-enrolled in their current or similar plan. For the 2015 coverage year, the key dates are as follows:

- November 15, 2014: Open Enrollment starts -- the first day you can apply for 2015 coverage
December 15, 2014: The last date to enroll for coverage that starts January 1, 2015

December 31, 2014: Date when all 2014 Marketplace exchange coverage ends, no matter when you enrolled

January 1, 2015: The date 2015 coverage can start if you apply by December 15, 2014, or if you accept automatic enrollment in your 2014 plan or a similar plan

February 15, 2015: The last day to enroll in 2015 coverage. If you miss this deadline, you can’t sign up for a health plan inside or outside the Marketplace exchange for the rest of 2015. The only exception is if you qualify for a Special Enrollment Period.

Even if you are automatically renewed because you did not choose a plan by December 15, 2014, you can still shop and choose a new plan before the open enrollment period ends on February 15, 2015. Reminder: Coverage in the individual market may not be purchased except during the open enrollment period or during a special enrollment period during the year if certain events occur.

During the year, consumers with coverage through the [insert name of state exchange], must report certain life changes to the [insert name of state exchange]. Consumers should report changes as soon as possible, especially in the case of changes that qualify a consumer for a special enrollment period. Consumers eligible for a special enrollment period typically have 60 days to enroll in new coverage. (See Q 11.) Changes include changes in income from a new job to getting married or divorced. See https://www.healthcare.gov/how-do-i-report-life-changes-to-the-marketplace/ for information about reporting life changes.

Consumers who have not requested financial assistance do not need to report changes related to financial assistance eligibility. The [insert name of state exchange] will review available data sources on a quarterly basis for individuals who become eligible for Medicare, Medicaid or CHIP.

Q 674: How will insurance agents and brokers be able to help consumers with enrollment through the [insert name of state exchange]?

In [insert name of state], health insurance companies will appoint agents and brokers. Insurance companies will make sure the agent’s license is valid and registered with the [insert name of state exchange]. The agent can help consumers log-on to the [insert name of state exchange]. Consumers will log into their own [insert name of state exchange] account. The agent or broker can help consumers as needed. The agent or broker will then work with consumers to complete the application.

Consumers will be prompted to enter the insurance professional’s [insert name of state exchange] user identification number and national producer number on the application to show that the professional helped them.

The agent or broker can help consumers compare qualified health plans (QHPs) and submit the application (see Question 71). The agent or broker can answer questions from consumers about the differences in QHPs and which plan would be best for consumers and their families. Consumers will enter the insurance professional’s [insert name of state exchange] user identification number and national producer number on the enrollment page to show that the professional helped them with plan selection and enrollment.

Drafting Note: States should change this answer as appropriate to reflect the process in the state.

Q 685: How will a navigator be able to help consumers with enrollment through the [insert name of state exchange]?

In [insert name of state], navigators can help consumers create an account and log-on to the [insert name of state exchange]. Consumers will log into their own [insert name of state exchange] account. The navigator can help consumers as needed to complete the application. Consumers may be prompted to enter the navigator’s [insert name of state exchange] user identification number on the application to show that the navigator helped them.

The navigator can help consumers to compare qualified health plans (QHPs) and answer questions about health insurance policies in general. The navigator can answer questions from consumers about the differences in QHPs and what they might mean for them, but the navigator CANNOT recommend or suggest which health plan would be best for consumers and their families. Navigators are not permitted to collect premium payments on behalf of an insurer or the [insert name of state exchange]. Consumers will be asked to enter the navigator’s [insert name of state exchange] user identification number on the enrollment page to show that the navigator helped them.

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Navigators CANNOT sell, solicit, or negotiate a QHP through the [insert name of state exchange]. They CANNOT suggest that one plan would be better for the individual than another.

Drafting Note: States should change this answer as appropriate to reflect the process in the state.

<table>
<thead>
<tr>
<th>Q 696: How will the in-person assistor or the certified application counselor be able to help consumers with enrollment through the [insert name of state exchange]?</th>
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<tr>
<td>In [insert name of state], the in-person assistor or certified application counselor can help consumers create an account and log-on to the [insert name of state exchange]. Consumers will log into their own [insert name of state exchange] account. The in-person assistor or certified application counselor can help consumers as needed to complete the eligibility application. Consumers may be prompted to enter the in-person assistor’s or the certified application counselor’s [insert name of state exchange] user identification number on the application to show that the assistor or counselor helped them. The in-person assistor or certified application counselor can help consumers compare qualified health plans (QHPs) and answer questions about health insurance policies in general. The assistor or counselor can answer questions from the consumer about the differences in QHPs and what they might mean to them (such as explaining deductibles or out-of-pocket limits), but the assistor or counselor CANNOT recommend or suggest which QHP would be best for consumers and their families. Consumers will be asked to enter the in-person assistor’s or certified application counselor’s [insert name of state exchange] user identification number on the enrollment page to show that they helped them. The in-person assistor or certified application counselor CANNOT sell, solicit, or negotiate a QHP through the [insert name of state exchange]. They CANNOT suggest that one plan would be better for the individual than another.</td>
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Drafting Note: States should change this answer as appropriate to reflect the process in the state.

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<tr>
<th>Q 7067: Can small employers use licensed insurance agents or brokers to buy health insurance through [insert name of state SHOP exchange]?</th>
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<tr>
<td>Yes, licensed insurance agents and brokers are available to help small employers compare and determine which health plan best meets their needs, like they do today. This is true whether they're interested in buying coverage in the market outside the [insert name of state SHOP exchange] or through the [insert name of state SHOP exchange]. Licensed insurance agents and brokers will be able to compare plans in the market outside the [insert name of state SHOP exchange] against those offered through the [insert name of state SHOP exchange] to decide where they can buy the best plan for them. Employers may wish to talk with more than one agent or broker before making a decision on which plan to buy.</td>
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<th>Q 7168: Will small employers be able to use navigators to buy health insurance?</th>
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<tr>
<td>Navigators, by law, aren’t allowed to sell health insurance unless they have an agent/broker license. Navigators are available to help small employers view plan options displayed on the [insert name of state SHOP exchange] website and can help consumers with enrolling through the SHOP. Navigators can explain the parts of the plans offered through the [insert name of state SHOP exchange] but CANNOT legally offer advice as to which plan is a better fit for the small employer. Only a licensed insurance agent or broker is qualified and allowed to offer this service.</td>
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<tr>
<th>Q 7268: How can an insurance agent or broker help a small employer interested in participating in the [insert name of state SHOP exchange]?</th>
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<tr>
<td>An insurance agent or broker will be able to help any small employer, as they have in the past. The agent or broker can help the employer decide which health insurance policy would be best for them, enroll employees in the plan, file health insurance claims, and understand the process of enrollment. In the [insert name of state SHOP exchange], HHS expects that insurance agents and brokers will be in contact with employers both before and after enrollment, as they will be a primary contact for customer service issues.</td>
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<tr>
<th>Q 730: What is the benefit of using an insurance agent to enroll in the [insert name of state exchange] or [insert name of state SHOP exchange]?</th>
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Whether consumers are individuals or small group businesses, the insurance agent or broker can work with their needs and requirements. Agents and brokers have a working knowledge of the qualified health plans and their benefits. Consumers may be more comfortable sharing their medical wants and needs for a health insurance policy with an agent or broker.

The agent or broker may help individual consumers or small employers to create their account with the [insert name of state exchange] or [insert name of state SHOP exchange] if needed, but consumers, or a legally authorized representative, must create their own [insert name of state exchange] username and password. Consumers should not share this information with third parties, including insurance agents or brokers.

**Q 741:** Will an insurance agent or broker show consumers all of the plan choices available through the [insert name of state exchange]?

In [insert name of state], agents and brokers aren’t required to show consumers all available health plans. If the consumer is using the [insert name of state exchange] website with the help of an agent or broker, all qualified health plan choices will be displayed. If the agent or broker goes through an insurance company portal, all plans available through the [insert name of state exchange] may not be shown but other plans available in the market outside the exchange, that aren’t eligible for the advance premium tax credit, may be shown. Consumers should ask the insurance agent or broker if they’re being shown all of the plans available through the [insert name of state exchange] and whether tax credits or cost-sharing reductions apply to the plans they are looking at (see Questions 71 and 78).

Drafting Note: States should modify this answer if agents and brokers are required to show consumers all options available through the exchange.

**Q 752:** Will consumers have to share their personal information, including their tax returns, with an agent or broker, navigator, in-person assistance personnel or certified application counselor?

No, a consumer isn’t required to share personal information, including tax returns with an agent or broker, navigator, in person assistance personnel or certified application counselor. If a consumer is completing the application on the [insert name of state exchange] website with the help of an agent or broker, navigator or assistor, the consumer should be able to fill out and submit their eligibility application without the agent, navigator or assistor in direct view of the application. Income figures from the IRS won’t be shown during the application process, whether or not the consumer gets help filling out the application or does it independently. In [insert name of state], after completing the registration and training, agents or brokers, navigators, in-person assistance personnel and certified application counselors will fill out a privacy and security agreement and get a user ID to use with the [insert name of state exchange].

Drafting Note: States should modify this answer if agents and brokers are required to show consumers all options available through the exchange.

**Q 763:** Will consumers have to share their account username and password with an insurance agent or broker, navigator, in-person assistor or certified application counselor?

No. An agent or broker, navigator, in-person assistance personnel and certified application counselor shouldn’t ask for a consumer’s account username and password. If a consumer is asked to share a username or password, he or she should contact the [insert name of state insurance department] at [insert phone number] and discuss this with the consumer assistance representatives.

**Q 774:** What help should an insurance agent or broker, navigator, in-person assistor or certified application counselor give consumers if they or their dependents are eligible for Medicaid or CHIP?
Agents or brokers, navigators, in-person assistors and certified application counselors will work with all consumers who ask for help with [insert name of state exchange] enrollment, including those eligible for Medicaid or CHIP. The [insert name of state exchange] will send a notice to consumers who are eligible for Medicaid or CHIP. An agent or broker, navigator, in-person assistor, or certified application counselor working with these consumers is expected to refer consumers to the [insert name of state agency]. Agent and broker, navigator, in-person assistor and certified application counselor training will include information about where to direct Medicaid or CHIP-eligible consumers.

Agents and brokers should be able to give consumers a referral to a navigator, in-person assistor, certified application counselor or the [insert name of state Medicaid agency]. Navigators, in-person assistors, and certified application counselors should help all consumers seeking assistance with completing an application through the [insert name of state exchange.] If the [insert name of state exchange] assesses the consumer as Medicaid or CHIP eligible, the Navigator, in-person assistor, or certified application counselor may refer the consumer to the state Medicaid agency for additional information. Navigators, in-person assistors, and certified application counselors are often not required to help consumers fill out a state Medicaid application if it is different from the application used by the [insert name of state exchange], but can refer consumers to appropriate resources in those cases.

Q 785: May an insurance agent or broker continue to work with consumers once they’re enrolled in a plan through the [insert name of state exchange]?

Insurance agents and brokers may continue to communicate with consumers after they’ve enrolled in a plan through the [insert name of state exchange], as long as the communications follow any laws and regulations that apply.

The communications also must follow the privacy and security standards the [insert name of state exchange] has adopted (pursuant to 45 C.F.R. §155.260). These standards limit how an agent or broker may use any information gained to provide help and services to qualified consumers.

HHS expects to issue more rules about privacy and security requirements.

COSTS AND ASSISTANCE WITH COSTS

Q 79XX: Is there cost-sharing for contraceptives?

With the exception of health plans sponsored by certain exempt “religious employers”, all plans offered through the [insert state name of state exchange] must cover in-network doctor prescribed, FDA-approved methods of contraception without cost-sharing.

For specific information about a plan’s contraceptive coverage, consumers should check the plan’s SBC or ask their employer or benefits administrator. There’s more information about contraceptive coverage on the federal website at www.healthcare.gov.

Q 8076: May consumers directly enroll for coverage through insurers?

Yes, consumers may buy coverage directly from an insurance company. However, consumers should make sure that the coverage they buy is offered through the [insert state name of state exchange] and that the insurer has an agreement to do direct enrollment through the [insert name of state exchange] so they can get any tax credits or cost sharing reductions to which they are entitled.

Consumers enrolling directly through the insurance company portal may not see all plans available through the [insert name of state exchange] (see Question 71).

Drafting Note: States that do not allow insurers to enroll consumers directly into plans through the exchange should change this answer accordingly.

Q 8127: How much does all plans offered through the [insert name of state exchange] cost?
There will be a wide variety of plans intended to fit different budgets, both through the [insert name of state exchange] and in the market outside the exchange. Also, many consumers will qualify for the new premium tax credits (see Questions 79-80), which will pay part of their premium and help lower the cost of coverage. To see specific costs of plans offered through the [insert name of state exchange] for consumers, go to [insert state exchange webpage], call [insert state exchange telephone number], or talk to a navigator, certified application counselor, in-person assistor, insurance agent or broker, or other assistor (see Question 57).

**Q 8278: Will plans offered through the [insert name of state exchange] have large out-of-pocket costs?**

The health insurance plans available through the [insert name of state exchange] feature a wide variety of out-of-pocket costs for consumers. But, the ACA requires that all plans limit consumers’ annual out-of-pocket costs for in-network services to no more than roughly $6,250 for individuals and $12,700 for families in 2014. In 2015, these numbers change to $6,600 for individuals and $13,200 for families. These maximum out-of-pocket amounts will go up in future years. However, out-of-network services do not count toward these limits on annual out-of-pocket costs (see Question 27). There are separate out-of-pocket maximums for stand-alone dental plans.

Plans are also required to cover certain preventive services without cost-sharing (see Question 24). These maximum out-of-pocket amounts will go up in future years.

Also, consumers whose incomes are below a certain amount may be eligible for a premium tax credit which will enable them to buy a plan that features lower cost-sharing and lower out-of-pocket costs (co-payments, coinsurance, and deductibles) without paying a higher premium. Check with the [insert name of state exchange] at [insert link]. Navigators, certified application counselors, in-person assistants, agents or brokers or other assistors should be able to help consumers learn if they qualify. Also, the exchange application will tell consumers whether they might be eligible for Medicaid or CHIP programs, which have very limited out-of-pocket costs.

**Q 8379: Where can consumers go to learn if they’re eligible for help paying premiums or for Medicaid?**

Consumers may apply with the [insert name of state exchange] or the [insert name of state Medicaid agency].

The [insert name of state exchange] will determine eligibility for advance payments of premium tax credits and cost-sharing reductions. They will also assess Medicaid and CHIP eligibility and make a referral, if appropriate, to the [insert name of state Medicaid agency] for a final determination.

Consumers also may apply directly with the [insert name of state Medicaid agency] and the [insert name of state Medicaid agency] will enroll eligible consumers in Medicaid or CHIP, or send their information to the [insert name of state exchange] to determine their eligibility for advance payments of the premium tax credit and cost-sharing reductions if they aren’t eligible for Medicaid or CHIP.

**Drafting Note:** States with a different process will need to modify this answer accordingly.

**Q 840: Is there help for consumers who can’t afford coverage? Who’s eligible for premium tax credits?**

Depending on their income and other factors, consumers may be eligible for Medicaid or CHIP or they may be eligible for tax credits or cost sharing reductions through [insert name of state exchange].

Currently, in [insert name of state], nonelderly adults without minor children don’t qualify for Medicaid. For years 2014-???, beginning in 2014, the federal government will pay to expand the program so that Medicaid also would cover adults with an income at or lower than 138% of the federal poverty level, or $15,414 for a family of one and $31,809 for a family of four. Consumers should contact the [insert name of state exchange] or the [insert name of state Medicaid agency] directly if they think they might be eligible for Medicaid.

**Drafting Note:** States with Medicaid programs covering nonelderly adults without minor children should modify the previous paragraph.

The ACA also created new premium tax credits and cost sharing reductions to help cut costs for eligible consumers who buy a plan through the [insert name of state exchange] (see Question 80). The amount of the tax credit or cost sharing reduction...
depends on family size and income. Larger families and families with lower incomes get the most help. Tax credits and cost-sharing reductions aren’t available for individuals who are eligible for Medicaid, CHIP, Medicare, or qualifying employer-sponsored coverage. More information about tax credits and cost-sharing reductions is available at www.healthcare.gov.

In [insert name of state], children may be able to get coverage through Medicaid or CHIP programs for which their parents aren’t eligible. Some families may find it more affordable to enroll their children in Medicaid or CHIP and buy coverage for the parents through the exchange.

**Drafting Note:** States may need to modify the answer to this question depending on the state’s decisions regarding Medicaid expansion.

[This link has general information about income levels at which financial help or coverage is available, as well as what counts as income.](https://www.healthcare.gov/lower-costs/qualifying-for-lower-costs/)

**Q 815:** How do premium tax credits to buy coverage through the [insert name of state exchange] work?

Consumers who qualify for the premium tax credits can use them at any time—they don’t have to pay on a monthly basis as they pay their premiums, or they can wait until they file their taxes. The advance payment is sent to the insurance company that offers the plan the consumer has chosen and is used to reduce the monthly insurance premium. Consumers also have the choice to wait to receive their tax credits until they file their taxes. They also can use just part of their estimated tax credit in advance.

Consumers who want to use their tax credit in advance need to be as accurate as possible to estimate how much income they expect to have in the coming year. If they underestimate their income and the tax credit is overestimated, they may have to repay part of their tax credits at tax time.

Consumers need to update the [insert name of state exchange] during the year about any changes in income, family size (like having a baby), employment (like getting a job where health insurance coverage is offered), or becoming eligible for Medicare. The [insert name of state exchange] will change the tax credit amount to reflect the new information. A consumer who forgets to update the [insert name of state exchange] might owe money at tax time or realize they could have been using a larger tax credit amount in advance.

Consumers who don’t use the tax credit in advance don’t have to tell the [insert name of state exchange] about any changes to their income, or employment during the year. They can get the tax credit on their tax returns.

Consumers may go to the [insert name of state exchange] website at [insert link] or call the [insert name of the state exchange] at [insert telephone number] for more information about tax credits. Navigators, certified application counselors, in-person assistors, agents or brokers or other assistors also are able to give consumers information about the tax credit.

There’s more information about premium tax credits on the federal website at www.healthcare.gov.

**Q 826:** Are health insurance premiums and other healthcare costs tax deductible?

For taxpayers, and their spouses younger than age 65, health care expenses and premiums greater than 10% of adjusted gross income (AGI) are currently deductible as an itemized deduction on Schedule A of the federal tax return. For taxpayers, or their spouses, older than age 65, the AGI percentage is currently 7.5%, but will increase to 10% in 2017. For more information, visit the Internal Revenue Service (IRS) website at [http://www.irs.gov/Individuals/2013-changes-to-itemized-deduction-for-medical-expenses](http://www.irs.gov/Individuals/2013-changes-to-itemized-deduction-for-medical-expenses).

**Q: 87XX:** Is an individual who is a victim of domestic abuse and separated (but not divorced) from his or her spouse eligible for subsidies on the exchange?

Yes. In general, married couples must file a joint tax return in order to be eligible for a premium tax credit and cost sharing reductions. For victims of domestic abuse, however, contacting their spouses to file a joint return may present a risk and may be legally prohibited if a restraining order is in place. For calendar year 2014, a married individual who is a victim of domestic abuse may still be eligible for subsidies if they are living separately from their spouse when they file their 2014 taxes using a filing status of married filing separately. For more information, see [http://www.irs.gov/pub/irs-drop/i-12-25.pdf](http://www.irs.gov/pub/irs-drop/i-12-25.pdf).
Q: 88XX: If I am eligible for subsidy assistance, is there a grace period before a company can terminate me for non-payment of premiums?

Yes. The ACA requires insurance companies to give enrollees who receive subsidies a 90-day grace period for non-payment of premiums before the policy can be terminated, provided the enrollee has paid at least one month’s premium. Claims must be paid during the first [30][60] days of the grace period, but the insurer may send payments to providers during the remainder of the grace period. In order to keep coverage at the end of the grace period, a consumer’s account must be fully paid within 90 days of missing a premium payment. For example, if a consumer misses a payment in July but makes payments in August and September, the consumer will be terminated in October if he or she has not also paid the missing payment from July.

QUESTIONS ABOUT OTHER TYPES OF COVERAGE

Q 893: What is available in the market outside the [insert name of state exchange]?

In [insert state name], health insurance coverage will continue to be available in the market outside the [insert name of state exchange]. However, if consumers want to take advantage of premium tax credits to help pay for part of their premiums, they must buy coverage through the [insert name of state exchange] (see Questions 79-80).

Consumers still will be able to buy plans in the market outside the exchange that don’t cover the essential health benefits, such as fixed indemnity plans or insurance coverage and discount plans that include only specialty or ancillary services (for example, hearing, chiropractic, etc.) Note, though, that these policies do not provide minimum essential coverage and will not satisfy the individual mandate (see Question 53). The NAIC has some resources discussing these types of plans: http://www.naic.org/documents/consumer_alert_high_deductible_plans.htm http://www.insureuonline.org/consumer_guide_cancer.pdf

Contact an insurance agent or broker for help.

Q 90: 84: If consumers already have coverage, may they buy separate policies for their children?

Consumers who already have coverage for themselves are eligible to buy a policy for a child through the [insert name of state exchange]. The ACA requires that any health plan offered through the exchange also must be offered as a child-only plan at the same tier of coverage. Consumers also may be eligible for tax credits for child-only plans they buy through the [insert name of state exchange]. Visit the [insert name of state exchange] website at [insert website for the state exchange] for more information about child-only plans available through the [insert name of state exchange].

However, children who aren’t citizens or legal residents of the United States aren’t eligible for child-only plans through the [insert name of state exchange]. Consumers may be able to buy a child-only policy in the market outside the [insert name of state exchange], either directly from an insurer or through an agent or broker. For a list of licensed insurers in [insert name of state], visit the [name of state department of insurance] website at [insert website of state dept. of insurance]. A child also may be eligible for Medicaid (contact [insert name of state Medicaid agency] at [insert contact information]) or coverage through [insert state Children’s Health Insurance Program (CHIP)]. To learn more about CHIP plans, visit www.insurekidsnow.gov.

ACA MEDICARE-RELATED QUESTIONS

Q 9185: Who should consumers contact with questions about Medicare, Medicare Supplement insurance, or Medicare Advantage plans?

Medicare coverage, Medicare Supplement insurance (Medigap), and Medicare Advantage plans are not available through the [insert name of state exchange]. Consumers who are currently enrolled in Medicare may not purchase coverage on-through the exchange. Direct questions involving the ACA and Medicare, Medicare Supplement insurance, or Medicare Advantage Plans to [insert name of State Health Insurance Program (SHIP)] at [insert contact information]. The federal government’s Medicare website, www.medicare.gov, also has more information about health reform and Medicare changes.

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Drafting Note: Some states closing their high risk pools have enrollees who are on Medicare because of end stage renal disease (ESRD) or some other high cost medical disorder. In those states, beneficiaries with other high cost medical disorders in those states may have a limited special right to enroll in a Medicare Advantage plan. The federal government will allow companies participating in that state’s exchange to issue coverage to people with Medicare because of ESRD, and will waive enforcement of the prohibition against selling coverage to someone with Medicare for this special population until 2017. Companies issuing coverage to this special population will be permitted to pay secondary benefits, although it remains unclear how those benefits will be coordinated with Medicare. However, in addition, the federal government does not have the authority to require insurance companies to issue coverage to this special population. The [insert name of State Health Insurance Assistance Program (SHIP)] at [insert contact information] should be able to give consumers more information about these special enrollment rights.

Q 92XX: Are certain people paying for Medicare Part A able to enroll through the [insert name of exchange]?
If a person has to pay the premium for Part A because they are not entitled to those benefits, they can buy coverage through [insert name of exchange] instead of Medicare, and they may also be eligible for a tax credit. This includes those beneficiaries who only enrolled in Medicare Part B because they couldn’t afford the Part A premium. In both cases these beneficiaries have to disenroll from Medicare Part A, if they have it, and from Medicare Part B, if they have it. There are consequences to substituting a QHP for Medicare. A person may incur higher premiums for Medicare if they decide to enroll in the future and may have a gap in benefits. The [insert name of State Health Insurance Assistance Program (SHIP)] at [insert contact information] should be able to give consumers more information about their choices.

Q 93XX: Can a person with ESRD enroll in or stay in a QHP instead of enrolling in Medicare?
If a consumer with ESRD has not applied for Medicare they can stay in or apply for coverage through the [insert name of exchange]. However, there are consequences in delaying Medicare benefits. An individual with ESRD may not be eligible for certain Medicare benefits if they enroll in Medicare in the future, may pay a higher premium for late enrollment, or may have a delay in when benefits begin. The [insert name of State Health Insurance Assistance Program (SHIP)] at [insert contact information] should be able to give consumers more information about these complex choices.

Q 94XX: If a person becomes eligible for Medicare and is already in a QHP can they stay in their plan?
If a person stays in a QHP* and is eligible for Medicare, he or she is no longer eligible to receive any tax credits. They are receiving will end, whether they enroll in Medicare or not. If the consumer has been receiving an advance premium tax credit, the consumer must report the change to the [insert name of state exchange] to end the tax credit. If the consumer does not do this, the consumer will be liable to repay the tax credits for which he or she was not eligible. Although under federal laws the QHP cannot terminate coverage, a QHP is not designed to coordinate its benefits with Medicare. Both the premium and the benefits of a QHP are designed to provide primary coverage not supplemental coverage. Depending on state law a QHP may reduce its benefits to pay covered expenses that remain after Medicare pays, but the premium will stay the same. This may happen even if you don’t sign up for Part B of Medicare. In addition, a person who is eligible for Medicare and does not enroll within the time periods allotted will pay a premium penalty later and have a delay in when benefits begin. Consumers are encouraged to enroll in Medicare when they are eligible to do so to avoid premium penalties and delayed benefits later. The [insert name of State Health Insurance Assistance Program (SHIP)] at [insert contact information] should be able to give consumers more information about how and when to enroll in Medicare and any penalties that can apply.

*Note that this information (except for the tax credit) applies to individual coverage inside and outside an exchange.

Q 9586: Is there anything consumers and their dependents who are already on Medicare and have employer-based coverage need to do because of the ACA?
Generally, there’s nothing consumers need to do because of the ACA if they’re already on Medicare and have employer-based coverage. If consumers have coverage through an employer, and that employer’s current benefits pay first and Medicare pays second, the ACA doesn’t change that.
If the employer changes the benefits that cover consumers or their dependents, then they will send consumers a notice about those changes. Consumers can ask their employer’s human resources department how those changes work with Medicare.

The [insert name of State Health Insurance Assistance Program (SHIP)] at [insert contact information] should be able to give consumers more information about how their existing coverage work with Medicare.

Q 9687: Is there anything consumers and their dependents who are already on Medicare and have retiree coverage from an employer need to do because of the ACA?

The ACA doesn’t change those benefits. Consumers should contact their employer’s human resources department for help. If they need more information about how Medicare and retiree benefits work together, they can contact the State Health Insurance Assistance Program (SHIP) at [insert contact information].

Q 9788: Will consumers with Medicare Supplement insurance be affected by the ACA?

No. The ACA doesn’t change the cost sharing for Medicare supplement policies.

Q 9889: How will consumers’ Medicare prescription drug “donut hole” be affected?

The ACA began closing the “donut hole” in 2011, and it’s expected that the “donut hole” will be closed by 2020. This means that Medicare beneficiaries whose prescription drug costs are greater than the Part D deductible will need to pay only a 25% coinsurance rate until their expenditures reach the catastrophic level. The “donut hole” is being closed by combining a 50% discount on the cost of brand-name drugs and a gradual increase in the share of prescription drug costs for both generics and brand-name drugs that Medicare pays, until a beneficiary only owes 25% of the total cost.

Q 9991: What about long-term care insurance policies?

The [insert name of state exchange] doesn’t include long-term care insurance policies, and policies sold on the [insert name of state exchange] don’t typically cover long-term care services. Insurance agents and brokers still sell long-term care insurance outside the exchange. The HHS website www.longtermcare.gov has information about long-term care insurance.

ACA RELATED MEDICAID QUESTIONS

Q 10092: Where can consumers find more information about Medicaid?

Contact the [insert name of state Medicaid agency] at [insert contact information] with any questions or concerns about Medicaid and the ACA. Also, the HHS website has basic information about Medicaid posted at www.healthcare.gov.

Q 10193: Will consumers' eligibility for Medicaid change under the ACA?

The same categories of consumers will continue to be eligible for Medicaid, although the financial methodology is changing. They still need to be part of an eligible group, such as children, pregnant women, parents (or other caretaker relatives), blind, disabled, or elderly, and still need to meet the financial eligibility test set by [insert name of state]. Contact the [insert state Medicaid agency] at [insert contact information] for more information.

Drafting Note: States that have expanded Medicaid should modify this answer as appropriate.

There is more information on who is eligible for Medicaid that this link: https://www.healthcare.gov/medicaid-chip/eligibility/.

Q 10294: What is the expanded Medicaid eligibility under the ACA?

Starting in 2014, adults who weren’t already eligible for Medicaid may become eligible under the new ACA rules. [Insert name of state] has decided to expand Medicaid coverage to new groups, now covering [explain new eligibility criteria]. Contact the [insert name of state Medicaid agency] at [insert contact information] for more information.
Q 10395: What is the Federal Poverty Level (FPL) and why is it important in the context of health care coverage?

The federal poverty level (FPL) is how the federal government defines poverty, and it's used to decide who's eligible for federal subsidies and entitlement programs. In states that expanded Medicaid, people under 65 with incomes up to 138% of the FPL (or just under $33,000 for a family of four) generally can get Medicaid coverage. People with incomes above this level but less than 400% FPL may be eligible for premium tax credits to help them purchase a plan through the [insert name of state exchange]. Cost-sharing reductions will be available until a family's income reaches 250% of the FPL.

FPL is based on a family’s annual cash income and family size. Percentages of FPLs that are most relevant to Medicaid eligibility are 133% and 138%. As written in the ACA, 133% of poverty will be the new maximum income eligibility level for non-disabled adults under age 65 in [insert name of state], and other states that have expanded Medicaid eligibility. However, because 5% of a family's income isn't counted when computing FPL for Medicaid eligibility, the actual maximum income will be 138%, or $15,414 for a family of one and $31,809 for a family of four. Above this limit, premium tax credits will be available until a family’s income reaches 400% of the FPL. Cost-sharing reductions will be available until a family’s income reaches 200% of the FPL.

Drafting Note: States that didn’t expand Medicaid will need to revise the previous paragraph accordingly.

This link has general information about income levels at which financial help or coverage is available, as well as what counts as income. https://www.healthcare.gov/lower-costs/qualifying-for-lower-costs/

Q 10496: Will consumers’ Medicaid benefits change under the ACA?

Under the ACA, benefits will be similar for most consumers already receiving Medicaid. Contact the [insert name of state Medicaid agency] at [insert contact information] for more information.

Q 10597: What benefits will be available for adults newly-eligible for Medicaid?

Each state can define the benefit package for this newly-eligible group. The benchmark benefit package needs to at least include the essential health benefits available through the [insert name of state exchanges] (see Question 16). Contact the [insert name of state Medicaid agency] at [insert contact information] for more information.

Q 10798: Are undocumented immigrants eligible for Medicaid?

No.

Q 10899: Will the ACA change the way consumers apply for Medicaid?

Consumers can apply online through the [insert name of state exchange]. They also can apply by mail, fax, or in person. If a consumer applies through the [insert name of state exchange], their eligibility for Medicaid also will be assessed and the consumer’s application will be transferred to the [insert name of state Medicaid agency] for final determination. Under the law, there’s “no wrong door” to apply for health coverage, whether it’s through [insert name of state Medicaid agency], the Children’s Health Insurance Program (CHIP), or the [insert name of state exchange]. If a consumer isn’t eligible for Medicaid, then the consumer’s eligibility for coverage through the [insert name of state exchange] and for premium tax credits or cost-sharing reductions will be evaluated. This “one-stop” shopping experience should be convenient and fast (see Question 81).

Q 1090: Will consumers still need to submit documents to prove their income?
As much as possible, the [insert name of state exchange] can use existing data sources or get information from various federal and state agencies, such as the IRS, to verify income. The rules are designed to ensure a high degree of program integrity and reduce the amount of paperwork that consumers need to provide.

Some consumers will be asked to provide documents to prove their income. There are separate processes to verify income in order to qualify for Medicaid and CHIP and for premium tax credits and cost-sharing reductions. To verify income for Medicaid, CHIP, premium tax credits and cost-sharing reductions, [insert name of state exchange] will use data from the IRS, the Social Security Administration, and other income data sources.

For Medicaid and CHIP, issues that come up about verifying income will be resolved through a process of explanations and documentation. For premium tax credits and cost-sharing reductions, most verification issues will be resolved through a process of explanations and documentations. But, in the first year of operations, to limit the administrative burden, the [insert name of state exchange] may use a sample-based review in some cases.

COMMON CONCERNS ABOUT HOW THE ACA AFFECTS CONSUMERS

Q 11001: Does the ACA eliminate private health insurance?

No, there is still private health insurance under the ACA. The ACA created health insurance exchanges (see Question 5) where consumers can compare and shop for private insurance plans. The ACA also sets many new federal rules and protections that apply in each state (see Questions 1-4).

Q 11102: Does the ACA include new rules about insurance premiums?

In the individual and small group health insurance markets, premiums may vary based on an individual’s age, the area of the state in which the policy is sold, tobacco use, and family composition. Under the ACA, these are the only factors that an insurance company can use when they set premiums for individuals and small employers. Insurance companies can’t refuse to insure or charge higher premiums to consumers with medical problems. The ACA also reduces the difference in premiums charged for younger and older people and eliminates differences between premiums charged for men and women. Health plans in the individual and small group markets must, under the ACA, cover certain services (see Question 16).

To help make coverage affordable, many consumers who buy health insurance in the individual market will be eligible for premium tax credits. Also, consumers under age 30 or who can’t afford coverage may be eligible to buy catastrophic plans, which cost less.

Q 11203: Does the ACA address discrimination?

ACA explicitly prohibits insurance companies from discriminating on the basis of age, disability, or expected length of life. The ACA regulations prohibit discrimination against individuals on the basis of race, color, national origin, sex, age, disability, sex stereotypes, gender identity, or sexual orientation. These nondiscrimination standards apply to the exchanges and exchange activities, insurers and insurance plans, and the essential health benefits, among others.

Also, health insurers must follow any state laws and regulations that apply about marketing and can’t use marketing practices or benefit designs that will discourage individuals with significant health needs from enrolling. Health insurers also can’t discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions. Health insurers cannot require people to join an association to buy a plan.

Insurance companies won’t pay for services not covered by a plan, such as care that isn’t medically necessary. Consumers have the right to ask their insurance company to reconsider a decision to deny coverage and, after that, consumers have the right to an independent external review of the decision (see Questions 108 and 109).

Q 11304: What are the income tax implications of the ACA?

The [insert name of department of insurance] does not interpret or enforce obligations under the tax code. Consumers can contact the IRS or their tax advisor for information.
Q 11405: Where else can I find answers to health insurance questions?

[Insert links to State DOI, Exchange, Medicaid, navigator organizations, etc.]

Q 11506: What does the health plan “accreditation status” information on the exchange web page mean?

Accreditation is a comprehensive process by private, non-profit organizations that review how well health plans deliver care and how they work to improve the delivery of care over time. Health plans offered through the [insert name of state exchange] must be certified by a recognized accrediting body, such as [insert URAP and/or NCQA].

Part of the certification requires that the plan is accredited by a recognized accrediting entity within a timeframe set by the [insert name of state exchange]. Accreditation ensures that the plans sold on the [insert name of state exchange] meet minimum quality, access, non-discrimination and marketing standards in the ACA.

Q 11607: What does the health plan “consumer experience” information on the [insert name of state exchange] web page mean?

Consumer experience ratings come from surveys that ask individuals who have coverage through a health insurance plan how they like the plan. These individuals also rate the quality of the medical care they receive and the accessibility of the medical care that they need.

Q 11708: What appeal rights do consumers have?

Consumers have a right to appeal an unfavorable coverage decision by their health insurance company. Insurance companies must give consumers owning an individual policy a first-level internal appeal, administered by the company, and then, for certain adverse decisions, a second-level external review administered by an independent third party may be available. However, those two levels of internal appeals must also be done within the time limit imposed by the law for all internal appeal process, whether one- or two-level. Expedited review for emergency situations is available. For group policies, the insurance company may require two levels of internal appeals before the external review option, with provisions to allow for consideration of emergency services under an expedited process. For more information about how to appeal a health insurance company’s unfavorable decision, contact [insert state insurance department] at [insert telephone number].

Consumers also can file complaints with [insert name of state insurance department] when claims are denied, or when they believe that their health insurance company isn’t properly following the legal appeals process. To reach the state insurance department, consumers can contact [insert contact information].

Also, if a consumer is dissatisfied with an eligibility decision made by [insert name of state exchange] there will be an separate appeals process. The consumer can contact [insert name of state exchange] for more information.

Q 11809: Where do consumers file a complaint for a product sold through the [insert name of state exchange]? What about plans sold in the market outside the [insert name of state exchange]?

Consumers should first contact the insurance company with any complaint about benefits or services they’re not receiving. If consumers aren’t satisfied, they should contact the [insert name of state exchange] for help with questions or complaints.

The [insert state department of insurance] investigates complaints about insurance companies and can either look up consumers’ complaints or direct consumers to the right place to file a [insert name of state exchange] related complaint. The [insert state insurance department] is ready to help consumers with any question or complaint they may have about their coverage. To find out more about filing appeals, consumers can contact the [insert state department of insurance] at [insert contact information].

Q 11940: If consumers apply for coverage in the market outside the [insert name of state exchange], what are the rules regarding open and special enrollment?

In [insert name of state], insurance companies will sell policies in the market outside the exchange. Enrollment periods for coverage outside the [insert name of state exchange] generally are the same as enrollment periods through the exchange (see
Questions 11 and 63). Contact the [insert name of state department of insurance] at [insert contact information], or an insurance agent or broker, for more information about enrollment.

If someone is not eligible to enroll in health coverage through the [insert name of state exchange] or does not want to enroll in coverage through the [insert name of state exchange], insurers must make policies available in the [insert name of state exchange] available outside the [insert name of state exchange], although the policies are not required to be marketed as available outside the [insert name of state exchange].

QUESTIONS INVOLVING SPECIAL CIRCUMSTANCES AND POPULATIONS

Q 1204: What is available for consumers with chronic conditions? Will the new law help them get better coverage?

Yes, under the ACA, insurance companies can’t refuse to insure consumers with a chronic or preexisting medical condition, can’t refuse to cover preexisting conditions and can’t charge higher premiums because of a health or medical condition. The ACA also requires insurance companies in the individual and small employer markets to offer more comprehensive coverage than is currently available for some people with chronic illnesses. It prohibits discrimination on the basis of age, disability, or expected length of life. Coverage for these benefits is available from the beginning of the policy coverage period, without a waiting period for that condition, even if there was no prior coverage. Many plans include wellness programs to help consumers manage chronic conditions.

Q 1214: What options are there for consumers with children who aren’t citizens or legal residents?

Consumers won’t be able to buy a policy through the [insert name of state exchange] for those children who aren’t citizens or legal residentslawfully present, but they may be able to buy a policy directly from an insurance company or through an agent. Insurers that sell policies through the exchange, however, must make those policies available upon request to individuals, including children, who are not eligible to participate in the [insert name of state exchange]. For a list of licensed insurance companies in [insert name of state], visit [insert link]. Lawfully present children also may be eligible for the [insert name of state Children’s Health Insurance Program (CHIP)]. To learn more about CHIP plans, go to www.insurekidsnow.gov.

Q 1224: Does coverage provided through a religious health care sharing ministry satisfy the individual mandate?

Yes, the ACA includes an exemption from the individual mandate for individuals who are members of certain health care sharing ministries (see Question 55). This type of organization doesn’t guarantee payment of health care claims or expenses. In [insert name of state] health care sharing ministries aren’t exempt from state insurance laws and requirements.

Drafting Note: States that exempt health care sharing ministries from their insurance laws and requirements should modify this answer.

Q 1234: Are undocumented immigrants not legally present eligible for coverage through the [insert name of state exchange] or for premium tax credits?

No, undocumented immigrants not legally present aren’t eligible for coverage through the [insert name of state exchange]. They also aren’t eligible for advance payment of premium tax credits. Insurers that sell policies through the exchange, however, must make those policies available upon request to individuals, including children, who are not eligible to participate in the [insert name of state exchange].

Q 1244: Are incarcerated people eligible for coverage through the [insert name of state exchange] or for premium tax credits?

No, incarcerated people aren’t eligible for coverage through the [insert name of state exchange]. They also aren’t eligible for advance payments of the premium tax credits. Insurers that sell policies through the exchange, however, must make those policies available upon request to individuals, including children, who are not eligible to participate in the [insert name of state exchange].
Q 12516: Are tribal members eligible for coverage through the [insert name of state exchange] or for premium tax credits?

Yes, tribal members may buy coverage through the [insert name of state exchange]. Tribal members have access to enrollment continuously. They’re also eligible for premium tax credits. And, because of the federal government’s special trust responsibility, members of federally-recognized Indian tribes are eligible to receive benefits not available to others, such as plans with no cost-sharing, under certain circumstances. For more information, go to www.healthcare.gov.

QUESTIONS ABOUT MLR

Q 12617: What is the “Medical Loss Ratio” (MLR) requirement?

The ACA’s “medical loss ratio” (MLR) requirement is that health insurers must spend at least a certain percentage of consumers’ premium dollars on direct medical care and health care quality improvement. That limits the amount of premium dollars spent on administrative expenses, such as overhead, marketing, salaries, and profit.

The ACA requires that health insurance companies providing coverage in the large employer market (usually 50 or more employees) must spend at least 85% of premiums on direct medical care and quality improvement activities. Health insurers who provide coverage in the small employer market (usually fewer than 50 employees) and individual market must spend at least 80% of premiums on direct medical care and quality improvement activities, or they have to refund the extra premium.

Q 12718: What is an MLR Rebate?

Under federal law, if a health insurer doesn’t meet the MLR target (described in Question 119), that health insurer must give consumers or employers a rebate for the amount of premiums they collected that was greater than the target.

Q 12819: How can consumers learn if their insurer paid rebates?

Companies that pay rebates send notices to enrollees and the list of the rebates paid can be found at: http://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html

QUESTIONS ABOUT WHETHER A PLAN IS LEGITIMATE

Q 1290: Why is this a time to be especially on guard against health insurance fraud?

The health insurance reforms now underway as the ACA is implemented are bringing big changes. Few Americans are aware of all of the ACA requirements. Unfortunately, experience shows that during times of big change or confusion, fraud flourishes.

As the ACA is phased-in, con artists posing as representatives of the federal government or posing as legitimate insurance agents, brokers, or navigators might try to steal consumers’ money or identity through various health insurance schemes. For instance, criminals might try to convince consumers to reveal personal information to receive a “national health insurance card” or a new Medicare card under the ACA. Or they might try to sell consumers health insurance policies that are fake and worthless.

Q 13021: Can consumers get help from their current insurance agent or insurance company to buy health insurance coverage through the [insert name of state exchange]?

Yes. Working with individuals known personally or known to be working for legitimate organizations is a dependable way to avoid fraud.

Q 13122: If consumers don’t have a relationship with an insurance agent or company, where should they go for help?

When consumers contact the [insert name of state exchange], they’ll have the option to contact a navigator specifically trained to help them choose the best health insurance product for their needs.
Q 13223: How do consumers know that the insurance they're being sold is what they need to comply with the law?

If consumers are buying a plan because the ACA requires them to have health insurance coverage, consumers should be sure they’re given a “Summary of Benefits and Coverage (SBC).” This form also will be available online at healthcare.gov. The SBC will indicate whether a particular insurance plan provides “minimum essential coverage.”

Q 13324: If someone comes to consumers’ homes, calls consumers out of the blue, or sends e-mails to offer consumers health insurance coverage at a terrific price, how will consumers know whether the person and the health insurance coverage are legitimate?

Remember this simple formula: STOP – CALL – CONFIRM.

STOP – Consumers should ask the person for identification and a phone number where they may be reached later. If the person refuses to give this information for any reason, or tries to pressure them into signing any document, consumers should immediately hang up, close their door, or walk away.

Consumers should NOT volunteer their Social Security Number or a credit/debit card number to anyone unless they personally know the individual. Likewise, they should NOT sign any paperwork or write a check.

CALL – Consumers then should contact the [insert name of state department of insurance] or the [insert name of state exchange]. The insurance company or agent or broker, as well as the navigator, must be registered or licensed with the [insert state department of insurance] before they can sell coverage or counsel consumers through the [insert name of state exchange].

Drafting Note: States should modify the previous paragraph as necessary to reference the entity charged with registering or licensing navigators.

CONFIRM – Consumers should always confirm that the company, agent, or broker offering insurance coverage, or the navigator trying to provide assistance, is authorized to provide information or coverage before they sign any documents or give any personal information.

Remember that if something seems too good to be true, it usually is.

ATTACHMENTS FOR STATE INSURANCE DEPARTMENT STAFF

A. GLOSSARY

B. FLOW CHART