The Health Insurance Marketplace: Continuing Education Training
Self-Study Guide

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- Estimated time to complete activity: 1.25 hours
- Joint sponsored/co-provided by Postgraduate Institute for Medicine and National AHEC Organization

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**Target Audience**
This activity has been designed to meet the educational needs of health professionals who accept health insurance coverage, including physicians, registered nurses, and social workers.

**Statement of Need/Program Overview**
The new health insurance marketplaces provide insurance options for patients who have never had insurance, or now need to seek alternative sources of insurance. The new options for insurance available to patients are vast and providers need to be able to refer patients to the appropriate sources for insurance and/or assistance.

**Educational Objectives**
*After completing this activity, the participant should be better able to:*

- Discuss with patients the legal requirement for health insurance coverage and the various enrollment pathways now available under the Affordable Care Act to obtain health insurance coverage.
- Explain to patient Medicaid in their state and the enrollment procedures.
- Inform patients eligible for the CHIP program on enrollment procedures.
- Outline for patients the new health insurance rules along with their impact on their care.
- Discuss with patients, changes in the provider networks and how to navigate these networks for specific provider under the Affordable Care Act.
- Discuss with patients and office staff the new options for small businesses to cover its employees under the Affordable Care Act.

**Faculty**

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**Physician Continuing Medical Education**

**Accreditation Statement**
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Course meets the qualifications for up to 1.25 hours of continuing education credit for MFTs or LCSWs as required by the California Board of Behavioral Sciences, the Postgraduate Institute for Medicine, Provider Number 5114.
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<th>Name of Faculty or Presenter</th>
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1. Click on the “Find Post-Test/Evaluation by Course:” at the top of the page.
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What This Training Will Cover

This training discusses the goals of the new health care law, “The Patient Protection and Affordable Care Act of 2010” (as amended by the Health Care and Education Reconciliation Act of 2010) and its major provisions that affect individuals and small businesses. In this training, the law is referred to as “The Affordable Care Act”.

The Affordable Care Act is the largest expansion of health care coverage since the creation of Medicare and Medicaid. Its broad goal is to provide America’s population with accessible and affordable health coverage that meets some minimum standards of quality. The Affordable Care Act both provides and requires coverage for all legal U.S. residents in an effort to foster better health care for the entire population. In this way, the Affordable Care Act is intended to improve the overall health of the population.

The Affordable Care Act provides three pathways for individuals to obtain affordable health care coverage for themselves and their families:
- The expanded Medicaid Program,
- The Children’s Health Insurance Program (CHIP), and
- Private insurance coverage purchased through the newly-created “Health Insurance Marketplace” (which is referred to in this presentation as the “Marketplace”).

This training discusses all three pathways, but focuses mainly on the Marketplace, including:
- The rules governing the new health plans sold in the Marketplace – which are called Qualified Health Plans (QHPs);
- The Federal assistance available to help individuals pay for the insurance premiums and the out-of-pocket costs associated with QHPs; and
- The new “small group health plans” sold through the Marketplace’s Small Business Health Options Program (SHOP) (which health professionals, as small business owners, can purchase for their employees) and the tax credits available to help cover the employer contribution for these plans.

Finally, this training describes how and when individuals, families and businesses can access coverage through each pathway.
The Affordable Care Act provides access to an affordable option for quality coverage for almost everyone by:

- Giving states the option to expand Medicaid – which will help to cover more low-income adults who are currently uninsured;

- Funding through 2015 (and authorizing through 2019) the existing nationwide coverage for children – under the Children’s Health Insurance Program (CHIP); and

- Creating the Health Insurance Marketplace – The Marketplace is comprised of new organizations that are set up at the Federal level, and in each state, to create more organized and competitive markets for buying health insurance. The Marketplace offers a choice of health plans called Qualified Health Plans (QHPs), which are certified to provide certain coverage and consumer protections, and also makes available Federal subsidies to help pay for QHP premiums and out-of-pocket costs. [See “The Health Insurance Marketplace” in the Glossary of Terms.]

The Affordable Care Act also requires a new streamlined application process in which the same application is used for applying to Medicaid and CHIP, and for purchasing QHPs in the Marketplace.


**Individual Shared Responsibility** (4), (5)

To help guarantee that everyone obtains coverage, the Affordable Care Act institutes what is called the “individual shared responsibility payment” or “individual mandate.” This requires all individuals who can afford health insurance to obtain what is called “minimum essential coverage” (MEC) or be subject to a tax penalty or “fee.” The fee is collected by the IRS by withholding the applicable amount from any tax refund that may be due.

An individual has MEC if he or she is covered by one of many programs and plans including:

- Any Marketplace plan or employer plan;
- Medicare, Medicaid or CHIP; and
- Veterans health care programs or TRICARE.

[See “Minimum Essential Coverage (MEC)” in the Glossary of Terms for a complete list.]

Individuals may be exempt from the fee under circumstances such as those listed on this slide. The “hardship exemption” that is listed includes: homelessness, death of a close family member, medical or caregiver costs, or natural or human-caused disasters.

[See “Hardship Exemption” in the Glossary of Terms for a complete list of qualifying hardships.]

The tax fee is triggered when an individual is without MEC for three consecutive months. At that time, 1/12 of the annual penalty applies to each month an individual is uninsured. All fees calculated from household income are capped at the national average yearly premium for a bronze-level plan.

The annual fee for not obtaining MEC is as follows:

- 2014: $95 for each adult and $47.50 for each child under 18 (with a maximum fee per family of $285) or 1% of the individual's annual household income – whichever is higher.
- 2015: $325 for each adult or 2% of household income.
- 2016: $695 for each adult or 2.5% of household income.
- After 2016: Adjusted for inflation.


The Affordable Care Act gives the option to states to expand their Medicaid program to cover adults between the ages of 18 and 64 who have incomes up to 133% of the Federal Poverty Level (FPL). On this map, the states that are green (or lightest) have expanded their Medicaid program. The states that are blue (or darkest) have not expanded their Medicaid program. As of March, 2014, more than half of the states in the U.S. have exercised this Medicaid expansion option. [See “Federal Poverty Level” in the Glossary of Terms for a list of household income levels used to calculate Medicaid eligibility.]

The FPL is based on annual income. For 2014, the FPL used for Medicaid eligibility is:
- $11,670 per year for an individual; and
- $23,850 per year for a family of four.

133% of this FPL is:
- $15,521 for an individual; and
- $31,721 for a family of four.

It is important to note that while the Affordable Care Act gives states the option to expand Medicaid eligibility up to 133% of the FPL, consumers in Medicaid expansion states may actually qualify for Medicaid with incomes up to 138% of the FPL. This is because the Affordable Care Act also states that five percent of a Medicaid-eligible individual’s income will be “disregarded” when their adjusted gross income is calculated. This effectively results in Medicaid eligibility for individuals with incomes up to 138% of the FPL. [See “Five Percent Disregard” in the Glossary of Terms.]

For 2014, 138% of the FPL used for Medicaid eligibility is:
- $16,105 for an individual; and
- $32,913 for a family of four.

The Affordable Care Act gives the options to states to exercise Medicaid expansion at any time. Even if a state has not expanded Medicaid, states differ in the level and scope of Medicaid coverage they offer above the Federal minimum program requirements. Therefore, individuals are still encouraged to apply for coverage to see if they qualify.
Medicaid Coverage (8), (9)

The Affordable Care Act allows for a significant expansion in the number of people who can be covered by Medicaid, but it does not change:

- The minimum Federal Medicaid coverage guidelines for low-income families and children, pregnant women, people with disabilities or the elderly; or
- Each state’s existing ability to provide additional Medicaid coverage to these populations.

In states that have chosen not to expand Medicaid, there is currently a "coverage gap" for many uninsured adults. The Affordable Care Act was originally structured on the premise that Medicaid expansion would be required in all states. Therefore, all adults between the ages of 18 and 64 who earn up to 133% of the FPL would be covered by Medicaid – and Federal tax credits would be provided for others with incomes between 100% and 400% of the FPL to help them buy private insurance.

However, in June, 2012, the U.S. Supreme Court ruled that state Medicaid expansion had to be voluntary. As a result, in states that have not expanded Medicaid, uninsured adults with incomes below 100% of the FPL fall into a coverage gap. Their incomes are too high to qualify for Medicaid under their state’s current rules – but their incomes are too low to qualify for Federal subsidies to help them buy coverage in the Marketplace. These individuals may, however, be eligible for an exemption from having to pay a fee for not having health insurance coverage.

Eligible individuals and families may enroll in Medicaid at any time and Medicaid coverage begins immediately upon enrollment. Individuals and families in all states can determine eligibility and apply for Medicaid by:

- Calling the national 1-800 number (1-800-318-2596) or visiting the Federal Marketplace website (www.healthcare.gov) and submitting an application. The same application is used across the Marketplace for applying for Medicaid, CHIP and Marketplace QHPs. If an individual qualifies for Medicaid, the

individual’s state Medicaid agency is notified so the individual can complete the enrollment process with the state agency.

- **Contacting their state Medicaid office directly and submitting an application.** The Federal Marketplace website provides information regarding the status of Medicaid expansion in every state. It also links directly to each state’s Medicaid office website.


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**CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP) COVERAGE**

CHIP is for children in families that earn too much to qualify for Medicaid but not enough to afford private insurance coverage

- Offered in all states
- Not tied to state Medicaid program expansion
- Comprehensive CHIP coverage funded through 2015
- Open enrollment and immediate coverage

**States may choose to:**

- Integrate CHIP into Medicaid program
- Operate CHIP separately from Medicaid (with different income eligibility thresholds)
- Cover additional benefits
- Cover pregnant women and parents

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**Children's Health Insurance Program (CHIP)**

CHIP is a nationwide program that provides comprehensive health care coverage to children in families that earn too much to qualify for Medicaid, but not enough to afford private insurance coverage.

The Affordable Care Act funded CHIP through 2015 and authorized its continuance through 2019. The Affordable Care Act does not change the program’s eligibility or enrollment. In every state, children from birth through the age of 18 may be eligible for the program. Some states cover young adults beyond the age of 18. The Affordable Care Act requires all states to maintain CHIP eligibility and enrollment policies that were already in place at the time the Affordable Care Act was enacted (March 23, 2010) and to keep them in place until September 30, 2019 for children in both Medicaid and CHIP.

CHIP copays and premiums vary by state, but never total more than 5% of annual household income.

CHIP benefits are not affected by any possible state Medicaid expansion. States may differ regarding eligibility thresholds and may choose to provide additional program benefits for children or to cover pregnant women and parents. However, all states remain required to provide comprehensive coverage for children, including:

- Routine check-ups,
- Doctor visits,
- Immunizations and Prescriptions,
• Dental and vision care,
• Inpatient and outpatient hospital care,
• Laboratory and X-ray services, and
• Emergency services.

CHIP has open enrollment in all states and coverage starts immediately upon enrollment. Individuals may determine eligibility and apply for CHIP by:
• Calling the national 1-800 number (1-800-318-2596) or visiting the Federal Marketplace website (www.healthcare.gov) and submitting an application. If an individual qualifies for CHIP, the individual's state agency is notified so the individual can complete the enrollment process with the state agency.
• Contacting their state CHIP agency directly and submitting an application. The Federal Marketplace website provides the name of each state’s program and a link to its website.
• Contacting “Insure Kids Now” at 1-877-KIDS-NOW or visiting www.insurekidsnow.gov. This call center and website is operated by the U.S. Department of Health and Human Services and dedicated to providing information about Medicaid and CHIP services for families who need health insurance coverage.


State Options for Marketplace Structures (12), (13), (14)

The Affordable Care Act requires the establishment of a Marketplace in each state – which is often called an “exchange.” States may choose to operate their Marketplaces in one of three ways:

Federal-facilitated Marketplace (FFM) – The states with Federally-facilitated Marketplace are blue (or darkest) on the map. In these states, the Marketplace is run by the Federal Government. QHPs available in these states can be viewed and purchased through the Federal Health Insurance Marketplace website or the national 1-800 number.
State-based Marketplace (SBM) – The states with State-based Marketplaces are white on the map. In these states, the Marketplace is run entirely by the state. They also have their own state website through which the QHPs available in these states can be viewed and purchased.

State-partnership Marketplace (SPM) – The states with State-partnership Marketplaces are green (or grey) on the map. In these states, the Marketplace is a combination of the Federal and State approaches. States vary in the operations they choose to run.


How Individuals and Families Access the Health Insurance Marketplace

Regardless of a state’s Marketplace structure, the Federal Marketplace’s website or national 1-800 number can be the first stop for all individuals, families and small businesses seeking affordable, quality coverage provided by each pathway under the Affordable Care Act. This slide shows the overview of the Marketplace process.

#1 Go to the Marketplace: The Federal website will automatically link consumers to the appropriate state website or send them directly to another part of the Federal website in order to obtain the information, additional web links and phone numbers that may be necessary for them to enroll in all forms of coverage. It also provides contact information for “navigators” and “assistors” and others who are trained to help with choosing and enrolling in plans and are required to be available in every local area.

#2 Determine eligibility for lower-cost or free health care coverage options: The Affordable Care Act requires one standardized application for individuals and families seeking to obtain coverage through Medicaid, CHIP or new private coverage. This application can be filled out online or by phone. It collects all of the information
necessary to determine eligibility for Medicaid, CHIP or Federal assistance with QHP premiums or out-of-pocket costs. [Federal subsidies are further discussed on the “Federal Subsidies for QHPs through the Insurance Affordability Program” slides.]

#3 Choose a form of coverage: If an individual qualifies for Medicaid or CHIP, his or her application information will be conveyed to the appropriate state office where the enrollment process can continue. Individuals seeking private coverage will either browse the available QHPs in their area on the Federal Marketplace website, or they will be linked to their State Marketplace website for information about these plans.

All QHPs sold in a Marketplace must have an accompanying Summary of Benefits and Coverage (SBC) which allows individuals and small businesses to compare premiums, out-of-pocket costs, coverage and provider networks. [SBCs are further discussed on the “QHP Summary of Benefits and Coverage” slide.]

#4 Enroll: For Medicaid and CHIP, coverage starts immediately upon enrollment. For private QHPs, coverage start dates vary. [Enrollment and coverage dates are further discussed on the “Important Marketplace Enrollment Dates” slide.]


QHPs Subject to Insurance Reforms

The Affordable Care Act implements many insurance reforms that are intended to protect consumers and ensure the quality of coverage. These new insurance rules apply to all QHPs sold through a Marketplace to both individuals and small businesses. They include:

A ban on excluding pre-existing conditions – No one can be denied insurance coverage or coverage for a particular medical condition that existed prior to applying for a particular QHP.

Determining rate variations – Only four factors can be used when determining insurance rate variations: geography, age, family size and tobacco use. Insurers are no longer permitted to deny coverage or charge higher premiums on the basis of gender or health status. Additionally, while rate increases do not need to be
approved by the U.S. Department of Health and Human Service (HHS), insurance companies must submit
documentation to the Department justifying the reasons for the rate increase.

Required coverage of a minimum set of care and services called “Essential Health Benefits” – Essential Health
Benefits (EHBs) are the required minimum set of care and services that must be covered by all QHPs. [EHBs
are discussed in greater detail on the “QHPs Cover Ten Categories of Essential Health Benefits” slide.]

Prohibiting annual or lifetime limits or caps on the dollar value of coverage – This applies to all covered EHBs.

Required annual out-of-pocket cost limit – Out-of-pocket costs include deductibles, copays and coinsurance
and all costs for services that aren't covered by the QHP. While out-of-pocket costs vary between QHPs in the
Marketplace, the Affordable Care Act places a maximum on overall out-of-pocket costs for all individual and
small group coverage. For 2014, the out-of-pocket cost sharing limit is: $6,350 each year per individual and
$12,700 each year per family. However, these limits only apply to in-network EHBs.

Required coverage of certain preventive benefits with no out-of-pocket costs – Certain preventive care benefits
for all adults, and specifically for women and children, must be covered by QHPs with no copay or coinsurance
charge regardless of whether the plan deductible has been met. The Federal Marketplace website provides a
comprehensive list of these free preventive care benefits for each population which include a variety of
vaccinations, screenings, well-visits, testing and counseling.

2014.
18) Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for
19) Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review (Final Rule). Federal Register 78:39
The “Essential Health Benefits” (EHB) standard is one of the major ways in which the Affordable Care Act ensures the quality of QHPs and protects consumers against discriminatory insurance benefit designs. With limited exception, all individual and small group QHPs sold through a Marketplace (and some plans sold outside of the Marketplace) are required to include items and services in the ten categories of services shown on this slide. [See “Habilitative Services” in the Glossary of Terms.]

States do, however, retain some flexibility in determining the scope of these services. Each state is required to establish an “Essential Health Benefits Benchmark Plan” which defines the standard set of benefits that must be covered by plans in that state.

Each state’s Department of Insurance is responsible for choosing a benchmark plan from four types of group plans that are already offered in the state and have the largest enrollment. These group plans are: small group health insurance products, state employee health plan options, Federal employee health plan options, or the largest commercial HMO plan sold in the state. [See “Essential Health Benefits Benchmark Plan” in the Glossary of Terms for details regarding the current benchmark plan in each state.]

Insurers in the state are then required to offer plans with benefits that are “substantially equal” to those found in a state’s benchmark plan. Additionally, the types of services covered must be balanced across the required categories of services. If a state’s EHBs Benchmark Plan does not include services in all of the required benefit categories, states must identify supplemental coverage to complete their benchmark packages. This is likely to be the case for services that were previously not covered by most group plans such as pediatric dental and vision care.

However, certain benefits can be included but do not count as EHBs including: adult routine dental and eye exams, cosmetic orthodontia, and long-term/custodial nursing home care.


QHPs Grouped into Metal Levels (23), (24), (25)
States must use the same cost-sharing levels for QHPs offered in their state. This means all insurance carriers must develop the cost-sharing features for the products they offer based on the actuarial values for the different “Metal Level Plans” – bronze, silver, gold, and platinum.

The average amount consumers must pay out-of-pocket for covered services is determined by a measure called “actuarial value” (AV). The “Metal Levels” of the QHPs correlate to actuarial values, which are the average percentage of health care expenses a plan would cover for EHBs for a standard population. For example, a plan with an AV of 70% would be expected to cover on average 70% of health care expenses, with consumers paying the remaining 30% through some combination of deductibles, copays, and coinsurance. In general, plans with lower out-of-pocket costs have higher premiums – and those with lower premiums have higher out-of-pocket costs.

Deductibles are not standardized by Metal Level. They will vary within each Metal Level and vary by state. But deductibles are included in the calculation for the limit on out-of-pocket costs that is required by the Affordable Care Act. [See “Out-of-Pocket Maximum/Limit” in the Glossary of Terms.]

The estimated costs at each Metal Level are averages. A consumer could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on their actual health care needs and the terms of the policy. Further, these average costs are non-premium, out-of-pocket expenses such as copays, coinsurance and deductibles. Consumers are also responsible for varying amounts of premiums depending on the plan they choose and possible eligibility for reduced premiums.

All insurers who participate in a Marketplace must offer:
- Child-only plans at the same Metal Levels;
- At least one gold and silver plan; and
- A catastrophic plan (which is not a Metal Level plan). [Catastrophic plans are discussed in greater detail on the next slide.]

Dental care for children must be covered as an EHB in all Marketplace QHPs. Many adults 18 and older will have to purchase separate, stand-alone dental plans which do not correlate with Metal Levels and have their own premium and out-of-pockets cost structures.


Catastrophic coverage in the Marketplace retains its traditional purpose of providing a kind of "safety net" coverage in case of a serious accident or illness.

Every insurance carrier selling QHPs in a Marketplace must offer one plan that provides catastrophic coverage. But catastrophic plans are not Metal Level QHPs and do not follow the same required cost-sharing rules. Plans will vary, but, in general, the premiums for these plans are very low, and the deductibles (and overall out-of-pockets costs) are very high. These plans do not cover EHBs until the high deductible is met.

There are a few new requirements for catastrophic plans offered in the Marketplace:

- They can only be made available to individuals under 30 years old – or those who have qualified for a hardship exemption and cannot afford Metal Level coverage. [See “Hardship Exemption” in the Glossary of Terms for the types of qualifying hardships.]
- They must cover three primary care visits per year at no cost and before the deductible is met; and
- They must cover free preventive services including screenings, vaccines and certain counseling services.

Catastrophic coverage could be an option for individuals who fall into the Medicaid “coverage gap” previously discussed – or for those whose plans have been cancelled because they do not offer the new benefits and protections required of plans under the Affordable Care Act.

Federal Subsidies for QHPs through Insurance Affordability Programs: Cost Sharing Reduction Plans (CSR) (28)

The Affordable Care Act establishes “Insurance Affordability Programs” which include two types Federal subsidies for QHP premiums and out-of-pocket costs. First, assistance with out-of-pocket costs is offered through Cost Sharing Reduction Plans (CSR).

Within each Metal Level, insurers can design a wide range of options with varying deductibles, copays, and coinsurance, but must observe the Affordable Care Act’s required maximum annual out-of-pocket cost limit for EHBs. The cost limit for 2014 is: $6,350 for an individual and $12,700 for a family. CSR helps pay these out-of-pockets costs for those with annual incomes between 100% and 250% of the FPL. [See “Federal Poverty Level (FPL)” in the Glossary of Terms for a list of household income levels used to calculate QHP subsidy eligibility.]

For 2014:
• For an individual
  • 100% of the FPL used for determining QHP subsidies is $11,490; and
  • 250% is $28,725.
• For a family of four:
  • 100% of this FPL is $23,550; and
  • 250% is $58,875.

Eligibility for CSR is based on information provided during enrollment regarding income and household members. However, an individual can only qualify for CSR if they enroll in a silver level plan through the Marketplace and earn between 100% and 250% of the FPL. For qualified individuals enrolled in a silver level plan, the out-of-pocket costs for EHBs will be lower based on a sliding scale. For these individuals, costs will be less than the current out-of-pocket cost limit that applies to all individuals in all Metal Level QHPs. CSR is not available for catastrophic plans.

To determine eligibility for Federal subsidies, call the national 1-800 number or go to the Federal Marketplace website to use the “Health Insurance Cost and Savings Calculator” or “Quick Check Chart” or submit an application.

Federal Subsidies for QHPs through Insurance Affordability Programs:
Advance Payment Tax Credit (APTC) (29), (30)

The second Federal subsidy related to QHPs is premium assistance which is offered through the Advance Premium Tax Credit (APTC).

To qualify for the APTC, individuals must obtain insurance through the Marketplace. During enrollment through the Marketplace, the information provided regarding projected annual income and family composition will be used to estimate the amount of the tax credit an individual could claim in a given tax year.

Premium assistance is provided on a sliding scale for individuals with incomes between 100% and 400% of the FPL. [See “Federal Poverty Level (FPL)” in the Glossary of Terms for a list of household income levels used to calculate QHP subsidy eligibility.]

For 2014:
- For an individual:
  - 100% of the FPL used to determine QHP subsidies is $11,490; and
  - 400% is $45,960.
- For a family of four:
  - 100% of the FPL is $23,550; and
  - 400% is $94,200.

The amount of the APTC will be calculated based on the premium rate for the second-lowest cost silver level plan in the applicable Marketplace. Individuals who qualify for the APTC can choose to:

- **Take the credit now:** Which means the Federal Government will pay some or all of the estimated tax credit in advance, directly to the insurance company, to reduce the individual’s monthly premiums; or
- **Take the credit later:** Which means the individual will receive the entire tax credit when they file their annual Federal income tax return for that year, but will have to pay the full premium in the meantime.

If the amount of advance credit payments an individual gets for the year is less than the tax credit they are due, they will get the difference as a refundable credit when they file their Federal income tax return. If the amount
of the advance payments for the year is more than the amount of the tax credit they are due, they must repay
the excess advance payments when they file their Federal income tax return.


QHP Summary of Benefits & Coverage (SBC)

Insurers are required to provide an accompanying Summary of Benefits & Coverage (SBC) with every QHP
offered in a Marketplace. There is a link to each QHP’s SBC in the Marketplace when consumers are
comparing plans.

The SBC is intended to allow consumers to make an apples-to-apples comparison of plans by providing
information across the same categories regarding coverage and costs and in a standardized format. It
includes standardized questions about the QHP such as:
• What is the overall deductible?
• Do I need a referral to see a specialist?
• Does this plan use a network of providers?

It includes information regarding the cost of "common medical events" when using a network provider or a non-
network provider such as:
• If you have a test
• If you have outpatient surgery
• If you have a hospital stay
• If you need help recovering or have special health needs
• If you are pregnant

It also lists some services that are explicitly NOT covered by the plan.

The SBC is intended to protect consumers by making it easier for them to compare plans and know what they
are buying. However, it should be noted that while these summaries are a useful new tool, they are not yet as
comparable as they need to be. Additionally, they offer only estimates of costs and examples of common care. They are a good starting place, but not a substitute for reviewing the complete terms of the plan.


QHPs Maintain Provider Network Adequacy

QHPs must meet a set of minimum standard requirements for provider network adequacy. Each QHP network must:

• Include essential community providers – which are providers that serve predominately low-income, medically underserved individuals (such as community health centers, sole community hospitals and rural health clinics); and

• Maintain sufficient numbers and types of providers (including providers that specialize in mental health and substance abuse services) to assure that all services will be accessible without unreasonable delay.

In general, QHPs with more extensive networks will have higher premiums – and plans with lower premiums will have more restrictive networks. However, out-of-pocket costs and costs for seeing a non-network provider will differ. Each individual will have to weigh their personal considerations and choose a QHP that works best for them.

If it is important to an individual that they be able to see a certain provider, that individual should consult the QHP’s provider directory or call the insurance carrier to double-check that the desired provider is in the QHP’s network. Each carrier must make a provider directory available for each plan it sells in the Marketplace. Each QHP’s SBC must provide a link to the provider directory as well as to the insurance carrier’s phone number.

Individual providers will not be automatically notified of their inclusion in or exclusion from various QHP networks. Providers should call the insurance carriers with whom they have historically participated – and
those that offer QHPs in their area through the Marketplace – to ask if they are included in the provider network.


Important Marketplace Enrollment Dates (35)

The Marketplace has open enrollment each year for individuals and families.

As the system is being implemented, the open enrollment period for coverage in 2015 is currently scheduled to start on Nov. 15, 2014 and end on Feb. 15, 2015. Thereafter, Federal Regulation states that open enrollment will occur each year from Oct. 15th to Dec. 7th (subject to change if necessary).

Consumers should call the national 1-800 number or consult the Federal Marketplace website for updated information.

Premium rates are published each year, but whether rates are published prior to the start of open enrollment will vary by geographical area. Early release of rates is the decision of the state, the Marketplace and each insurance company.

Coverage start dates are fairly standard. During open enrollment, if an individual or family enrolls between the 1st and 15th days of the month, their coverage will start on the first day of the next month. If they enroll between the 16th and last day of the month, their coverage will start on the first day of the second following month.

Some insurance companies differ from these general start dates. Consumers should double-check when comparing and enrolling in plans.
Any time an individual has what is considered a “qualifying life event” they are eligible for a “special enrollment period” which usually allows them 60 days to obtain coverage. These events include: moving to new state, losing a job, or a change in the size of their family. [See “Qualifying Life Event” in the Glossary of Terms for a complete list of these events.]


Small Business Health Options Plan (SHOP) (36)

The Small Business Health Options Plan (SHOP) Marketplace is a new way for employers to purchase small group plan health coverage for their employees.

Small group plans sold in the Marketplace are subject to the same insurance reforms and QHP requirements as individual plans. Under the Affordable Care Act, small employers (up to 50 employees) may keep the coverage they already have, obtain a SHOP plan to offer coverage to their employees, or offer no coverage at all.

SHOP plans also follow the same Metal Levels as individual plans sold in the Marketplace. Employers may choose any Metal Level and control the amount paid toward employee premiums, subject to state minimum contribution requirements. The plan chosen affects how much employees will pay out-of-pocket for:

• Deductibles and copays;
• Costs that could be incurred depending on the amount of care an employee receives; and
• The coinsurance percentage of the cost of that care for which they are responsible.

For 2014 and 2015, employers with 50 or fewer full-time equivalent employees (FTEs) may offer a SHOP plan to their employees. Consult the Federal Marketplace website for instructions on how to properly calculate a businesses’ number of FTEs. [See “Full-time Equivalent Employee (FTE)” in the Glossary of Terms.]

To be eligible to enroll in SHOP plans, employers must:

• Offer coverage to all FTEs – which generally means those working 30 or more hours per week on average;
• Meet the minimum participation of at least 70% of FTEs – which differs in the following states: Arkansas, Iowa, New Hampshire, New Jersey, South Dakota and Texas require 75% and Tennessee requires 50%;

• Enroll between November 15th and December 15th each year in order to be exempt from any minimum participation requirements; and

• Meet their state’s employer premium contribution requirements.


Small Business Health Options Plan (SHOP): Business Tax Credits

Some small businesses may qualify for a Small Business Tax Credit for SHOP plans.

To qualify for the tax credit, employers must:

• Have fewer than 25 FTEs – who earn an average of about $50,000 a year or less; and

• Pay 50% of FTEs’ premium costs – but they are not required to offer coverage to part-time employees or dependents.

The tax credit is worth up to 50% of the employer contribution toward employees’ premium costs (and up to 35% for tax-exempt employers). Employers may still deduct, from their taxes, the rest of the premium costs not covered by the tax credit.

The credit is highest for companies with fewer than 10 employees who are paid an average of $25,000 or less. In general, the credit is structured such that the smaller the business, the bigger the credit.

How Small Businesses Access SHOP (39)

There is a SHOP Marketplace in each state. A small business must have an office or employee work site within that Marketplace's area to use that particular Marketplace.

Enrollment and start dates for SHOP coverage are the same as in the individual insurance market. If an employer enrolls by the 15th of any month, coverage for their employees generally begins on the 1st day of the following month. If an employer enrolls between the 16th and the last day of the month, coverage generally begins on the 1st day of the second following month.

However, enrollment in a SHOP plan through the Federal Marketplace has been postponed until 2015 – and the functionality of enrollment using State Marketplaces varies by state. Small business in Federally-facilitated states, and in some State-based and State-partnership states, must work directly through an insurance agent, broker, or insurance company to fill out an application and enroll in these plans.

Small businesses may still begin the enrollment process by calling the national 1-800 number or visiting the Federal Marketplace website. The Federal website allows a business to choose their state and then either links them to the appropriate state website, or links them directly to an SBC for each health plan and dental plan available in their area. Employers can compare coverage and get sample price quotes.

Each SHOP plan’s SBC provides the contact information for the insurance carriers with whom employers can complete the enrollment process.

The Affordable Care Act is intentionally structured to include and cover almost everyone in the new health care system. It is based on the premise that people who are uninsured still get urgent and often expensive care when they are sick, but have no help paying for it and can face bankruptcy. Meanwhile, the cost of their care is spread across everyone else who is insured and raises insurance rates.

To remedy both problems, the law mandates that just about everyone must buy health insurance coverage through the Marketplace, unless they have another accepted form of minimum essential coverage. If they don’t obtain the required coverage, a fee will be deducted from any future tax refunds.

While the Affordable Care Act requires coverage and some level of financial responsibility from most everyone, it also provides new affordable pathways for people and businesses to meet these requirements – including a significant expansion of Medicaid and Federal subsidies for insurance coverage through the Marketplace.

The Affordable Care Act has instituted many insurance reforms to protect consumers. These reforms help assure the quality and consistency of the coverage; limit the consumer’s exposure to out-of-pocket costs; and assure minimum requirements for the composition of provider networks.

As was the case with insurance coverage prior to the Affordable Care Act, Marketplace QHPs still structure their coverage and costs differently; offer different networks of providers; and charge different costs when patients use non-network providers. QHPs with lower premiums may have more limited provider networks and higher exposure to out-of-pocket expenses. QHPs with higher premiums may have broader networks and lower exposure to out-of-pocket expenses. Ultimately, the choices patients make will affect the premiums and out-of-pocket costs they will face.

The Affordable Care Act State Fact Sheets, which accompany this presentation, provide state specific information regarding how individuals and small businesses in each state (and the District of Columbia) can access the Marketplace and find help with determining eligibility, comparing plans and enrolling. They also provide the basic parameters of current eligibility in each state for Medicaid and CHIP.
FEDERAL RESOURCES

**Health Insurance Marketplace**
Individual, family, small business coverage options/enrollment
- www.healthcare.gov
- www.cuidadodesalud.gov

**Medicaid**
- www.medicaid.gov

**Children’s Health Insurance Program (CHIP)**
- www.insurekidsnow.gov

MORE FEDERAL RESOURCES

**Internal Revenue Service**
Section on all Affordable Care Act tax provisions
- www.irs.gov

**The Center for Consumer Information and Insurance Oversight (CCIIO)**
Section on Affordable Care Act rules for private insurance and marketplaces
- www.cms.gov/CCIIO

**BusinessUSA**
Section on all health care changes of interest to businesses
- www.business.usa.gov
The Health Insurance Marketplace: Continuing Education Training

Obtaining Credits

Please go online to CME University at: www.cmeuniversity.com, and register or login (takes less than one minute).

Once logged in, follow these steps:
1. Click on the “Find Post-Test/Evaluation by Course:” at the top of the page.
2. Type in “9949” and hit enter.
3. Click on the activity title when it appears.
4. Choose your profession/type of credit you are seeking.
5. Successfully complete the online posttest (see the questions listed below) with a passing score of 75% or better, and complete the online Evaluation Form.

Upon successful completion of the online posttest and Evaluation Form, you will have immediate access to a certificate of attendance to print or save for your files.

If you have any questions regarding the CE certification for this activity, please contact Postgraduate Institute for Medicine at: information@pimed.com or (303) 799-1930.

Self-Study Guide Questions

1) The broad goal of the Affordable Care Act (ACA) is to provide America's population with accessible and affordable health coverage that meets some minimum standards of quality. What are the pathways to affordable health coverage provided by the ACA?

A. Medicaid
B. CHIP
C. The Health Insurance Marketplace
D. All of the above

2) Individuals are subject to a tax penalty or “fee” if they are not enrolled, for more than three months of any year, in what type of health coverage?

A. A Qualified Health Plan (QHP)
B. Minimum Essential Coverage (MEC)
C. Essential Health Benefits (EHBs)
D. A SHOP Plan

3) The Federal Health Insurance Marketplace can be the first stop for all individuals, families and small businesses seeking coverage provided under the ACA. Which information cannot be obtained through the Federal Marketplace by visiting www.healthcare.gov or calling 1-800-318-2596?

A. Determining eligibility for Medicaid or QHP subsidies
B. Comparing each QHP's Summary of Benefits Covered (SBC)
C. Finding current rules for private Medicare supplemental insurance
D. Finding Navigators or Assistors in a particular local area

4) The ACA implements many insurance reforms that are intended to protect consumers and ensure the quality of coverage. Which is not an insurance reform required of QHPs by the ACA?
A. Ban on pre-existing condition exclusions  
B. Required coverage of EHBs  
C. Standardized premium and deductible costs  
D. Annual out-of-pocket cost limit  

5) The ACA requires all states to use the same cost-sharing levels for QHPs offered in their state. These cost-sharing levels are based on the actuarial values of the different “Metal Level Plans.” Which “Metal Level” is likely to have the highest premiums and the lowest out-of-pocket costs for covered services?  
A. Bronze  
B. Silver  
C. Gold  
D. Platinum  

6) The ACA sets forth minimum standard requirements for provider network adequacy that every QHP offered in the Marketplace must meet. Which of the requirements below is not a provider network adequacy requirement under the ACA?  
A. Must include all current providers in the local area  
B. Must include essential community providers  
C. Must maintain sufficient numbers and types of providers  
D. Must assure that all services will be accessible without unreasonable delay  

7) The Small Business Health Options Plan (SHOP) Marketplace is a new way for employers to purchase small group plan health coverage for their employees. Some small businesses may also qualify for a Small Business Tax Credit to help defray the costs of these SHOP plans. Which of the requirements below is necessary in order for a small business enrolled in a SHOP plan, to also be eligible for the tax credit?  
A. Must offer coverage to all full-time employees  
B. Must have fewer than 25 full-time equivalent employees who earn an average of about $50,000 a year or less  
C. Must meet the minimum participation of at least 70% of full-time employees (unless state law differs)  
D. Must meet state employer premium contribution requirements