FAQ-Health Insurance

Market Place - FAQ

What is the health insurance Marketplace?

Health Insurance Marketplaces (also known as Exchanges) are organizations set up to create more organized and competitive markets for buying health insurance. They offer a choice of different health plans, certify plans that participate, and provide information and in-person assistance to help consumers understand their options and apply for coverage. Through the Marketplace, individuals and families can shop for coverage if they need to buy health insurance on their own. Premium and cost sharing subsidies based on income are available through the Marketplace to make coverage affordable for individuals and families. People with very low incomes can also find out at the Marketplace if they are eligible for coverage through Medicaid and CHIP. Finally, small businesses can buy coverage for their employees through the Small Business Health Options Program (SHOP) Marketplace.

There is a health insurance Marketplace in every state for individuals and families and for small businesses. Some are operated by the State and have a special state name (such as CoveredCalifornia or The Maryland Health Benefit Exchange.) In other states where the federal government runs the Marketplace, it is called HealthCare.gov.

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How do I find my state Marketplace?

Links to all state Marketplaces can be found at www.healthcare.gov

Who can buy coverage in the Marketplace?

Most people can shop for coverage in the Marketplace. To be eligible you must live in the state where your Marketplace is, you must be a citizen of the U.S. or be lawfully present in the U.S., and you must not currently be incarcerated.

Not everybody who is eligible to purchase coverage in the Marketplace will be eligible for subsidies, however. To qualify for subsidies (also called premium tax credits) people will have to meet additional requirements having to do with their income and their eligibility for other coverage.

This year there was a lot of talk about repealing Obamacare. Is Open Enrollment for 2018 coverage still happening? Does it still make sense to sign up?

Yes. Open Enrollment for 2018 health insurance and subsidies is still happening in every state. Uninsured individuals who need coverage can apply now for health plans and financial help for the 2018 year. People already enrolled in private policies should return to the Marketplace to review 2018 plan choices and renew or change coverage, and to update their application for financial assistance. And the Medicaid and Children's Health Insurance Programs remain open for enrollment year-round for individuals who are eligible for this public coverage.

The requirement to have health coverage also is still the law. People who don't sign up for coverage may owe a tax penalty unless they qualify for an exemption.

Can I buy a plan in the Marketplace if I don't have a green card?

If you are not a U.S. citizen, a U.S. national, or an alien lawfully present in the U.S., you are not eligible to buy a plan on the health insurance Marketplace. However, you can shop for health insurance outside of the Marketplace in the non-group market. Insurers outside of the Marketplace are prohibited from turning you down based on your health status or your immigration status and must follow generally the same rules as plans in the Marketplace. To obtain coverage, contact a state-licensed health insurance company or a licensed agent or broker. Your state Department of Insurance can help you find one.

When can small employers enroll in coverage through the SHOP Marketplace?

Small employers can buy coverage for their employees through the SHOP Marketplace at any time during the year.

Can I buy or change private health plan coverage outside of Open Enrollment?

In general, you can have a special enrollment opportunity to sign up for private, non-group coverage during the year, other than during Open Enrollment period, if you have a qualifying life event. Events that trigger a special enrollment period (SEP) are:

- Loss of eligibility for other coverage (for example if you quit your job or were laid off or if your hours were reduced, or if you lose student health coverage when you graduate) Note that loss of eligibility for other coverage because you didn't pay premiums does not trigger a special enrollment opportunity
- Marriage (limitations apply)
- Gaining a dependent (for example, if you give birth to or adopt a child). Note that pregnancy does NOT trigger a special enrollment opportunity in most states
- Loss of coverage due to loss of dependent status (for example, because of divorce, legal separation, death, or "aging off" a parents' plan when you turn 26)
- A permanent move to another state or within a state if you move outside of your health plan service area (limitations apply)
- Exhaustion of COBRA coverage
- Losing eligibility for Medicaid or the Children's Health Insurance Program

- For people enrolled in a Marketplace plan, income increases or decreases enough to change your eligibility for subsidies
- Change in immigration status
- Enrollment or eligibility error made by the Marketplace or another government agency or somebody, such as an assister, acting on their behalf.

Note that some triggering events will only qualify you for a SEP in the health insurance Marketplace; they do not apply in the outside market. For example, if you gain citizenship or lawfully present status, the Marketplace must provide you with a special enrollment opportunity.

When you experience a qualifying event, your SEP will last 60 days from the date of that triggering event. If you can foresee loss of other coverage (for example, you know the date when you will graduate and lose student health coverage) you can ask the Marketplace for a SEP up to 60 days in advance so new coverage will take effect right after your old coverage runs out. However, in healthcare.gov states, you cannot ask for an advance SEP if you anticipate coverage loss due to a permanent move.

States have flexibility to expand special enrollment opportunities for consumers. Check with your State Marketplace for more information.

How does the "marriage" special enrollment period work?

When you get married, you can qualify for a special enrollment period (SEP). You and your spouse can sign up for coverage in the marketplace. The special enrollment period lasts for 60 days from the date of marriage. If you enroll in coverage through the marriage SEP, coverage will start on the first day of the following month.

If you live in a healthcare.gov state, restrictions apply. To be eligible for the marriage SEP, at least one of you must have been enrolled in

minimum essential coverage (such as a job-based plan, Marketplace plan, or Medicaid) for at least 1 day during the 60 days preceding the date of marriage.

There are exceptions to this limit on marriage SEP eligibility:

- If at least one spouse was living in a foreign country or U.S. territory during the 60-days prior to enrollment, the prior coverage requirement does not apply
- If at least one spouse is a member of a federally recognized Native American tribe or an Alaskan Native, the prior coverage requirement does not apply

In addition, for people currently enrolled in the marketplace through healthcare.gov, the marriage SEP can only be used either to add the new spouse to the current marketplace plan or to enroll the new spouse in a separate marketplace plan. The currently-enrolled spouse cannot use the marriage SEP to change plans.

This restriction on plan selection does not apply for Native Americans or Alaska Natives, or for victims of domestic abuse or spousal violence.

These restrictions on eligibility for the marriage SEP and on plan selection do not apply in the SHOP marketplace or for people using an SEP to join an employer-sponsored group health plan.

State-run Marketplaces have flexibility to expand special enrollment opportunities for consumers. Check with your State Marketplace for more information.

I just moved from State A to State B. I don't have a permanent home yet, am staying with a friend until I find a job and can get settled, but I need health insurance right away. How can I establish/document residency in State B?

The fact that you don't have a permanent home should not affect your eligibility in State B as long as you are currently residing there and intend to remain there.

In healthcare.gov states, you will be required to document your move. You will have to submit documents showing your former address (such as a lease, voter registration card, pay stub, or phone bill showing your old address). As for your new address, you can submit a signed statement to the marketplace stating that you are living with your friend and you aren't just visiting temporarily. Your friend will also have to submit documents, such as those described above, to prove their own residency.

Also, in healthcare.gov states, to qualify for a special enrollment due to a permanent move, you must have had been enrolled in other minimum essential coverage, such as under a job-based health plan, another Marketplace plan, or Medicaid. You must have been enrolled in such coverage for at least one day during the 60-day period leading up to your move. There are exceptions to this rule for people moving from another country and for American Indians and Alaska Natives.

In addition, in HealthCare.gov states, the Marketplace will not make this special enrollment period available to you until you have actually moved.

Contact your state Marketplace for more information about the permanent move special enrollment period.

I have COBRA and it's too expensive. Can I drop it during Open Enrollment and enroll in a Marketplace plan instead?

During Open Enrollment, you can sign up for a Marketplace plan even if you already have COBRA. You will have to drop your COBRA coverage effective on the date your new Marketplace plan coverage begins. After Open Enrollment ends, however, if you voluntarily drop your COBRA coverage or stop paying premiums, you will not be eligible for a special enrollment opportunity and will have to wait until the next Open Enrollment period. Only exhaustion of your COBRA coverage triggers a special enrollment opportunity.

I have COBRA and am finding it difficult to afford, but Open Enrollment is over. Can I drop my COBRA and apply for non-group coverage outside of Open Enrollment?

No, voluntarily dropping your COBRA coverage or ceasing to pay your COBRA premiums will not trigger a special enrollment opportunity. You will have to wait until you exhaust your COBRA coverage or until the next Open Enrollment (whichever comes first) to sign up for other non-group coverage.

I'm leaving my job and will be eligible for COBRA. Can I shop for coverage and subsidies on the Marketplace instead?

Yes, leaving your job and losing eligibility for job-based health coverage will trigger a special enrollment opportunity that lasts for 60 days. You can

apply for Marketplace health plans and (depending on your income) for premium tax credits and cost sharing reductions during that period. If you enroll in COBRA coverage through your former employer, however, you will need to wait to the next Marketplace Open Enrollment period if you want to switch to a Marketplace plan.

What health plans are offered through the Marketplace?

All health plans offered through the Marketplace must meet the requirements of “qualified health plans.” This means they will cover essential health benefits, limit the amount of cost sharing (such as deductibles and co-pays) for covered benefits, and satisfy all other consumer protections required under the Affordable Care Act.

Health plans may vary somewhat in the benefits they cover. Health plans also will vary based on the level of cost sharing required. Plans will be labeled Bronze, Silver, Gold, and Platinum to indicate the overall amount of cost sharing they require. Bronze plans will have the highest deductibles and other cost sharing, while Platinum plans will have the lowest. Health plans will also vary based on the networks of hospitals and other health care providers they offer. Some plans will require you to get all non-emergency care in-network, while others will provide some coverage when you receive out-of-network care.

I notice Marketplace plans are labeled “Bronze,” “Silver,” “Gold,” and “Platinum.” What does that mean?

Plans in the Marketplace are separated into categories — Bronze, Silver, Gold, or Platinum — based on the amount of cost sharing they require. Cost sharing refers to health plan deductibles, co-pays and co-insurance. For most covered services, you will have to pay (or share) some of the cost, at least until you reach the annual out of pocket limit on cost sharing. The exception is for preventive health services, which health plans must cover entirely.

In the Marketplace, Bronze plans will have the highest deductibles and other cost sharing. Silver plans will require somewhat lower cost sharing. Gold plans will have even lower cost sharing. And Platinum plans will have the lowest deductibles, co-pays and other cost sharing. In general, plans with lower cost sharing will have higher premiums, and vice versa.

What is the Cadillac tax?

The so-called Cadillac tax is an excise tax on high cost health plans offered by employers. Beginning in 2020, health plans that cost more than $10,200 for an individual or $27,500 for a family plan will be subject to the tax, which is 40% of the amount that exceeds those thresholds. For example, if a family plan costs $30,000, the employer that offers the plan would owe 40% of $2,500 ($30,000 minus $27,500), or $1,000 for each family it covers under that plan.

The tax was intended to be a disincentive for employers to provide overly rich health benefits, and the cost of the health plan is one measure of the level of benefits. However, some plans may cost more because they cover people with higher-than-average health care costs, including retirees,

older workers and workers in high-risk occupations. The cost thresholds for plans that cover a significant number of individuals in any of those categories are higher.

Individual Mandate

I'm uninsured. Am I required to get health insurance?

Everyone is required to have health insurance coverage – or more precisely, "minimum essential coverage" – or else pay a tax penalty, unless they qualify for an exemption. This requirement is called the individual responsibility requirement, or sometimes called the individual mandate.

What's the penalty if I don't have coverage?

The penalty for not having minimum essential coverage is either a flat amount, or a percentage of household income, whichever is greater. The penalty has been phased in and will be adjusted in the future for inflation.

For 2017 and 2018, the penalty is the greater of

- $695 for each adult and $347.50 for each child, up to $2,085 per family, or
- 2.5% of family income above the federal tax filing threshold, which is $10,400 for a single filer, $20,800 for people who file jointly in 2017

In later years, the flat penalty amounts will be indexed based on the cost of living.

In all years, the penalty is also capped at an amount equal to the national average bronze health plan premium available through the Marketplace. For 2017, that amount was $3,264 for a single individual ($16,320 for a family of five or more). This amount is updated annually in the instructions for IRS Form 8965.

The penalty is assessed based on "coverage months." This means that each month you are uninsured, you may owe 1/12th of the annual penalty. However, short spells of uninsurance may not be subject to a penalty. For more information about the penalty, also called the individual responsibility payment, see instructions for Form 8965 on the IRS web site.

Are there exemptions to the penalty? What are they?

Yes. You may be eligible for an exemption if you:

- Cannot afford coverage (defined as those who would pay more than 8.05 percent of their household income for the lowest cost bronze plan available to them through the Marketplace in 2018)
- Are not a U.S. citizen, a U.S. national, or a resident alien lawfully present in the U.S.
- Had a gap in coverage for less than 3 consecutive months during the year
- Won't file a tax return because your income is below the tax filing threshold (For the 2017 tax year, the filing threshold is $10,400 for individuals and $20,800 for married persons filing a joint return)
- Are unable to qualify for Medicaid because your state has chosen not to expand the program
- Participate in a health care sharing ministry or are a member of a recognized religious sect with objections to health insurance

- Are a member of a federally recognized Indian tribe
- Are incarcerated

Others who do not qualify through these categories but have experienced a hardship that makes it difficult to purchase insurance may apply through the health insurance Marketplace for an exemption to the individual responsibility requirement.

On what grounds can I apply for a hardship exemption to the individual mandate?

People may apply for a hardship exemption if they have experienced difficult financial or domestic circumstances that prevent them from obtaining coverage – such as homelessness, death of a close family member, bankruptcy, substantial recent medical debt, or disasters that substantially damage a person's property. In addition, a hardship exemption may be granted to people who were determined ineligible for Medicaid only because their state hasn't expanded Medicaid coverage to residents with income up to 138% of the federal poverty level. (Note, most hardship exemptions must be obtained by applying directly to the Marketplace. However, the exemption for low income persons living in states that have not expanded Medicaid can also be claimed directly on the tax return.) People may also apply for a hardship exemption if obtaining coverage would be so burdensome as to cause the applicant to experience other serious deprivation of food, shelter, or other necessities. Consult your Marketplace for more information about hardship exemptions.

I had several short coverage gaps in a year – I was uninsured in March, then again in August. Since the total gap was less than 3 months, am I exempt from the penalty?

The rule for short coverage gaps is that only the first short coverage gap in a year will be recognized. You wouldn't be penalized for lacking coverage in March, but you may owe a penalty for your second gap in coverage in August if you don't otherwise qualify for an exemption during that period.

How do I prove that I had coverage and satisfied the mandate?

Health insurance companies, employer-sponsored health plans, and public health programs such as Medicaid are required to provide you with documentation of coverage. In January, you should receive a form 1095-B from your health plan or insurance company indicating the months during the prior year when you were covered under the plan. If you were enrolled in family coverage, Form 1095-B will indicate the names of all family members who were covered with you under the plan. (If you worked for a large employer, with more than 50 employees, you might receive a Form 1095-C instead of Form 1095-B. Form 1095-C documents an offer of coverage by a large employer in addition to documenting months of coverage under the plan.) A copy of this form will also be reported to the Internal Revenue Service.

If you were covered by more than one plan during the year, you should receive a Form 1095-B (or 1095-C) from each plan. When you file your tax return for this calendar year (most people will do this by April 15 next year) you will have to enter information about your coverage (or your exemption) on the return.

If I owe a penalty, when and how do I have to pay it?

If you did not maintain minimum essential coverage every month of this year and you don't qualify for an exemption you will need to pay a "shared responsibility payment" to the IRS on your federal income tax return . If you are like most people, you will need to file your tax return by April 15 next year.

How do I apply for an exemption?

For some types of exemptions, you must apply through the health insurance Marketplace; for other types, you must apply when you file your taxes; some types of exemptions can be claimed either way.

The religious conscience exemption and most hardship exemptions are available only by going to a health insurance Marketplace and applying for an exemption certificate. In the federal Marketplace, you cannot apply for an exemption online. Instead, you can download a paper application for an exemption from healthcare.gov, fill it out and mail it in. You will receive a response by mail and, if the exemption is approved, it will include an exemption certificate number. Save this document, you will need to include the exemption certificate number on IRS Form 8965, which you will need to submit with your tax return when you file your federal income taxes. If you need help applying for an exemption, you can contact the Marketplace call center or a Navigator or other in-person assister. Your Marketplace website has a list of Navigators and other assisters.
The exemptions for unaffordable coverage, members of Indian tribes, members of health care sharing ministries, and individuals who are incarcerated are available either by going to a Marketplace and applying for an exemption certificate or by claiming the exemption as part of filing a federal income tax return.

The hardship exemption for persons who live in states that have not expanded Medicaid eligibility and who have income below 138% of the federal poverty level can also be claimed as part of filing a federal income tax return.

The exemptions for short coverage gaps, certain hardships and individuals who are not lawfully present in the United States can be claimed only as part of filing a federal income tax return. You will need to file a return and include with it Form 8965. If you already received an exemption from the Marketplace, you will include the Marketplace exemption certificate number on this form. Otherwise, instructions for this form will explain the steps you must take and information you must enter on your federal tax return so that you won't owe a tax penalty.

The exemption for having income under the federal income tax return filing threshold is available automatically. No special action is needed. However, if you are filing a tax return anyway (for example, to have refunded taxes that were withheld during the year), you should include Form 8965 with your tax return and check the special box indicating that your income is below the tax filing threshold.

I didn't apply for a hardship exemption from the Marketplace during Open Enrollment. Is it too late to apply for a hardship exemption for this year?

No, you can apply to the Marketplace for a hardship exemption at any time during the year. Most hardship exemptions will be granted for the month before the hardship, the months of the hardship, and the month after the hardship. You will need to document the timing of the hardship in your application. For people ineligible for Medicaid only because their state hasn't expanded Medicaid eligibility, the hardship exemption will be granted for the entire calendar year. You can claim this exemption directly

on your tax return; you are not required to apply for the exemption from the Marketplace. However, if you do apply for this type of hardship exemption from the Marketplace, you will also have to apply for Medicaid coverage and be denied, then submit the Medicaid denial to the Marketplace with your hardship exemption application. If you need help applying for an exemption, you can contact the Marketplace call center or a Navigator or other in-person assister. Your Marketplace website has a list of Navigators and other assisters.

Employer Sponsored Health Benefit

I work full time for a large employer (more than 50 full time employees). Is my employer required to offer me health benefits?

Your employer is not required to offer health benefits. However, large employers that don't offer health benefits to full-time employees and to their dependent children may be liable for a tax penalty. If your employer doesn't offer you health benefits, you can apply for coverage in the Marketplace; and, if your income is between 100% and 400% of the federal poverty level, you may apply for a premium tax credit that may reduce the cost of coverage in the Marketplace.

Note that a full-time employee is one who works, on average, at least 30 hours per week. If your hours vary during the year, your employer may have some options in determining your status as a full-time or part-time worker. Your employer can tell you whether you are a full or part-time worker.

I work part-time for a large employer. Is my employer required to offer me health benefits? What about benefits for my spouse and kids?

No, large employers are not required to offer health benefits to part time employees and there is no penalty for large employers that don't offer health benefits to part-time employees or their dependents. If you work part-time and you are not offered health benefits, you (and your family) can apply for coverage in the Marketplace; and, if your income is between 100% and 400% of the federal poverty level, you can apply for a premium tax credit that may reduce the cost of coverage in the Marketplace.

Note that a part-time employee is one that works, on average, fewer than 30 hours per week. If your hours vary during the year, your employer may have some options in determining your status as a full-time or part-time worker. Your employer can tell you whether you are a full or part-time worker.

I work for a large employer (more than 50 full time employees) but my hours vary during the year. I work full-time during the summer but part-time the rest of the year. Does my employer have to offer me health benefits?

Large employers must offer health benefits to employees who work, on average, at least 30 hours per week, or else pay a tax penalty. Check with your employer/human resources department to find out if your hours worked over the year meet this threshold. If your hours vary during the year, your employer may have some options in determining your status as

a full-time or part-time worker. Your employer can tell you whether you are a full or part-time worker.

I work full time for a small business (fewer than 50 employees). Does my employer have to offer me health benefits?

No, small businesses are not required to offer health benefits to either full-time or part-time employees, or to their dependents. Small businesses are not subject to tax penalties when they don't offer health benefits. If your small employer doesn't offer health benefits, you (and your family) can apply for coverage in the Marketplace; and, if your income is between 100% and 400% of the federal poverty level, you can apply for a premium tax credit that may reduce the cost of coverage in the Marketplace.

We just had a baby. Before that my spouse and I were each covered under our own health plans at our own jobs, but now we want the family covered under one policy. Can we all switch to my employer plan now?

Yes. Having a baby is one of the special circumstances that allow you to add dependents to your health plan even outside of the regular open season. You have 30 days from the date of your child's birth to notify your employer and request that your spouse and your baby be enrolled in your coverage.

I was just hired and told I'm not eligible for health benefits right away. New employees have to satisfy a waiting period. Is that allowed?

Yes, employers can require a waiting period before new employees are eligible to enroll in a group health plan. These waiting periods are not allowed to be longer than 90 days. If you are concerned that your employer requires a waiting period longer than 90 days, you can contact the US Department of Labor at 1-866-444-3272.

My employer offers health benefits but doesn't contribute much toward the premium. I can't afford my share. Can I apply for coverage and subsidies in the Marketplace instead?

You can always shop for health coverage in the Marketplace. However, if you're offered employer health benefits, you can't qualify for premium tax credits in the Marketplace unless your employer coverage is considered unaffordable. If your share of the premium for self-only coverage in your employer plan is 9.56% or more of your 2018 household income, it is considered unaffordable, and you can apply for premium tax credits in the Marketplace.

My employer offers health benefits to me and my family. The company pays the entire cost of my coverage but contributes nothing toward the cost of covering my family. We can't afford to enroll my spouse and kids. Can they get coverage and subsidies in the Marketplace instead?

You can always shop for health coverage in the Marketplace. However, your employer-provided coverage is considered "affordable." That's because the affordability of employer sponsored coverage is only measured with respect to self-only coverage. Because your employer pays the entire cost of the employee-only coverage, you are technically considered to have affordable coverage (even though practically speaking, it was unaffordable to you.) As a result, neither you nor your spouse and children are eligible to apply for premium tax credits in the Marketplace. Sometimes this rule is referred to as "the family glitch."

There are a few other things you should know. First, depending on your family income, your children might qualify for the Children's Health Insurance Program in your state. Check with your state Marketplace to find out if your children may be eligible for CHIP.

Second, if the amount you would have had to pay to actually cover your spouse and kids is more than 8.05% of your family income in 2018, they won't be penalized for not having health coverage that year.