HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Health Insurance and Managed Care (B) Committee Dec. 7, 2020, Minutes
Health Insurance and Managed Care (B) Committee Nov. 2, 2020, Minutes (Attachment One)
Health Insurance and Managed Care (B) Committee 2021 Proposed Charges (Attachment One-A)
Consumer Information (B) Subgroup Oct. 29, 2020, E-Vote Minutes (Attachment Two)
Updated Frequently Asked Questions About Health Care Reform (Attachment Two-A)
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Draft Pending Adoption

Draft: 12/14/20

Health Insurance and Managed Care (B) Committee
Virtual 2020 Fall National Meeting
December 7, 2020

The Health Insurance and Managed Care (B) Committee met Dec. 7, 2020. The following Committee members participated: Jessica K. Altman, Chair (PA); Lori K. Wing-Heier, Vice Chair (AK); Michael Conway (CO); Vicki Schmidt (KS); Kathleen A. Birrane (MD); Grace Arnold (MN); Mike Chaney represented by Mark Haire (MS); Jon Godfread (ND); Linda A. Lacewell represented by John Powell (NY); Glen Mulready (OK); Andrew R. Stolfi represented by TK Keen (OR); Carter Lawrence (TN); Tanji J. Northrup (UT); and Mike Kreidler (WA). Also participating were: Jim L. Ridling (AL); Elizabeth Perri (AS); David Altmaier (FL); Dean L. Cameron (ID); Sharon P. Clark (KY); Eric A. Cioppa (ME); Anita G. Fox (MI); Bruce R. Ramge (NE); Tynesia Dorsey (OH); and Elizabeth Kelleher Dwyer and Marie Ganim (RI).

1. Adopted its Nov. 2 and Summer National Meeting Minutes

The Committee met Nov. 2 and Aug. 11. During its Nov. 2 meeting, the Committee took the following action: 1) adopted the 2021 proposed charges of the Health Actuarial (B) Task Force, the Regulatory Framework (B) Task Force, and the Senior Issues (B) Task Force; 2) adopted its 2021 proposed charges; 3) adopted revisions to the *Health Maintenance Organization Model Act* (#430). The revisions address conflicts and redundancies in Model #430 with provisions in the revised *Life and Health Insurance Guaranty Association Model Act* (#520), which added health maintenance organizations (HMOs) as members of the guaranty association; and 4) received an update on the Consumer Information (B) Subgroup's work related to its charge to develop information or resources that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance. The Subgroup recently adopted updates to its "Frequently Asked Questions (FAQ) About Health Reform" (FAQ) document in preparation for the 2021 open enrollment period. The Subgroup also developed a new document for consumers to use when considering purchasing a short-term policy; i.e., a policy that is not subject to the requirements of the federal Affordable Care Act (ACA).

Commissioner Conway made a motion, seconded by Commissioner Birrane, to adopt the Committee's Nov. 2 (Attachment One) and Aug. 11 (*see NAIC Proceedings – Summer 2020, Health Insurance and Managed Care (B) Committee*) minutes. The motion passed unanimously.

2. Adopted its Subgroup, Working Group and Task Force Reports

Interim Commissioner Northrup made a motion, seconded by Commissioner Schmidt, to adopt the following reports: the Consumer Information (B) Subgroup, including its Oct. 29 (Attachment Two) and Oct. 20 (Attachment Three) minutes; the Health Innovations (B) Working Group (Attachment Four); the Health Actuarial (B) Task Force; the Regulatory Framework (B) Task Force; and the Senior Issues (B) Task Force.

3. Heard an Update on ACA Federal Court Cases

Katie Keith (Out2Enroll) gave an update on ACA federal court cases. She discussed her observations from the recent oral arguments before the U.S. Supreme Court (Court) in the case of *California v. Texas*, which challenges the constitutionality of the individual mandate and the potential impact of the decision on other key ACA provisions. She said the Court seemed to focus its questions about the case on standing and constitutionality, but she could not discern any consensus as to how the Court might decide the case based on the questions.

Ms. Keith also discussed the potential spectrum decisions that the Court could make in the case and its implications: 1) status quo—no standing/subject matter jurisdiction mandate is constitutional or mandate is unconstitutional but fully severable; 2) some disruption—preexisting condition protections are struck down or Title I of the ACA is struck down; or 3) severe disruption—entire ACA is struck down. It is anticipated that any decision in the case will not be released until 2021, possibly as early as spring 2021 or as late as summer 2021.

Ms. Keith also noted the recent oral arguments before the Court on Oct. 6 in the *Rutledge v. Pharmaceutical Care Management Association* case. This case challenges the authority of the states to regulate pharmacy benefit managers (PBMs).

Ms. Keith discussed other cases that the Committee might want to keep track of that have petitions for *certiorari* currently pending before the Court, including *American Medical Association v. Azar*—validity of restrictions on Title X family planning

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service providers. She said the Court granted a writ of *certiorari* on Dec. 4 in the *Gresham v. Azar* case, which challenges the validity of approval of Medicaid work requirements. She also highlighted a number of cases still pending in other courts, such as two cases still pending in the Washington, DC Circuit Court of Appeals—*Association of Community Affiliated Plans, et al. v. U.S. Department of Treasury, et al.*, which upheld the legality of the federal short-term limited-duration (STLD) plan regulation, and *State of New York v. U.S. Department of Labor* (DOL), which concerns the regulation of association health plans (AHPs).

Commissioner Altman asked Ms. Keith if she knows why the Washington, DC Circuit Court of Appeals has yet to issue a decision in the case concerning the regulation of AHPs, given that the case was heard over a year ago. Ms. Keith said she has no insights on the delay, but one possibility could be the case's complexity resulting in the court having trouble reaching any sort of consensus on a decision.

Commissioner Altman said she received a question asking Ms. Keith about what options the states might have if the Court overturned the ACA. Ms. Keith said the options that states would have to address and fill-in any gaps left if the ACA is overturned depends on whether the Court overturns the ACA in its entirety or if the decision is more narrowly tailored by overturning certain ACA provisions. For example, she said if Title I of the ACA, which includes the individual and group market reform requirements and other major health insurance reform components, is overturned, it would be a challenge for a state to address by itself. However, if the Court decides that the individual mandate is unconstitutional but retains the remainder of the ACA, the states could address this.

4. Heard a Federal Legislative and Administrative Update and Outlook for 2021

Brian R. Webb (NAIC) provided an outlook for 2021, including a federal legislative and administrative update on Congressional and Trump Administration activity of interest to the Committee. He said Ms. Keith explained in her presentation that one key factor that will determine health activity in 2021 is the Court's decision in *California v. Texas*. The other key factor is the final makeup of the U.S. Senate (Senate).

Mr. Webb also discussed Congressional activity that could happen in the meantime that possibly has bipartisan support, such as passing legislation related to surprise billing. He noted that the NAIC continues to urge the U.S. Congress (Congress) to include protections related to air ambulances in such legislation. Other legislation could include prescription drug reform, telehealth expansion, and a COVID-19 relief package.

Mr. Webb said keeping in mind the key factors affecting what could happen in Congress in 2021, he said there is the possibility that Congress could look at health insurance reform legislation that would include provisions related to STLD plans, reinsurance, network adequacy, and the public option. He said other health reforms could include reforms related to mental health parity, long-term care (LTC), and health care sharing ministries (HSCMs). He also outlined potential administrative action by the incoming Biden Administration, such as new administrative rulemaking on: 1) STLD plans; 2) AHPs; 3) cost-sharing reduction (CSR) payments; 4) ACA Section 1332 guidance; and 5) health reimbursement arrangement (HRA) payments for HCSMs. These new rules could potentially overturn the Trump Administration's rules on these issues.

5. Received an Update on the Work of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup

Mr. Keen updated the Committee on the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup's work to complete its charge to "consider developing a new NAIC model to establish a licensing registration process for pharmacy benefit managers (PBMs)" and "consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency."

Mr. Keen discussed the Subgroup's drafting process. He said after the Subgroup was appointed in late 2018, it decided during its first meetings in early 2019 that it wanted to obtain more information before drafting the new [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM model). He said the Subgroup met 12 times throughout the summer and early fall of 2019 to hear from various stakeholders on the issues the Subgroup wanted to hear more about, such as rebating, discounts, prescription drug pricing, and how PBMs are currently regulated. He said because the Subgroup included over 25 members, the goal was to have the Subgroup members all equally educated on these issues before it started drafting a model.

Mr. Keen said following the conclusion of these informational meetings, the Subgroup established an ad hoc drafting group to develop an initial draft based on the Subgroup's discussions. He said after a series of meetings late last year and early this year, the ad hoc drafting group developed a draft for the Subgroup's review. He said the Subgroup met July 16 to discuss the ad hoc drafting group's draft and expose the draft for a public comment period ending Sept. 1. The Subgroup received 19 comment letters, which it discussed during its Oct. 29, Oct. 22, Oct. 8, Sept. 24 and Sept. 14 meetings. After these discussions, the

Subgroup adopted the proposed new PBM model on Oct. 29 and forwarded it to the Regulatory Framework (B) Task Force for its consideration.

Mr. Keen described some provisions in the proposed PBM model. He explained that at its core, the model is a PBM licensing model. He said given the lack of national consensus on some issues, particularly issues related to PBM pricing and cost transparency, the Subgroup decided on this framework. He said Sections 1 through 4 of the proposed PBM model set out the model's purpose, scope and definitions. He noted that the Subgroup wanted to avoid any issues currently pending in the *Rutledge v. Pharmaceutical Care Management Association* case, and it carefully crafted these provisions to avoid such issues. Section 5 provides the PBM licensing provisions, including provisions related to approving initial PBM licenses and renewals.

Mr. Keen said the Subgroup had a lot of discussion concerning Section 6—Gag Clauses and Other Pharmacy Benefit Manager Prohibited Practices. He said the Subgroup received comments from a wide range of stakeholders on this section in terms of the language related to gag clauses and information-sharing for the purposes of enforcement. He noted how beneficial it was to have a member of the Subgroup that could provide a pharmacist's perspective when discussing this section. Section 7 of the proposed PBM model provides enforcement language and penalties for any violations of the model.

Mr. Keen said the Subgroup spent the bulk of its time discussing the framework for Section 8—Regulations. He explained that the Subgroup decided to add a drafting note to Section 8 to provide state statutory citations for 15 topic areas that some states might want to consider when developing their state legislation regulating PBMs. He said the 15 topic areas are those areas where the Subgroup found, at this time, a lack of national consensus to include in the proposed PBM model. He said Section 9 and Section 10 provide, respectively, for the severability of the PBM model's provisions and an effective date.

Mr. Keen said the Subgroup presented the proposed PBM model to the Regulatory Framework (B) Task Force during its Nov. 19 meeting. He said the Task Force deferred action on the proposed PBM model and exposed it for a 30-day public comment period ending Dec. 22. He said it is anticipated that the Task Force will meet sometime in January 2021 to discuss any comments received.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

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Health Insurance and Managed Care (B) Committee
Conference Call
November 2, 2020

The Health Insurance and Managed Care (B) Committee met via conference call Nov. 2, 2020. The following Committee members participated: Jessica K. Altman, Chair (PA); Lori K. Wing-Heier, Vice Chair, represented by Sarah Bailey (AK); Michael Conway (CO); John F. King represented by Teresa Winer (GA); Vicki Schmidt (KS); Kathleen A. Birrane and Mary Kwei (MD); Grace Arnold (MN); Mike Chaney represented by Bob Williams (MS); Jon Godfread (ND); Linda A. Lacewell represented by Tom Dudek (NY); Glen Mulready (OK); Andrew R. Stolfi (OR); Hodgen Mainda represented by Brian Hoffmeister (TN); Tanji J. Northrup (UT); and Mike Kreidler (WA). Also participating were: Barbara D. Richardson (NV); and Jeff Rude (WY).

1. Adopted the Revisions to Model #430

Jolie H. Matthews (NAIC) said the revisions to the *Health Maintenance Organization Model Act* (#430) represent the work of the Health Maintenance Organization (HMO) Issues (B) Subgroup to complete its charge to revise provisions in the model to address conflicts and redundancies with provisions in the revised *Life and Health Insurance Guaranty Association Model Act* (#520), which added HMOs as members of the guaranty association. The Subgroup met in 2019 and early this year to discuss its work. Ms. Matthews said during these meetings, the Subgroup identified several provisions in Model #430 to delete to reconcile its provisions with the 2017 revisions to Model #520.

Ms. Matthews said the provisions identified include Section 14—Continuation of Benefits, Section 20—Uncovered Expenditures Deposit, and Section 3HH, the definition of "uncovered expenditures." She said for reference, for the states not intending to adopt the revised Model #520, the Subgroup added an appendix to Model #430 that includes the deleted provisions. She said the Subgroup also deleted Section 21—Open Enrollment and Replacement Coverage in the Event of Insolvency because its provisions are obsolete due to the federal Affordable Care Act (ACA).

Ms. Matthews said the Subgroup unanimously adopted the revisions on July 13 via conference call. The Regulatory Framework (B) Task Force also unanimously adopted the revisions on Sept. 24 via conference call.

Commissioner Conway made a motion, seconded by Interim Commissioner Northrup, to adopt the revisions to Model #430 (*see NAIC Proceedings – Summer 2020, Regulatory Framework (B) Task Force, Attachment Four-B*). The motion passed unanimously.

2. Adopted its Task Forces' 2021 Proposed Charges

Commissioner Altman said prior to the call, NAIC staff distributed the 2021 proposed charges for the Health Actuarial (B) Task Force, the Regulatory Framework (B) Task Force, and the Senior Issues (B) Task Force. Ms. Matthews said generally, the task forces' 2021 proposed charges differ little from their 2020 charges. She explained that the Health Actuarial (B) Task Force disbanded the Health Reserves (B) Subgroup and, as such, deleted its charges. Similarly, the Regulatory Framework (B) Task Force disbanded the HMO Issues (B) Subgroup, so its charges were deleted. Ms. Matthews said the Health Actuarial (B) Task Force and the Senior Issues (B) Task Force adopted their 2021 proposed charges on Oct. 8 via conference call. The Regulatory Framework (B) Task Force adopted its charges on Oct. 23.

Commissioner Mulready made a motion, seconded by Commissioner Godfread, to adopt the 2021 proposed charges for the Health Actuarial (B) Task Force, the Regulatory Framework (B) Task Force, and the Senior Issues (B) Task Force. The motion passed unanimously.

3. Adopted its 2021 Proposed Charges

Commissioner Altman said prior to the call, NAIC staff distributed the Committee's 2021 proposed charges and posted them on the Committee's website; but, similar to many of the task force charges, there are not significant changes. The Committee will continue much of the important work that is already ongoing. Commissioner Altman said one change made from its 2020 charges is merging three charges related to the Committee's work with the Market Regulation and Consumer Affairs (D) Committee into one charge.

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Commissioner Mulready asked if the Committee's charges include any activities related to health care sharing ministries (HCSMs). He said during the 2020 Commissioners' Conference small group sessions, there was discussion of the Committee looking into these types of entities at some point. Commissioner Conway said the Regulatory Framework (B) Task Force heard presentations on HCSMs at the Summer National Meeting. He said at the conclusion of the presentations, there was no discussion among the Task Force members to take any additional action related to HCSMs. However, he said he would add a discussion on HCSMs to the Task Force's agenda for its Nov. 19 meeting.

Commissioner Conway made a motion, seconded by Commissioner Mulready, to adopt the Committee's 2021 proposed charges (Attachment One-A). The motion passed unanimously.

4. Received a Report from the Consumer Information (B) Subgroup

Ms. Kwei provided an update on the Consumer Information (B) Subgroup's work related to its charge to develop information or resources that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance. She said the Subgroup recently adopted updates to its "Frequently Asked Questions (FAQ) About Health Reform" document in preparation for the 2021 open enrollment period. She said the Subgroup updates this document each year for state departments of insurance (DOIs) to use this document to answer questions from consumers as they consider their health plan enrollment options for the upcoming open enrollment period. She said the Subgroup also developed a new document for consumers to use when considering purchasing a short-term policy. She said this document generally alerts consumers and tries to assist them in making an informed choice to enroll in such coverage.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

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Adopted by the Executive (EX) Committee and Plenary, Dec. 9, 2020
Adopted by the Health Insurance and Managed Care (B) Committee, Nov. 2, 2020

2021 Proposed Charges

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

The mission of the Health Insurance and Managed Care (B) Committee is to consider issues relating to all aspects of health insurance.

Ongoing Support of NAIC Programs, Products or Services

1. The **Health Insurance and Managed Care (B) Committee** will:
   A. Respond to inquiries from the U.S. Congress (Congress), the White House and federal agencies; analyze policy implications and their effect on the states of proposed and enacted federal legislation and regulations; and communicate the NAIC's position through letters and testimony, when requested.
   B. Monitor the activities of the Health Actuarial (B) Task Force.
   C. Monitor the activities of the Regulatory Framework (B) Task Force.
   D. Monitor the activities of the Senior Issues (B) Task Force.
   E. Serve as the official liaison between the NAIC and the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission), the National Committee for Quality Assurance (NCQA) and URAC.
   F. Examine factors that contribute to rising health care costs and insurance premiums. Review state initiatives to address cost drivers.
   G. Coordinate with appropriate Market Regulation and Consumer Affairs (D) Committee groups, as necessary, on health benefit plan and producer enforcement issues.
   H. Coordinate with the Market Regulation and Consumer Affairs (D) Committee, as necessary, to collect uniform data and monitor market conduct trends on plans that are not regulated under the federal Affordable Care Act (ACA), including short-term, limited-duration (STLD) insurance, association health plans (AHPs) and packaged indemnity health products.

2. The **Consumer Information (B) Subgroup** will:
   A. Develop information or resources, as needed, that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance.
   B. Review NAIC publications that touch on health insurance to determine if they need updating. If updates are needed, suggest specific revisions to the appropriate NAIC group or NAIC division to make the changes.

3. The **Health Innovations (B) Working Group** will:
   A. Gather and share information, best practices, experience and data to inform and support health innovation at the state and national levels, including, but not limited to, state flexibility options through the ACA and other health insurance-related policy initiatives.
   B. Discuss state innovations related to health care—i.e., access, insurance plan designs, underlying medical and prescription drug costs, stability for health care and insurance as a whole, health insurer and provider consolidation or competition, the use of data in regulatory and policy decision-making, and health care delivery and financing models—to achieve better patient outcomes and lower spending trends.
   C. Explore sources and methods for state insurance regulators to obtain data to inform health reform initiatives.
   D. Disseminate materials and reports, via the NAIC, to the states and the U.S. territories wishing to utilize the information gathered by the Working Group.
   E. Take up other matters as directed by the Health Insurance and Managed Care (B) Committee.

NAIC Support Staff: Jolie H. Matthews/Brian R. Webb/Jennifer R. Cook

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Draft: 11/12/20

Consumer Information (B) Subgroup
E-vote
October 29, 2020

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee conducted an e-vote that concluded Oct. 29, 2020. The following Subgroup members participated: Mary Kwei, Chair (MD); Debra Judy, Vice Chair (CO); Anthony L. Williams (AL); Michele Baldock (IL); LeAnn Crow (KS); Judith Watters (ME); Carrie Couch (MO); Kathy Shortt (NC); Vickie Trice (TN); Tanji Northrup (UT); Todd Dixon (WA); and Jennifer Stegall (WI).

1. Adopted Updates to FAQ Document

The Subgroup conducted an e-vote to consider adoption of a revised and updated version of the "Frequently Asked Questions about Health Care Reform" document (Attachment Two-A). The motion passed unanimously.

2. Adopted a Consumer Guide on Short-Term Plans

The Subgroup conducted an e-vote to consider adoption of a consumer guide "Before You Buy That "Low Cost" Health Insurance" (Attachment Two-B). The motion passed unanimously.

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PURPOSE

This document is designed for state insurance departments to use as they give answers to frequently asked questions (FAQ) and guide consumers about their health care choices. This document reflects regulations and guidance received from the federal government as of September 2020 and is subject to change.

This document isn't intended to be given directly to consumers. States will need to modify this document to include state-specific information and terminology. Content in [brackets] must be edited to provide state-specific information. Drafting notes indicate where states may choose to add additional clarity on state policies. 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 federal Affordable Care Act (ACA) and related regulations refer to "exchanges" that operate in the states, while federal guidance documents refer to these 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 ACA**.**

Q 1: When did the ACA take effect?

The ACA was enacted March 23, 2010.

Q 2: What changes have taken place?

Several changes took place before January 1, 2014:

- Lifetime and annual dollar limits on essential health benefits (EHB) are not allowed. Annual dollar limits on EHB were also phased out by January 1, 2014.
- Consumers are guaranteed certain appeal rights.
- 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. (See Question 24.)
- Medical loss ratio (MLR) standards limit how much of premium dollars insurers can spend on administrative expenses.
- Many insurers must use a standardized Summary of Benefits and Coverage (SBC), which makes it easier to compare plans.
- 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." For 2021, consumers in a Medicare Part D standard plan no longer face a donut hole, but cost-sharing may vary for other plans.

Several major changes became effective for non-grandfathered individual and small group plans sold or renewed on or after January 1, 2014:

- Plans must include new consumer protections. Health insurers can't 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.
- Many, though not all, insurance plans must cover a minimum set of essential health benefits (EHB) and can't put annual dollar limits on these benefits.
- Individuals and families with incomes below 400% of the federal poverty level may qualify for financial assistance when they shop in the health insurance exchanges.
- In the small group market, from the period November 15 to December 15 each year, small employers can purchase coverage for their workers for the following year without having to meet minimum participation or minimum contribution requirements.

Note: Plans sold before March 23, 2010 that have had no significant changes are considered "grandfathered" and aren't required to comply with many of these requirements. (See Question 31 on grandfathering.) Additionally, plans sold before January 1, 2014 may—if allowed by the state—continue to be renewed through policy years beginning on or before October 1, 2021 without coming into compliance with certain reforms. (See Question 31 on transitional policies.)

Q 3: 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 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-xxxx].

There are also several other helpful sites and resources for more information about the ACA, including: Kaiser Family Foundation (*www.kff.org/health-reform/*); Commonwealth Fund (*https://www.commonwealthfund.org/health-care-coverage-and-access*); The Robert Wood Johnson Foundation (*www.rwjf.org*); the Georgetown Center on Health Insurance Reforms (*https://chir.georgetown.edu/#*); and the Center on Budget and Policy Priorities (*www.healthreformbeyondthebasics.org*).

Q 4: Do the consumer protections of the ACA apply to all health coverage?

No, the ACA consumer protections don't apply to all health coverage. The ACA largely established new protections in the individual and small group markets, which includes policies sold through the exchanges in every state. Health coverage sold outside of the individual or small group markets, or that is not considered insurance, may not be required to comply with some or any of these protections.

Consumers may have questions about several types of coverage other than the qualified health plans sold through exchanges.

- Short-term, limited duration insurance. Several protections applicable in the individual market do not apply to short-term, limited duration insurance. However, state law or regulation may add some protections. Because the ACA does not apply, these plans may do any or all of the things in the list below, unless prohibited by state law or regulation:
    - deny coverage or increase premium due to health status,
    - exclude essential health benefits,
    - refuse renewal,
    - limit coverage of pre-existing conditions,
    - establish annual or lifetime benefit maximums,
    - set a yearly out-of-pocket maximum above $8,550, or
    - exceed medical loss ratio standards without rebating premium.
- Association health plans. Depending on the structure of the association and state law, consumer protections in the individual, small group, or large group market plans may apply to association health plans.
- Health care sharing ministry. These coverage arrangements are **not** considered to be insurance, so the requirements and protections described in this FAQ do not apply.
- Fixed indemnity insurance. The requirements and protections described in this FAQ generally do not apply.

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Drafting Note: States may want to add more details about state-level protections that apply to the coverage types mentioned in the bullets above.

EXCHANGE BASICS

Q 5: What is the [insert name of state health insurance exchange]? (For questions about the [insert name of state SHOP exchange], see Questions 40-44, 46-50, and 69-72).

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 tax credit to help lower- and middle-income individuals pay for coverage. (See Questions 81-84.) Through exchanges, individuals may also 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 aren't available for plans sold outside the exchange.

Drafting Note: States that have no market outside the exchange should modify the previous paragraph accordingly. States should note, however, that some individuals such as incarcerated individuals and immigrants not legally present cannot be denied coverage on the basis of health status even though they will not be able to buy coverage through the exchange. (See Questions 118-119.)

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 at *https://www.healthcare.gov/what-is-the-health-insurance-marketplace*.

Q 6: 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 and state governments to operate the exchange. Please contact [insert state consumer affairs contact information] to learn how it is operated.

Q 7: What is a CO-OP plan?

CO-OP stands for Consumer Operated and Oriented Plan, which is a type of health insurer created under the ACA. The ACA gave low interest loans to private organizations to create a new type of nonprofit 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]. If a CO-OP in the state is no longer available or enrollment has been capped, then consumers can explore other coverage options through the exchange during the open enrollment period (or may be eligible for a special enrollment period (SEP) if their CO-OP coverage ends outside of the open enrollment period).

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 aren't any CO-OPs in the state, if the CO-OP is no longer available, or enrollment has been capped.

Q 8: If consumers live in one state but work in another, to which state's exchange should they apply?

Consumers who don't have access to coverage through their employer (or their spouse's employer) should apply for coverage in the state where they live.

Q 9: 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 those who are not lawfully present in the U.S. (see Questions 119-120), incarcerated individuals (other than pending disposition of charges) (see Question 121), and generally, people on Medicare (see Question 94). While most individuals and families **can** buy coverage through the exchange, eligibility for tax credits and subsidies is dependent on lacking access to other coverage, e.g., Medicaid/Medicare eligibility, offers of affordable employer-sponsored coverage (see Question 83). When individuals become eligible for Medicare while enrolled in an exchange plan, they will no longer be eligible for any premium tax credits or cost-sharing reductions.

Small employers (employers with fewer than [XX] employees) may buy health insurance for their employees through the [insert name of state SHOP exchange]. If a state SHOP exchange has not been established in a state, *healthcare.gov* generally directs small employers to contact brokers or insurance companies directly. (For more information about the [insert name of state SHOP exchange], see Questions 40-44, 46-50, and 69-72).

Drafting Note: States should insert the appropriate number in place of XX above, taking into account the specific state rules for SHOP participation.

Q 10: When are consumers able to enroll in plans through the [insert name of state exchange]?

Consumers may enroll during the annual open enrollment period or when they qualify for a special enrollment period. In [insert name of state], open enrollment through [insert name of state exchange] for 2021 coverage for individuals and families begins [November 1, YEAR], and continues through [December 15, YEAR].

Coverage effective dates depend on the date of enrollment and are contingent on consumers paying the first month's premium directly to the insurance company. Enrollment during open enrollment becomes effective on January 1, 2021. Enrollment during a special enrollment period will be effective on either the first day of the following month if a consumer enrolls by the 15th of the month, or on the first day of the second following month, if a consumer enrolls after the 15th of the month.

During open enrollment, consumers may change plans, change insurance companies, or stay with the plan they have, if it's still available. Current enrollees will also receive a new eligibility determination to determine if they will receive more or less financial help in the form of premium tax credits or cost-sharing reductions. If a consumer does not actively select a new plan and is eligible for auto-renewal, then they will be automatically re-enrolled into the closest comparable plan for [Plan Year]. So, consumers who want to make changes to their coverage effective on January 1 must choose a plan by [December 15].

Drafting Note: States should insert the appropriate dates for their Open Enrollment Periods.

Q 11: What if a consumer wants to enroll or change plans outside of the open enrollment period?

Consumers may be eligible to enroll in coverage at times other than during the open enrollment period. There are special enrollment periods (SEPs) for individuals or families if they experience certain events. Some examples of events that trigger an SEP include: 1) loss of minimum essential coverage for an individual or their dependent; 2) gaining or becoming a dependent (such as marriage or the birth/adoption of a baby); and 3) being enrolled in a plan through the exchange without tax credits and then becoming newly eligible for tax credits. (See Question 83.) The federal website *https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/* lists possible options for consumers to obtain coverage outside an open enrollment period. Consumers generally have 60 days from the date of the event that triggered a SEP to enroll in coverage. Additional information about SEP rules is available at *http://www.healthreformbeyondthebasics.org/wp-content/uploads/2015/06/SEP-Reference-Chart.pdf*.

Consumers can apply for coverage through [insert name of state exchange] any time during the year, regardless of whether it's an enrollment period. The [insert name of state exchange] will process applications and tell consumers whether or not they can enroll or must wait until an enrollment period. The exchange will also provide guidance on whether the applicant may be eligible for other types of coverage. 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 SEP. People who are eligible for Medicaid and the Children's Health Insurance Program (CHIP) can

apply and enroll in [insert name of state Medicaid agency] at any time. People who become eligible for Medicare while enrolled in [insert name of exchange] should immediately notify the exchange and enroll in Medicare. (See Question 94.)

Q 12: How can a consumer prepare to enroll in a plan through the [insert name of state exchange]?

The federal website *https://www.healthcare.gov/apply-and-enroll/get-ready-to-apply/* has suggestions for things consumers should think 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 also make an appointment with a navigator, certified application counselor, insurance agent or broker, or other assister to help prepare for enrollment and compare plans. To find those who can assist consumers, go to Find Local Help at: *https://localhelp.healthcare.gov/*.

Consumers can start gathering basic information about household income, such as their most recent tax return if they filed one, or other income information. A full list of required documents is available at *https://marketplace.cms.gov/outreach-and-education/marketplace-application-checklist.pdf*. 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/lower-costs/*.

SHOPPING FOR HEALTH INSURANCE: WHAT IS COVERED?

Q 13: What types of plans are available through the [insert name of state exchange]?

Health plans sold through the [insert name of state exchange] must 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] are organized in four tiers, or four levels, that estimate the generosity of the plans' coverage:

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

In addition, catastrophic plans cover the same services, but their coverage will be slightly less generous than the bronze level plans. A catastrophic plan may be a less expensive option for those who are eligible. Only individuals younger than age 30, individuals of any age who qualify for a hardship exemption, and those who cannot afford other coverage can buy catastrophic plans. Premium tax credits and cost-sharing reductions are not available for catastrophic plans. Also, catastrophic plans cannot be used with health savings accounts (HSAs).

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

Q 14: What is actuarial value?

Actuarial value is how much of a standard population's medical spending the health insurance plans in each metal level would cover. Percentages (60% for bronze, 70% for silver, 80% for gold, and 90% for platinum) represent the approximate actuarial value of plans at each level. A higher percentage means the plan covers more of a standard population's costs (and the population pays less out of pocket). A lower percentage means the plan covers less (and the people who have the plan pay more out of pocket). The actuarial value calculation focuses on cost-sharing charges so that a bronze plan would have higher enrollee cost-sharing amounts compared to a gold plan. There also may be differences in how benefits are covered, such as differences in the prescription drugs that are covered or how many physical therapy visits the plan covers. The law requires all metal level plans and catastrophic plans to cover the essential health benefits (EHB).

Actuarial value is calculated for a standard population and does not mean that the plan will pay that percentage of any 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 does not give other information about a plan that may be important to a particular person or affect their costs. It does not indicate how broad or narrow a plan's provider network is, the quality of the provider network, information about the plan's customer service and support, how broad or narrow the drug formulary is, or what the premium levels are. All of this information is important for consumers to consider when they choose a plan.

See *https://www.healthcare.gov/choose-a-plan/* for more consumer information about choosing a plan.

Q 15: 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 (EHB) (see Question 17), 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 EHB.

The metal levels show the amount of cost-sharing required by the plan. Metal levels do not give consumers a signal about the plan's provider network size, quality, or any other aspect of coverage.

Q 16: What services/benefits must plans cover? What are essential health benefits?

Many plans sold in the individual and small group market, including all of those sold through the [insert name of state exchange] and [insert name of state SHOP exchange] must cover, at a minimum, a comprehensive set of benefits known as essential health benefits (EHB). These EHB 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," "transitional," and "short-term" plans in the individual and small group markets aren't required to include EHB. For more information about these plans, see Questions 30-31.

For more detailed information about essential health benefits in [insert name of state] and other states, visit *https://www.cms.gov/cciio/resources/data-resources/ehb.html#ehb*

Q 17: What insurance companies will offer coverage through the [Insert name of state exchange]? How can consumers get a list of companies and plans available?

There are listings of the health plans available through the [insert name of state exchange] on its website: [Insert *link to state 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] or get help from an agent, broker, or other type of assister. (See Question 62.)

Q 18: How can a consumer find out the details about what a particular plan covers?

All individual and small group plans offered after January 1, 2014, will cover essential health benefits (EHB) (see Question 16), except grandfathered, transitional, and short-term plans. (See Questions 30-31 and 89.)

To learn if a specific benefit is covered, and at what level, check a plan's Summary of Benefits and Coverage (SBC). The SBC is a uniform document that includes details about what a plan does and does not 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 insurance company must provide an SBC for all health plans except for short-term and limited benefit plans. An SBC gives information in the same way for every plan to make it easier to compare plans. SBCs are available on the federal government's website at *www.healthcare.gov*, the [insert name of state exchange] website at [insert *link*], the insurance company's website, or from an agent or broker for plans offered in the market outside the exchange.

It should be noted that the SBC provides only a *summary* of the benefits. More detailed information is available through the insurer or an insurance agent or broker, and each SBC must include a link to a copy of the actual individual coverage policy or group certificate of coverage that will provide more detailed information.

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.

Consumers can read more about the SBC here:
www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/Summary-of-Benefits-and-Coverage-and-Uniform-Glossary.html

Q 19: How can consumers compare benefits and understand what a plan covers?

In addition to getting an SBC (see Question 18), 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 agents, brokers, navigators, or consumer assisters. To find those that can help consumers in their area, direct them to "Find Local Help" at *https://localhelp.healthcare.gov/*

Q 20: How can consumers see and compare premiums for plans?

The [insert name of state exchange] is set up to let consumers compare policies based on premiums, 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 because plans with the lowest premium often have the highest out-of-pocket costs.

Consumers can get information to compare premiums 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 assisters should be able to help consumers compare plans.

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

Q 21: Can a person or a health insurance issuer take benefits out of a plan? What if a consumer doesn't need all of the benefits in a plan?

No. Neither consumers nor health insurance issuers can take benefits out of a plan. At a minimum, every health plan on the [insert name of state exchange] must provide coverage for all the essential health benefits the ACA requires. (See Question 16.) Even though a person may not need every benefit in a plan, plans must cover all the essential benefits to share risk across a broad pool of consumers and be sure all benefits are available to everyone. This also helps to protect people from risks they cannot always predict across their lifetimes.

There may be short-term plans or limited benefit plans available that don't cover all the essential health benefits.

Drafting Note: States with an individual mandate may want to add: Consumers who don't have a plan that provides minimum essential coverage may have to pay a penalty when they file their state income taxes. The federal penalty was reduced to $0 starting with tax year 2019. (See Question 57.)

Q 22: Can consumers' health conditions affect what coverage they are able to get?

No. Under the ACA, health insurance companies no longer can leave coverage out of a plan based on a person's health condition, a practice that used to be known as a "pre-existing condition exclusion." Nor can they charge a higher premium because of a person's health condition. These protections apply whether a person buys an individual market plan through the exchange or outside the exchange. It is important to note that the prohibitions on pre-existing condition exclusions do not apply to short-term or limited benefit plans.

Q 23: Can an insurance company charge tobacco users more than non-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. People who use tobacco may be charged up to [insert state-specific tobacco surcharge – no higher than 50%] more than people who do not use tobacco. Consumers in group plans may not have to pay this extra charge if they complete a tobacco cessation program and cannot be charged more unless if they aren't given an opportunity to complete a tobacco cessation program. This does not apply to coverage that is not considered comprehensive individual coverage, including short-term plans.

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 cannot charge consumers a higher premium for being a tobacco user.

Q 24: 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 individual market and non-grandfathered group health plans cover many preventive services with no out-of-pocket costs (meaning no deductibles, copayments, and coinsurance) for all new plans sold after September 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 check-ups, as well as mammograms and cervical cancer screenings
- Well-baby and well-child exams for children

As long as there is an in-network provider in a plan to do a particular preventive service, the plan can charge for that preventive service when an out-of-network provider does it. If there is no in-network provider available to provide a particular preventive service, then the plan can't charge for the preventive service when an out-of-network provider delivers them.

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 25: 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, so children's vision benefits are included in plans 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 as long as the [insert name of state exchange] offers a stand-alone dental plan that includes a children's (pediatric) dental benefit.

Plans aren't required to include dental or vision coverage for adults, but a plan can choose to include these benefits as part of its 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.

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

Drafting Note: States where consumers may buy dental coverage without buying health coverage should add a sentence to explain, if appropriate.

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 change the answer to this question as appropriate.

Q 26: 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 "nonpreferred" brand name drug. Consumers should 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 Summary of Benefits and Coverage (SBC) includes an online link where consumers can find information about the plan's drug coverage. Consumers also can call health insurers for information about formularies.

Formulary information is also available on [insert name of state exchange]'s website [insert *link]*. If a consumer enrolls in coverage and needs access to a drug not on the plan's formulary, then the enrollee may be able to use the drug exceptions process to request and gain access to the needed drug.

Drafting Note: States should add language to describe their rules regarding whether the insurance company can change the formulary or tiering after the consumer has bought the plan.

Q 27: What are out-of-network services, and do consumers have any coverage for them?

Services are considered out-of-network if they are from a doctor, hospital, or other provider that does not 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 24 on preventive services and Question 29 on emergency services.) Whenever possible, consumers should find out whether a provider is in-network before they receive services. Consumers also should find out if their regular or desired health care providers are in-network before they buy a plan. Also, 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. When reviewing plans to buy, the specific plan name should be on the Summary of Benefits and Coverage (SBC). After a consumer buys a plan, he or she can find the specific plan name on the cover page of the policy document or on their health insurance identification card.

Though the ACA limits how much money a person must spend each year on his or her family's health care, health insurers are allowed, although not required by federal law, to count the cost of out-of-network services toward these limits.

A plan's SBC will include information about coverage for out-of-network services and a link to the plan's website and the provider network.

Q 28: How do consumers determine if their doctor or dentist is in the network?

The [insert name of state exchange] website (at [insert *website*]) lets consumers look up whether their doctor is in the plan network. For plans with a provider network, the Summary of Benefits and Coverage (SBC) includes an online link to a list of network providers. Because plan networks may change regularly, consumers also should check with the doctor or dentist before they schedule an appointment to learn if the provider is still in the plan's network.

Q 29: Do consumers have access to emergency care out-of-network?

Yes. The ACA requires many health plans that provide benefits for emergency services to cover them regardless of whether the provider is in or out of the network. Under the ACA, health plans are not allowed to charge a higher copayment or coinsurance amount 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 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 many health plans that provide benefits for emergency services to cover those services whether the provider is in or out of the network. While health plans are not 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 the amount the plan allows. For more information about [insert name of state]'s rules on balance billing, please contact [insert specific state contact information]. Under federal law, to limit amounts of balance billing for out-of-network emergency services, insurers must calculate amounts they pay for such services to yield the highest payment of the following three amounts:

(A) The amount negotiated with in-network providers for the emergency service provided, excluding any in-network copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee.

(B) The amount for the emergency service calculated using the same method the plan uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee.

(C) The amount that would be paid under Medicare Parts A or B for the emergency service, excluding any in-network copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee.

Q 30: What is a "grandfathered" health plan?

A grandfathered health plan is a plan that has existed continuously since before March 23, 2010, and that has not made certain significant changes in the plan. Grandfathered plans are not subject to many of the ACA requirements, such as the requirement that plans cover essential health benefits (EHB) (see Question 16), but they are considered to provide minimum essential coverage under the ACA. (See Question 57.)

If grandfathered plans make certain changes, such as major increases in their cost-sharing (such as coinsurance, deductibles, copayments) or dropping benefits to diagnose or treat a particular condition, may lose grandfathered status, then they would have to follow the applicable ACA requirements. Employer-sponsored plans that significantly increase 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. However, consumers who are already enrolled in an individual market plan as of March 23, 2010 can renew their coverage in that grandfathered plan.

A plan must show in the plan materials if it is a grandfathered plan. Also, consumers can check with their insurance company or employer to figure out if their plan is grandfathered.

Q 31: Can consumers keep an existing plan that isn't grandfathered, but doesn't comply with the ACA reforms (known as transitional plans or "grandmothered" plans)?

It depends. In November 2013, CMS announced a transitional policy that would let insurers, if the state allows, to extend policyholders' 2013 coverage for up to several more years even if the plan didn't follow certain ACA reforms. These transitional plans can no longer be sold to new customers (after January 1, 2014), and individuals who bought them aren't eligible for subsidies. An individual or small business that has one of these plans would be notified by the insurer. If a consumer has a transitional plan, they should check with their insurance carrier to learn if it will renew their plan and what changes, if any, it will be making to the plan.

Drafting Note: States that did not adopt this policy, applied it only in certain markets (i.e., in the small group market but not the individual market), or that have already phased out transitional plans would need to edit this answer accordingly or delete it entirely.

EMPLOYER-SPONSORED COVERAGE

Q 32: 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, then the employer may have to pay a tax penalty. (See Questions 53-54.) 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 *https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions*. Small employers with fewer than 50 employees that don't offer coverage to employees or their dependents are not subject to any tax penalties, but may qualify for a tax credit if they choose to offer coverage. (See Question 55.)

Also, if employer-based coverage includes children, then the ACA requires employers to let children up to age 26 stay on their parents' policy. Adult children up to age 26 can stay on their parents' policy whether or not they live in their parents' home, are married, or the parents no longer claim them as a dependent on their tax return. The employee can be required to pay for this coverage, however.

An employer who offers health benefits to employees must also offer the same health benefits to similarly-situated employees who are eligible for Medicare. This rule applies when an employee is 65 or older and the employer has 20 or more employees. This rule applies to dependents when an employer offers health benefits that include dependents.

Q 33: 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 employees and their dependents lose employer-based coverage, they are 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]. Employees or their dependents who are eligible for Medicare when employer group health coverage ends are eligible to enroll in COBRA. However, COBRA coverage is expensive and will only pay benefits secondary to Medicare benefits, even if the Medicare-eligible individual has not enrolled in Medicare. The most recent Department of Labor model COBRA notice includes more specific information about coordination of benefits between these two programs. This model notice can be found at *https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra*. If an individual is enrolled in COBRA coverage and subsequently becomes eligible for Medicare, then primary COBRA benefits will end.

Drafting Note: COBRA is secondary to Medicare benefits because Medicare secondary payer rules that apply to employer group health benefits don't apply to COBRA benefits. Most employer group health plans have strong coordination of benefit rules. Medicare-eligible individuals are subject to recovery actions if COBRA mistakenly pays primary benefits even if the Medicare-eligible individual has not actually enrolled for those benefits.

COBRA coverage can be expensive because 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 advance premium tax credits to buy a more affordable individual or family policy through the [insert name of state exchange] (see Questions 83-84), even if the loss of coverage occurs outside of the open enrollment period. Consumers enrolled in COBRA don't qualify for advance premium tax credits. Dropping COBRA coverage outside of an open enrollment period doesn't qualify as a special enrollment opportunity

Q 34: Must a consumer use all available COBRA coverage before buying coverage 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. Individuals who lose eligibility for minimum essential coverage, including employer-based coverage, will be eligible for a special enrollment period (SEP) during when they can buy coverage on the [insert name of state exchange] or in the individual market outside of the exchange. At this time, they also may apply for advance premium tax credits and cost-sharing reductions through [insert name of state exchange] to learn if they are eligible to receive them. However, individuals who have already enrolled in COBRA coverage must wait until the next open enrollment period or until that COBRA coverage has been exhausted before enrolling in an individual market plan.

Medicare-eligible former employees have an 8-month SEP to enroll in Medicare Part B that starts on the date of their last month of employment. If they enroll during this SEP, there is no late enrollment premium penalty or other coverage restrictions. They have 63 days to enroll in Medicare Part D from the last date without prescription drug benefits that are at least equivalent to Medicare's.

Q 35: 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. Employers also may impose an additional one-month orientation period before the waiting period begins. For more information, consumers should contact their employer's human resources department.

Q 36: 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. (See Question 83.) Consumers who have access to employer-based coverage that is affordable and provides minimum value 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 lowest-cost employer plan is more than 9.83% of the employee's annual household income in 2021. The plan doesn't provide minimum value if it pays for less than 60% of medical costs that the plan covers, or if it doesn't provide substantial coverage of inpatient hospital or physician services. The HHS and IRS have developed a minimum value calculator available at *www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mv-calculator-final-4-11-2013.xlsm*

Consumers can learn if an employer plan meets minimum value by looking at the Summary of Benefits and Coverage (SBC) or by asking the employer to fill out an Employer Coverage Tool. This form provides information that will help the consumer answer application questions correctly at the [insert name of state exchange]. The Employer Coverage Tool can be found at *https://marketplace.cms.gov/applications-and-forms/employer-coverage-tool.pdf*

There's more information on [insert name of state exchange]'s website at [insert *link*] and on the IRS websites listed below:

www.irs.gov/Affordable-Care-Act/Individuals-and-Families/The-Premium-Tax-Credit

www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Questions-and-Answers-on-the-Premium-Tax-Credit

Q 37: If a consumer is offered employer-based coverage that would cover a spouse or dependents, can that consumer's spouse or children get a tax credit to buy coverage through the exchange?

It depends on whether the employer-based coverage is affordable and meets minimum value. If the premiums for employee-only coverage in the lowest-cost plan are less than 9.83% of household income and the coverage provides minimum value, then no one in the family who is eligible for the plan is eligible for premium tax credits. This may be the case even when it would be unaffordable for a spouse or children to enroll in the plan, based on the cost of family coverage. Depending on state eligibility rules, the children may be eligible for Medicaid or CHIP coverage. (See Question 99.) Contact the [insert name of state exchange] to learn more.

Q 38: What is a health reimbursement arrangement?

In a health reimbursement arrangement (HRA), an employer may offer employees tax-free funds they can use to buy health coverage. There are different types of HRAs. In an integrated HRA, an employer may offer funds instead of a group health plan to some or all employees. The employees use the funds to buy individual market health plans for themselves and their families. In an excepted benefits HRA, an employer may offer funds and a group health plan. The employees and their families may use the HRA funds to buy health coverage other than comprehensive health coverage, such as dental and vision coverage or short-term, limited duration health insurance.

A Medicare-eligible employee can have an HRA if the employee is enrolled in a health care flexible spending account (HCFSA). The employer can pay Medicare Part B and Part D premiums for active employees only if the employer payment plan is integrated with the group health plan. (See Department of Labor rules.)

Q 39: If a consumer is offered a health reimbursement arrangement, can that consumer get a tax credit to buy coverage through the exchange?

The answer depends on the amount of the HRA the employer offers. If the employer offers enough money through an HRA to make an exchange plan affordable for an employee, then neither the employee nor their dependents are eligible for a premium tax credit. If the amount of the HRA isn't enough to make an exchange plan affordable, then the employee and their dependents may still receive a premium tax credit. If the HRA is a qualified small employer HRA (QSEHRA), then the amount of the tax credit is reduced by the amount of the QSEHRA. More information about HRAs and small businesses can be found at: *https://www.healthcare.gov/small-businesses/learn-more/qsehra/*

The [state exchange name] might not take a consumer's HRA into account when calculating how much premium tax credit the consumer is eligible for. In that case, the consumer may want to apply less than the full amount of the credit they are awarded when they pay their premiums each month. This can help to prevent the need to pay back some of the credit when the consumer files his or her federal income tax return.

Q 40: What are Health Savings Accounts?

Individuals may contribute to tax-advantaged Health Savings Accounts (HSAs) when they are enrolled in a health plan that meets certain IRS requirements to be an "HSA-qualified" health insurance plan. The plan must have a minimum deductible (presently $1400 for self-only coverage and $2800 for family coverage). The deductible must apply to all covered benefits received from in-network providers. Importantly, only certain "preventive care" benefits may be provided before the deductible is met. The health plan must not be limited to vision, dental, disability, workers' compensation and other so-called "excepted benefits" or other types of limited coverage.

An individual is not eligible to contribute to an HSA for any month that they: (1) have coverage under any health insurance plan or other arrangement (including employer-sponsored health flexible spending arrangements or health reimbursement arrangements) that does not apply a deductible equal to or exceeding the minimums described above; (2) are enrolled in Medicare; or (3) can be claimed as a dependent on another individual's tax return.

A Medicare beneficiary cannot contribute to an HSA once they are enrolled in Medicare. For individuals that enroll in Medicare after they turn 65, their Medicare effective date could be retroactive up to six months which could impact their eligibility to make HSA contributions. HSA account owners can still use their HSA funds to pay Medicare premiums (all Parts but not Medicare Supplement insurance), deductibles, co-pays, coinsurance, as well as other eligible expenses for services not covered by Medicare (e.g., dental, vision, hearing).

Q 41: When an employee is enrolled in employer-based coverage and in Medicare, is Medicare a primary or secondary payer?

When an employee or a dependent is eligible for Medicare, the size of the employer group determines if the group plan is primary or secondary to Medicare. When an employee or a dependent is 65 or older and there are 20 or more employees, the employer group health plan is primary. When an employee or their dependent is disabled and there are 100 or more employees, the group health plan is primary. The number of employees includes both full-time and part-time employees. If

the employer has fewer than 20 or 100 employees, then Medicare will be primary and the group health plan will be secondary coverage.

Q 42: What is the [insert name of state SHOP exchange]?

Under the ACA, states or the federal government 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]. The SHOP can allow a small employer to offer a range of small group plans to their workers. Eligible employers can apply for the Small Business Health Care Tax Credit if they offer coverage through the SHOP and meet certain other criteria. The SHOP has no minimum contribution requirements for employers, but some states may impose a contribution requirement in addition to a minimum participation rate. Employers who are interested in applying for the Small Business Health Care Tax Credit, however, must contribute at least 50% of the cost of their employees' premiums to be eligible for the credit. Just as with the regular small group market, employers who sign up for coverage during the small group open enrollment period that runs from November 15 to December 15 will face no minimum participation requirements. Coverage would then be effective for workers beginning January 1.

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 across all metal levels (See Question 13.) on the SHOP exchange. In some states, employers may also choose to offer coverage from one insurance company. Whether or not they offer employees choice, in most states, employers will work with their SHOP-registered agent or broker or insurance company (or companies) to obtain application, enrollment, and billing information.

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

http://healthcare.gov/small-businesses

U.S. Department of Labor Patient Protection and Affordable Care Act information
https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families

Affordable Care Act Tax Provisions
https://www.irs.gov/affordable-care-act

Q 43: Is there a cost to participate in [insert name of state SHOP exchange]?

There's no fee for small employers or their employees to enroll in SHOP coverage. Some employers may be eligible for the Small Business Health Care Tax Credit, which can be worth up to 50% of the employer's premium contribution.

Q 44: 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 45: What happens if an employer's staff increases to more than [50] employees in the year after the employer bought coverage through the SHOP?

Once enrolled in SHOP exchange, businesses can renew their coverage even if the number of their employees increases to more than [50].

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

Q 46: How are small employers defined?

In [state], small employers who are eligible for coverage in the small group market or in the SHOP exchange are those with [50] or fewer employees. The definition may be different in other states.

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

Q 47: How do employers with full-time and part-time employees know whether they're required to pay a penalty if they don't offer health insurance to their workers?

To avoid the penalty, employers must be considered to have at least 50 full-time equivalent employees. Even then, penalties will be assessed against employers with at least 50 full-time equivalent employees who 1) do not offer health coverage that meets minimum standards or 2) have an employee who gets coverage through the exchange and gets the premium tax credit. (See Questions 53-54.)

The IRS website provides more information: *https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions*

Q 48: Are health insurers required to sell their plans through the federal SHOP exchange?

Beginning January 1, 2018, SHOP plans are no longer offered through the federal SHOP Exchange. Instead, there are two options to enroll in a SHOP plan, which are:

1. Work with a SHOP-registered agent or broker.
2. Sign up with an insurance company.

For more SHOP information, including SHOP plans and prices, click on the Healthcare.gov link below.
https://www.healthcare.gov/small-businesses/choose-and-enroll/enroll-in-shop/

Drafting Note: Consumers should not create an account, log into an existing account, or start an application on HealthCare.gov for SHOP coverage, even if that is how they enrolled in SHOP coverage in the past.

Q 49: 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 be eligible for the Small Business Health Care Tax Credit (see Question 55), in most cases a small employer must have bought the coverage through the SHOP exchange. It is important for small employers to understand and compare all options available to them. State-licensed health insurance agents and brokers, including SHOP registered agents and brokers, are available to help small employers compare options and determine which plan best meets their needs.

More information about the Small Business Health Care Tax Credit is available at
https://www.irs.gov/affordable-care-act/employers/understanding-the-small-business-health-care-tax-credit

https://www.irs.gov/pub/irs-pdf/p4862.pdf

Drafting Note: States that require small employers to buy health insurance for their employees through the exchange should modify this answer as appropriate.

Q 50: Will consumers be better off with individual coverage through the [insert name of state exchange] rather than through the 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 plans available through the exchange. Employees, their spouses, and dependents offered coverage through an employer are usually not eligible for premium tax credits, so small employer-sponsored coverage could cost less than individual coverage through the federal exchange.

Employers and employees should compare rates for plans offered through the [insert name of state exchange] and for plans in the market outside the [insert name of state exchange].

Q 51: 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]?

As a result of the ACA, insurers offering coverage in the small group market can't deny coverage to a small employer who doesn't meet minimum participation requirements, if the employer seeks coverage during the small group open enrollment period that runs from November 15 to December 15 each year. Outside of that time period, insurers in the small group market can require small employers to meet participation requirements through the [insert name of state exchange] or outside the [insert name of state exchange] consistent with [insert name of state] law.

[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 qualified health plans (QHPs). The minimum participation rate also will be adjusted higher or lower depending on state law or general insurer practice. For more information, see this link: *https://marketplace.cms.gov/outreach-and-education/shop-minimum-participation-rates.pdf*

Q 52: Can small employers who are the sole employees of their business buy small group coverage either through the [insert name of state SHOP 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.

Contact the [insert name of state exchange] at [insert *link*] or [phone number] or a licensed agent or broker for help.

Q 53: How does rating work in the small group market?

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

The ACA offers states the option to combine the individual and small group markets. By combining the markets, risk is 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.

Q 54: Do small employers who don't offer health care insurance coverage to their employees have to pay a tax penalty?

No. Small employers who want to provide coverage may be eligible for the Small Business Health Care Tax Credit to help make insurance more affordable.

If the employer does offer coverage, then the coverage must meet the ACA's minimum standards for small group insurance plans, as well as specific requirements that apply to the small group market, such as coverage of essential health benefits (EHB) 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 55: 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 dependents[1]), and an employee gets a premium tax credit, then the employer has to pay a penalty. For employer-based coverage to be considered affordable in 2021, the premiums for the plan's employee-only option must be less than 9.83% of his or her 2021 annual household income.

To offer minimum value, the plan must pay at least 60% of the medical costs for services the plan covers and include substantial coverage of inpatient hospital and physician services. The 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*.

Large employers for this purpose 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 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 were assessed starting January 1, 2016 against employers with 50 or more FTE employees who do not offer health coverage if an employee gets the premium tax credit.

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

For more information, go to the IRS website at *https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions*.

This question does not take into account all possible situations. Employers should consult a tax professional for help with their particular situation.

[1] The rules implementing employer-shared responsibility provisions have interpreted the phrase "and their dependents" to mean children under age 26, but not spouses, stepchildren, or foster children. There is more information at *https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions*.

Q 56: 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 (see Question 53) for at least 95% of their full-time employees and their dependents, or all but five 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 for a large employer that doesn't offer coverage to full-time employees and their dependents is $2,320 multiplied by the number of full-time employees, if at least one full-time employee has received a premium tax credit. The first 30 employees are exempted in the count to calculate the penalty.

[1] The rules implementing employer shared responsibility provisions have interpreted the phrase "and their dependents" to mean children under age 26, but not spouses. There's more information at *https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions*.

Similarly, the penalty for a large employer that offers coverage that isn't affordable or doesn't give minimum value is $3,480 multiplied by the number of full-time employees who receive premium tax credits. (The maximum penalty may not be greater than $2,320 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 57: How do small employers find out if they're eligible for the Small Business Health Care Tax Credit?

Employers who buy coverage for their employees through the [insert name of state SHOP exchange] may be eligible for the Small Business Health Care Tax Credit. 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.

The tax credit operates on a sliding scale, with a maximum credit of 50% of the employer's share of the premium costs. It is only available to small employers buying health insurance through [insert name of state SHOP exchange]. The tax credit may be 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. The IRS provides additional information at *https://www.irs.gov/newsroom/small-business-health-care-tax-credit-questions-and-answers-calculating-the-credit*.

Q 58: What ACA requirements apply to large employers?

Several 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 Question 53 and Question 82, 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 59: What is the individual responsibility requirement, and does it mean consumers must buy coverage through the [insert name of state exchange]?

Under the ACA, consumers and their dependent children are required to have "minimum essential coverage," unless they qualify for an exemption. This requirement is known as "individual shared responsibility" or the "individual mandate." However, beginning in 2019, the federal tax penalty for going without coverage was reduced to $0. Therefore, those without coverage will have to pay out of pocket for any health care expenses they incur, but they will not pay an additional tax penalty.

This link to the IRS website has more information: *www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Minimum-Essential-Coverage*.

Coverage purchased through an exchange counts as minimum essential coverage, and so do other types of coverage. Employer-sponsored coverage, grandfathered plans, Medicare, Medicaid, and CHIP are all minimum essential coverage. Short-term health plans, fixed indemnity insurance, and coverage through a health care sharing ministry are not minimum essential coverage.

Check the website at *www.healthcare.gov/fees/fee-for-not-being-covered/* for more information.

Q 60: Without a tax penalty, is having minimum essential coverage important?

After 2018, the tax penalty for not having minimum essential coverage (MEC) was reduced to $0. There's more information about the penalty at *www.healthcare.gov/fees-exemptions/fee-for-not-being-covered/*.

Individuals who are not enrolled in minimum essential coverage (MEC) are not eligible for one type of Special Enrollment Period (SEP). Those who are enrolled in MEC that ends are eligible for an SEP that allows them to enroll in individual market coverage, including exchange coverage. Those who are enrolled in coverage that is not MEC do not qualify for this SEP. Therefore, if their coverage ends, they need to wait until the next Open Enrollment Period or until they qualify for another SEP to enroll. Individuals cannot be eligible for premium tax credits until they are enrolled in an exchange plan. More information on SEP rules is available at *http://www.healthreformbeyondthebasics.org/wp-content/uploads/2020/07/REFERENCE-CHART_Special-Enrollment-Periods-7.6.20.pdf*.

And, of course, having coverage offers consumers some protection against high health costs, even if there is no tax penalty for going without coverage.

Drafting Note: States with their own penalties for not having MEC should include that information.

ENROLLING IN HEALTH CARE COVERAGE: WHERE CAN CONSUMERS GET HELP?

Q 61: 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 their household income and set a budget for health insurance. Consumers should find out if they can stay with their current doctors and pharmacy, whether their medications are covered, and understand how insurance works—including understanding deductibles, out-of-pocket maximums, and copayments.

There are several resources from the Kaiser Family Foundation, *Consumer Reports*, the NAIC, HHS, and the U.S. Department of Labor (DOL) to help consumers understand how insurance works, the different insurance options, and what to consider when buying coverage. For questions about Medicare and other health coverage consumers, can contact the state SHIP.

A standard form called the Summary of Benefits and Coverage, or SBC, and the companion set of uniform definitions, also is available for many 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] at [insert *link to state exchange website*], 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 are available.

Consumers who are eligible to buy coverage through the [insert name of state exchange] 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].

Also, a few types of individuals are 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] have extra training from the HHS or the state-based exchange. They 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 66.)

Drafting Note: If a state doesn't have a list of agents and brokers on the exchange, then 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 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 67.)

Drafting Note: States where the HHS will be doing training and certification should modify the preceding paragraph accordingly. The 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. In [insert name of state], examples of application counselors include staff at [insert name of local community health centers or hospitals or consumer nonprofit organizations].

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

Q 62: 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].

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

Q 63: How are people who help consumers enroll in 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 insurance

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 or broker 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 64: 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 *link*] 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.

There's also helpful information at healthcare.gov *https://localhelp.healthcare.gov/.*

Drafting Note: States should modify this answer consistent with the information available in the state.

Q 65: 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 the HHS]. 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 about 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 don't require agents and brokers to be appointed to all the insurance companies selling through the exchange or that don't require agents to provide information about all plans available through the exchange should modify the previous paragraph accordingly.

Q 66: Where should consumers go if they have 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]. The phone number 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 59.) Consumers can also contact the [insert name of state insurance department] at [insert phone number] to file a complaint or report a concern about a negative experience with an insurance company, agent and broker, navigator, in-person assister, or certified application counselor during and after the enrollment process.

Q 67: 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. Those enrolled in a plan through the exchange in 2020 who are eligible for auto-renewal and choose not to re-enroll or enroll in a different plan by December 15, 2020 will be automatically re-enrolled in their current or similar plan. For the 2021 coverage year, the key dates are as follows:

- **November 1, 2020**: Open enrollment starts—the first day a consumer can apply for 2021 coverage.
- **December 15, 2020**: The last date to enroll for coverage that starts January 1, 2021. Consumers who miss this deadline can't sign up for a comprehensive individual market health plan inside or outside the exchange or change plans unless they qualify for a special enrollment period (SEP). (See Question 12.)
- **December 31, 2020**: The date when all 2020 exchange coverage ends, no matter when the consumer enrolled.
- **January 1, 2021**: The date 2021 coverage can start if consumers applied by December 15, 2020, or consumers were automatically enrolled in their 2021 plan or a similar plan.

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 changes that qualify a consumer for a SEP. Consumers eligible for a SEP typically have 60 days to enroll in new coverage. (See Question 12.) Life changes include changes in income from a new job and getting married or divorced. See *www.healthcare.gov/how-do-i-report-life-changes-to-the-marketplace/* [or cite to SBM if appropriate] for information about reporting life changes.

Consumers who have not requested financial assistance don't need to report changes related to financial assistance eligibility.

Drafting Note: Some state-based marketplaces may have different deadlines for automatic re-enrollment and end dates for open enrollment and the timeframes above should be revised accordingly.

Q 68: 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 should 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.

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

Q 69: 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 should 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 health plans and answer questions about health insurance policies in general. The navigator can answer questions from consumers about the differences in health plans 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 aren't 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.

Navigators **CANNOT** sell, solicit, or negotiate a health plan 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.

Q 70: How will the in-person assister or the certified application counselor be able to help consumers with enrollment through the [insert name of state exchange]?

In [insert name of state], the in-person assister or certified application counselor can help consumers create an account and log on to the [insert name of state exchange]. Consumers should log in to their own [insert name of state exchange] account. The in-person assister or certified application counselor can help consumers as needed to complete the eligibility application. Consumers may be prompted to enter the in-person assister's or the certified application counselor's [insert name of state exchange] user identification number on the application to show that the assister or counselor helped them.

The in-person assister or certified application counselor can help consumers compare health plans and answer questions about health insurance policies in general. The assister or counselor can answer questions from the consumer about the differences in health plans and what they might mean to them (such as explaining deductibles or out-of-pocket limits), but the assister or counselor **CANNOT** recommend or suggest which health plan would be best for consumers and their families. Consumers will be asked to enter the in-person assister'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 assister or certified application counselor **CANNOT** sell, solicit, or negotiate a health plan 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.

Q 71: Can small employers use licensed insurance agents or brokers to buy health insurance through [insert name of state SHOP exchange]?

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] with those offered through the [insert name of state SHOP exchange] to decide where they can buy the plan best for them. Employers may wish to talk with more than one agent or broker before making a decision about which plan to buy.

Q 72: Will small employers be able to use navigators to buy health insurance?

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 small employers to enroll 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 advice.

Q 73: How can an insurance agent or broker help a small employer participate the [insert name of state SHOP exchange]?

An insurance agent or broker can help any small employer, as has been true 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], the 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.

Q 74: What is the benefit of using an insurance agent to enroll in the [insert name of state exchange] or the [insert name of state SHOP exchange]?

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. An agent or broker may help individual consumers or small employers create an 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 75: 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, then all QHP 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.

All agents and brokers must follow applicable [insert name of state] laws, regulations, and [insert name of state exchange] requirements, including standards related to relationships or appointments with insurance companies.

[Insert name of state] expects that the insurance agent or broker will tell consumers if the information given is about health plans with which the agent or broker has a business relationship and that consumers can always directly access the [insert name of state exchange] website. They'll find information about other available qualified health plans there. The [insert name of state] expects that insurance agents and brokers will advise consumers to check with the [insert name of state exchange] about available tax credits or cost-sharing reductions.

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

Q 76: 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 shouldn't share personal information, including tax returns, with an agent or broker, navigator, in-person assistance personnel, or certified application counselor. When consumers complete the application on the [insert name of state exchange] website with the help of an agent or broker, navigator, or assister, they should be able to fill out and submit their eligibility application without the agent, navigator, or assister in direct view of the application. While consumers applying for financial assistance are asked to enter their income, income figures from the IRS won't be shown during the application process, whether 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 must complete and comply with a privacy and security agreement and get a user ID to use with the [insert name of state exchange].

Q 77: Will consumers have to share their account username and password with an insurance agent or broker, navigator, in-person assister, or certified application counselor?

No. An agent or broker, navigator, in-person assistance personnel, or certified application counselor should never ask for a consumer's account username and password. If a consumer is asked to share a username or password, then he or she should immediately contact the [insert name of state insurance department] at [insert phone number] and discuss this with the consumer assistance representatives.

Q 78: What help should an insurance agent or broker, navigator, in-person assister, or certified application counselor give consumers if they or their dependents are eligible for Medicaid or CHIP?

Agents or brokers, navigators, in-person assisters, 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 assister, or certified application counselor working with these consumers is expected to refer consumers to the [insert name of state Medicaid and CHIP agency]. Agent and broker, navigator, in-person assister, 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 assister, certified application counselor, or the [insert name of state Medicaid agency]. Navigators, in-person assisters, 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, then the navigator, in-person assister, or certified application counselor may refer the consumer to the state Medicaid agency for more information. Navigators, in-person assisters, and certified application counselors often are 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 they can refer consumers to appropriate resources in those cases.

Q 79: 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.

COSTS AND ASSISTANCE WITH COSTS

Q 80: Is there cost-sharing for contraceptives?

With the exception of health plans sponsored by certain employers that have religious or moral objections to contraception, all plans, including those 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 (see Question 18) or ask their employer or benefits administrator. There's more information about contraceptive coverage on the federal website at *www.healthcare.gov/coverage/birth-control-benefits/* and *www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/aca_implementation_faqs26.pdf*.

Q 81: How much do plans offered through the [insert name of state exchange] cost?

There are a 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 purchasing coverage through [insert name of state exchange] qualify for the premium tax credits (see Questions 82-83), which pay for part of their premium and help lower the cost of coverage. Consumers whose incomes are below a certain amount may be eligible for a premium tax credit and a Silver plan that features lower cost-sharing and lower out-of-pocket costs (copayments, coinsurance and deductibles) without paying a higher premium. Check with the [insert name of state exchange] at [insert *link*] or direct the consumer to an online calculator to estimate whether they may qualify for subsidies: *https://www.kff.org/interactive/subsidy-calculator/*.

To see specific costs of plans offered through the [insert name of state exchange], go to [insert *state exchange website*], call [insert state exchange telephone number], or talk to a navigator, certified application counselor, in-person assister, insurance agent or broker, or other assister. (See Question 59.)

Q 82: Do 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 variety of out-of-pocket costs for consumers. But, the ACA requires that all non-grandfathered plans (including most plans that people get from an employer) limit consumers' annual out-of-pocket costs for in-network essential health benefits (EHB) services to no more than $8,550 for individuals and $17,100 for families in 2021. 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 required to cover certain preventive services without cost-sharing. (See Question 24.) Also, consumers whose incomes are below a certain amount may be eligible for a premium tax credit and a Silver plan, which features lower cost-sharing and lower out-of-pocket costs (copayments, coinsurance and deductibles) without paying a higher premium. Check with the [insert name of state exchange] at [insert *link*] or direct the consumer to an online calculator to estimate whether they may qualify for subsidies: *https://www.kff.org/interactive/subsidy-calculator/*.

Navigators, certified application counselors, in-person assisters, agents or brokers, or other assisters should be able to help consumers learn if they qualify. Also, the exchange application tells consumers whether they might be eligible for Medicaid or CHIP programs, which have very limited out-of-pocket costs.

Q 83: Where can consumers inquire 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] determines eligibility for advance payments of premium tax credits and cost-sharing reductions. The [insert name of state exchange] also assesses Medicaid and CHIP eligibility and makes 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]. 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 84: Is there help for consumers who can't afford coverage?

Yes, consumers with low or moderate incomes can qualify for reduced costs, through Medicaid, CHIP, or exchange coverage, but eligibility rules apply. In [insert name of state], nonelderly adults without minor children don't qualify for Medicaid. Beginning in 2014, some states used federal government funds to expand the program so that Medicaid also would cover adults with an income at or lower than 138% of the federal poverty level. In 2021, that is roughly $17,600 for a family of one and $36,000 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.

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.

Q 85: Who's eligible for premium tax credits and cost-sharing reductions?

The ACA created 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 82.) The amount of the tax credit or cost-sharing reduction depends on family size and income and varies on a sliding scale: 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. Consumers who forget to update the [insert name of state exchange] about such changes might owe money at tax time. More information about tax credits and cost-sharing reductions is available at *www.healthcare.gov.*

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

Q 86: How do premium tax credits to buy coverage through the [insert name of state exchange] work?

Consumers who qualify for premium tax credits can either receive them in advance, 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 year they get coverage. If they underestimate their income and the tax credit is overestimated, then they may have to repay part of their tax credit 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 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. Consumers who forget to update the [insert name of state exchange] about such changes 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 assisters, agents or brokers, or other assisters also are able to give consumers information about the tax credit. There's more information about premium tax credits on the federal website *www.healthcare.gov.*

Q 87: 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 spouse to file a joint return may present a risk and may be legally prohibited if a restraining order is in place. As a result, married individuals who are victims of domestic abuse may still be eligible for subsidies if they are living separately from their spouse. Consumers in this situation should list "unmarried" on their exchange application and can do that without fear of penalty for misstating their marital status. For more information, see *www.healthcare.gov/income-and-household-information/household-size* or *www.irs.gov*.

Q 88: If a consumer is eligible for subsidy assistance, is there a grace period before a company can terminate the consumer 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 days of the grace period, but the insurer may suspend 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, a consumer who misses a payment in July but makes payments in August and September will be terminated in October if he or she has not also paid the missing payment from July. And, a

company may deny coverage in the next year if the consumer is in the grace period. For example, a consumer who misses a payment in November and December may be denied coverage in January if they haven't paid premiums due the year before.

Drafting Note: States should review their laws for other grace periods that might otherwise apply.

Q 89: What should consumers do if they find themselves enrolled in both exchange coverage with premium tax credits and Medicaid, CHIP, or Medicare?

The [insert name of exchange] conducts periodic data matching to identify individuals enrolled in both private insurance with premium tax credits and Medicare or private insurance with premium tax credits and Medicaid/CHIP and sends notices to those consumers. Upon receiving the notice, consumers may end their exchange coverage with premium tax credits by contacting the exchange.

When individuals become eligible for Medicaid, CHIP, or Medicare while enrolled in an exchange plan, they will no longer be eligible for any premium tax credits or cost-sharing reductions. If a consumer wants to maintain exchange coverage while enrolled in Medicaid or CHIP, they will have to pay the full premium. Private plans generally may not cover and individual for the same benefits covered by Medicare, so people who become eligible for Medicare while enrolled in [insert name of exchange] should immediately notify the exchange to end their coverage and enroll in Medicare.

A consumer who wants to maintain exchange coverage while enrolled in Medicaid/CHIP may apply for coverage without financial assistance during the annual open enrollment period or a special enrollment period (SEP). Consumers who are no longer enrolled in Medicaid/CHIP or the exchange with premium tax credits after the data match don't need to do anything else. However, they might opt to contact their state Medicaid or CHIP agency to confirm that they aren't enrolled. Consumers who **are** enrolled in both Medicaid/CHIP and private insurance with premium tax credits should end exchange coverage with premium tax credits, because consumers determined eligible for Medicaid/CHIP aren't eligible for exchange coverage with premium tax credits or cost-sharing reductions.

Consumers who are enrolled in exchange coverage with premium tax credits or cost-sharing reductions and are enrolled in Medicaid, CHIP, or Medicare when the tax filer(s) file their tax return likely will have to pay back all or some of the tax credits received for the months after they were determined to be eligible for Medicare or Medicaid/CHIP. Consumers who receive the notice but have more recently been denied eligibility for Medicaid or CHIP do not need to take any further action with [insert name of state exchange], but they may want to contact their state Medicaid or CHIP agency to confirm that they're not enrolled.

QUESTIONS ABOUT OTHER TYPES OF COVERAGE

Q 90: What is available in the market outside the [insert name of state exchange]?

In [insert state name], health insurance coverage is also 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 or for cost-sharing assistance, then they must buy coverage through the [insert name of state exchange]. (See Question 83 and Question 84.)

Consumers may buy plans in the market outside the exchange that aren't required to cover the essential health benefits (EHB), such as fixed indemnity plans, short-term policies, or insurance coverage and discount plans that include only specialty or ancillary services (for example, hearing, chiropractic, etc.) Note, though, that these policies don't have to comply with ACA reforms such as the requirement that plans cover pre-existing conditions. (See Question 4.) The NAIC has some resources discussing these types of plans:
www.insureuonline.org/consumer_guide_cancer.pdf
https://www.naic.org/documents/consumer_alert_health_sharing_ministries.htm.

Contact [insert state Department of Insurance contact] or an insurance agent or broker for help.

Q 91: What are short-term plans?

Under federal law, short-term plans are those with an initial term of no more than 364 days that include a statement describing potential coverage limitations. Short-term plans may be renewed at the option of the insurer, but the same policy may only be in effect for up to three years in total. Short-term plans are not required to comply with many of the consumer protections of the ACA. For instance, they may charge different premiums based on an applicant's health conditions, exclude essential health benefits, and exclude coverage for pre-existing conditions.

Drafting note: States with their own regulations on short-term plans should add a statement that describes allowable short-term plans, including duration restrictions, rating requirements, or benefit mandates.

Q 92: 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 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 *link*]. 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 93: 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 aren't available through the [insert name of state exchange]. Consumers who are currently enrolled in Medicare may not buy coverage through the exchange. Enrollees who are enrolled in Medicare because of end stage renal disease (ESRD) can enroll in a Medicare Advantage plan beginning in 2021. Questions involving the ACA and Medicare, Medicare Supplement insurance, or Medicare Advantage Plans can be referred 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.

Q 94: Are people who pay premiums for Medicare Part A able to enroll through the [insert name of exchange]?

Individuals who aren't entitled to premium-free Medicare Part A may buy coverage through [insert name of exchange] instead of paying the Part A premium and being enrolled in Part A, 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 must disenroll from Medicare Part A, if they have it, and from Medicare Part B, if they have it. There are consequences to substituting a qualified health plan (QHP) for Medicare. Consumers may pay higher premiums for Medicare if they decide to enroll in Medicare in the future and may have a gap in benefits. The [insert name of SHIP] at [insert contact information] should be able to give consumers more information about their choices.

Q 95: Can a person with ESRD (End Stage Renal Disease) enroll in or stay in an Exchange plan *instead* of enrolling in Medicare?

If a consumer with ESRD has not applied for Medicare, then she or he can stay in or apply for coverage through the [insert name of exchange]. However, there are consequences of delaying Medicare benefits. Individuals 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 benefits when they begin. The [insert name of SHIP] at [insert contact information] should be able to give consumers more information about these complex choices.

Drafting Note: In 2021, Medicare beneficiaries with ESRD can freely enroll in Medicare Advantage Plans.

Q 96: If individuals become eligible for Medicare and are already in a QHP, can they stay in their plan?

A person who stays in a QHP* and is eligible for or enrolled in Medicare is no longer eligible to receive any tax credits. If the consumer has been receiving an advance premium tax credit, then the consumer must report eligibility for Medicare to the [insert name of state exchange] to end the tax credit. A consumer who does not do this will be liable to repay the tax credits for which they were not eligible.

Without the enrollee's authorization, a QHP may not terminate coverage from a policy in which the individual was enrolled upon becoming eligible for Medicare. However, 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 the individual does not sign up for Part B of Medicare. Consumers are encouraged to enroll in Medicare when they are eligible to avoid premium penalties and delayed benefits later. The [insert name of 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.

If a person wants to remain in a QHP, but the QHP changes, then the QHP may be nonrenewed.

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

Q 97: 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 a large employer and that employer's current benefits pay first and Medicare pays second, then the ACA didn'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 SHIP] at [insert contact information] should be able to give consumers more information about how their existing coverage works with Medicare.

Q 98: 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 didn't change retiree benefits. Consumers should contact their employer's human resources department for help. Consumers who need more information about how Medicare and retiree benefits work together can contact the SHIP at [insert contact information].

Q 99: 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 100: How will consumers' Medicare prescription drug "donut hole" be affected?

The ACA began closing the "donut hole" in 2011, and it was closed entirely effective for 2019. The donut hole was closed by combining a 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 the Medicare Part D plan pays, until a beneficiary only owes 25% of the total cost. In the

standard plan, Medicare beneficiaries whose prescription drug costs are greater than the Part D deductible will need to pay only a 25% coinsurance rate (after meeting the plan's deductible, if any) until their expenditures reach the catastrophic level. In other plans, cost-sharing may vary.

For more information, contact Medicare at *www.medicare.gov* or 1-800-MEDICARE or the [insert name of SHIP] at [insert contact information].

Q 101: What about LTC insurance policies?

The [insert name of state exchange] doesn't include long term care (LTC) insurance policies, and policies sold on the [insert name of state exchange] don't typically cover LTC services. Insurance agents and brokers still sell LTC insurance outside the exchange. The HHS website *https://longtermcare.acl.gov/* has information about LTC insurance and the NAIC has produced a Shopper's Guide available at *https://www.naic.org/documents/prod_serv_consumer_ltc_lp.pdf*.

ACA MEDICAID-RELATED QUESTIONS

Q 102: 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 103: Did consumers' eligibility for Medicaid changed under the ACA?

The same categories of consumers continue to be eligible for Medicaid, although the financial method to decide eligibility has changed. Medicaid-eligible consumers still need to be part of an eligible group, such as children, pregnant women, parents (or other caretaker relatives), blind, disabled, or elderly, and they 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 about who is eligible for Medicaid at this link: *https://www.healthcare.gov/medicaid-chip/*.

Q 104: What is the expanded Medicaid eligibility under the ACA?

Adults who weren't eligible for Medicaid in the past may be eligible under the ACA. [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.

Drafting Note: States that have not expanded Medicaid will need to revise this answer accordingly.

There is more information about who is eligible for Medicaid at this link: *https://www.healthcare.gov/medicaid-chip/*.

Q 105: What is the federal poverty level (FPL), and why is it important in the context of health care coverage?

The 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 about $36,000 for a family of four) generally can get Medicaid coverage. People with incomes above this level but less than 400% of the FPL may be eligible for premium tax credits to help them buy a plan through the [insert name of state exchange]. Cost-sharing reductions are available until a family's income reaches 250% of the FPL. Individuals who are eligible for both Medicare and Medicaid, or whose incomes don't exceed certain amounts, may be eligible for one of several low-income programs to supplement their Medicare benefits. The [insert name of SHIP] at [insert contact information] should be able to give consumers more information about their eligibility for these low-income programs.

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: *www.healthcare.gov/lower-costs/qualifying-for-lower-costs/*.

Q 106: 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 (EHB) available through the [insert name of state exchange]. (See Question 17.) Contact the [insert name of state Medicaid agency] at [insert contact information] for more information.

Q 107: Are undocumented immigrants eligible for Medicaid?

Undocumented immigrants are not eligible for most categories of Medicaid coverage, but may receive services in emergency circumstances.

Q 108: How do 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], then his or her 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], 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.

Q 109: Will consumers still need to submit documents to prove their income?

As much as possible, the [insert name of state exchange] uses existing data sources or gets 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 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 (SSA), 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 documentation. But, 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 110: Does the ACA eliminate private health insurance?

No. There is still private health insurance under the ACA. The ACA created health insurance exchanges (see Questions 5-6) where consumers can compare and shop for private insurance plans. The ACA also sets many new federal rules and protections that apply to people who buy private health insurance in each state. (See Questions 2 and 4.)

Q 111: Does the ACA include rules about insurance premiums?

For individual and small group health insurance market plans covered by the ACA's rating rules, premiums may only vary based on an individual's age, the area of the state in which the policy is sold, tobacco use, and family composition. For covered plans, these are the only factors that an insurance company can use when it sets premiums. Covered plans can't

refuse to insure or charge higher premiums to consumers with medical problems. The ACA also reduces the difference in premiums covered plans charge for younger and older people and eliminates differences between premiums charged for men and women. These rating rules cover individual and small group health plans offered through the exchanges or outside of them, but do not apply to short-term, limited duration plans.

To help make coverage affordable, many consumers who buy qualified health plans through the individual market exchanges are eligible for premium tax credits. Also, consumers under age 30 or who obtain a hardship exemption may be eligible to buy catastrophic plans, which cost less.

Drafting Note: States may want to link to rate submissions and final approvals. States that don't allow the tobacco surcharge or use a different ratio than 1.5:1 should note that health insurance companies are prevented from charging consumers a higher premium for being a tobacco user or are limited in the amount of tobacco surcharge they can apply.

Q 112: Does the ACA address discrimination?

ACA explicitly prohibits insurance companies from discriminating on the basis of race, color, national origin, sex, age, or disability.

Section 1557 of the ACA prohibits discrimination by any health program or activity receiving funds from HHS. The scope of this prohibition was first outlined via final rule in 2016, which broadly defined the areas of prohibited discrimination. Gender identity was a controversial inclusion in the rule. On June 12, 2020, a final rule was published that changed the 2016 regulations to limit the applicability. One of the changes in the 2020 rule was to remove the prohibition on discrimination based on gender identity. On June 15, 2020, the U.S. Supreme Court held that discrimination on the basis of sex included discrimination based on gender identity. Subsequently, a federal court issue an injunction barring that change from taking effect.

Health insurers, however, must follow any state laws and regulations that apply to marketing and can't use marketing practices or benefit designs that will discourage individuals with significant health needs from enrolling. Health insurers must also provide meaningful access for individuals with limited English proficiency and post taglines in the languages spoken by persons with limited English proficiency.

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 Question 115.)

Q 113: 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 114: Where else can consumers find answers to health insurance questions?

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

Q 115: What does the health plan "accreditation status" information on the exchange website mean?

Accreditation is a comprehensive process by private, nonprofit 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 URAQ and/or the National Committee for Quality Assurance (NCQA).

Part of the certification requires that the plan is accredited by a recognized accrediting entity within a time frame 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, nondiscrimination, and marketing standards in the ACA.

Q 116: What does the health plan "consumer experience" information on the [insert name of state exchange] website 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 117: 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 if the company upholds its initial unfavorable coverage decision, then it must provide an external review administered by an independent third party. Consumers in individual policies may also be able to request a *voluntary* second-level internal appeal. 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 levels. 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. For more information about how to appeal a health insurance company's unfavorable decision, the consumer can refer to the notice of the insurance company's unfavorable coverage decision (often referred to an Explanation of Benefits, or EOB), plan or policy documents, or 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. Consumers can contact the state insurance department at [insert contact information].

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

Q 118: 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 119: 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 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 Question 12.) 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 aren't required to be marketed as available outside the [insert name of state exchange].

For more information about special enrollment periods (SEPs), see this link:
http://www.healthreformbeyondthebasics.org/wp-content/uploads/2020/07/REFERENCE-CHART_Special-Enrollment-Periods-7.6.20.pdf.

QUESTIONS INVOLVING SPECIAL CIRCUMSTANCES AND POPULATIONS

Q 120: What is available for consumers with chronic conditions? Does the ACA help them get better coverage?

Yes. All plans subject to the ACA must ensure consumers with a chronic or pre-existing medical condition, must cover pre-existing conditions, and can't charge higher premiums because of a health or medical condition. They are also required to offer comprehensive coverage. Discrimination on the basis of age, disability, or expected length of life is prohibited. Coverage for these benefits is available from the beginning of the policy coverage period, without a waiting period, even if there was no prior coverage. Many plans include wellness programs to help consumers manage chronic conditions.

Q 121: 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 lawfully 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 [insert name of state Medicaid and CHIP]. To learn more about these plans, go to *www.insurekidsnow.gov*.

Q 122: Are immigrants not legally present eligible for coverage through the [insert name of state exchange] or for premium tax credits?

No. 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 aren't eligible to participate in the [insert name of state exchange].

Q 123: 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. Consumers who are incarcerated pending the disposition of charges still are eligible. 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 124: 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* or the website for the Indian Health Service (IHS) agency within the HHS at *www.ihs.gov/*.

QUESTIONS ABOUT MLR

Q 125: What is the Medical Loss Ratio (MLR) requirement?

The ACA's 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. The MLR limits the amount of premium dollars spent on administrative expenses, such as overhead, marketing, salaries, and profit.

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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 must rebate (refund) the extra premium.

Q 126: What is an MLR Rebate?

Under federal law, if a health insurer doesn't meet the MLR target (described in Question 123), then that health insurer must give consumers or employers a rebate for the amount of premiums it collected that was greater than the target.

Q 127: How can consumers learn if their insurer paid rebates?

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

QUESTIONS ABOUT WHETHER A PLAN IS LEGITIMATE

Q 128: Why is this a time to be especially on guard against health insurance fraud?

Health insurance rules and regulations are constantly changing. Con artists posing as representatives of the federal government or posing as legitimate insurance agents, brokers, or navigators might try to steal consumers' money, identity, or health information 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, worthless, or not what they claim to be. These scams are often attempted through automated telephone calls or websites that mimic legitimate sites.

Q 129: 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 130: 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.

Drafting Note: States without navigators should update this response to provide alternates sources for consumer assistance.

Q 131: If someone comes to consumers' homes, calls consumers out of the blue, or sends emails to offer consumers health insurance coverage for a terrific premium, 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, then consumers should immediately hang up, close their door, or walk away.

Consumers should NOT volunteer their Social Security number (SSN) 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 providing 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.

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Before You Buy That "Low Cost" Health Insurance:
STOP, CALL, CONFIRM
Know What You're Buying. Get Advice from a Trusted Source.

To buy insurance that will cover a wide range of conditions, start with the federal Health Insurance Marketplace at *www.healthcare.gov* [or STATE exchange] or talk to an agent or broker that is licensed in [STATE]. If you have questions, call the [DOI] at [_____].

If you found less costly health insurance online or someone called with an offer, here are some questions to ask before you buy. For help, call your state [DOI]:

Open Enrollment for 2021 coverage is from November 1 to December 15 [or STATE OE period]. *You may still be able to enroll in comprehensive coverage outside of these dates if you have a qualifying life event, like losing other health coverage, moving, getting married, or having a child. Medicaid is always open to those who qualify.*

Financial Help May Be Available
Visit [MARKETPLACE OR EXCHANGE WEBSITE] to learn if you qualify for financial help to pay for Marketplace insurance or if you qualify for low- or no-cost coverage through Medicaid.

You can find brokers, agents and others qualified to review [MARKETPLACE or EXCHANGE] plans at https://localhelp.healthcare.gov/#/.

- Is it a Short-Term, Limited Duration plan, a Sharing Ministry plan, or other limited-coverage plan? Is it sold through an association that requires a membership fee? If so, it could cover less than Marketplace plans.
- Is the person selling the plan licensed in [STATE]? If so, ask for his/her state license number and contact [STATE DOI] at [phone number] to confirm.
- What is the insurance company and is it licensed in [STATE]?
- Does the plan cover your pre-existing conditions? Does it cover your medications?
- What are the deductibles? There may be different deductibles for different services.
- What services DOESN'T the plan cover?
- For services that ARE covered, how much will the plan actually pay? Is there a limit on the total amount the plan will pay per person, per service, or per year?
- How long will the coverage last? Will you be able to keep or renew your coverage if you get sick?
- Does the plan have a provider network?
    - If yes, how do you access information about it? Is your doctor or hospital in the network?
    - If not, will doctors and providers agree not to bill for amounts above what the plan pays?

Ask for a written example of how coverage works if you visited a physician and needed diagnostic tests and follow-up care. Also ask for a written example of how coverage works if you had a hospital stay for several days, and had testing and scans, surgery, and saw several specialists.

Before you buy, always ask for the plan's details in writing and take the time to review the materials carefully. Don't feel rushed to make a decision. Remember, there is free help available to you at [NAME OF INSURANCE DEPT WITH PHONE NUMBER].

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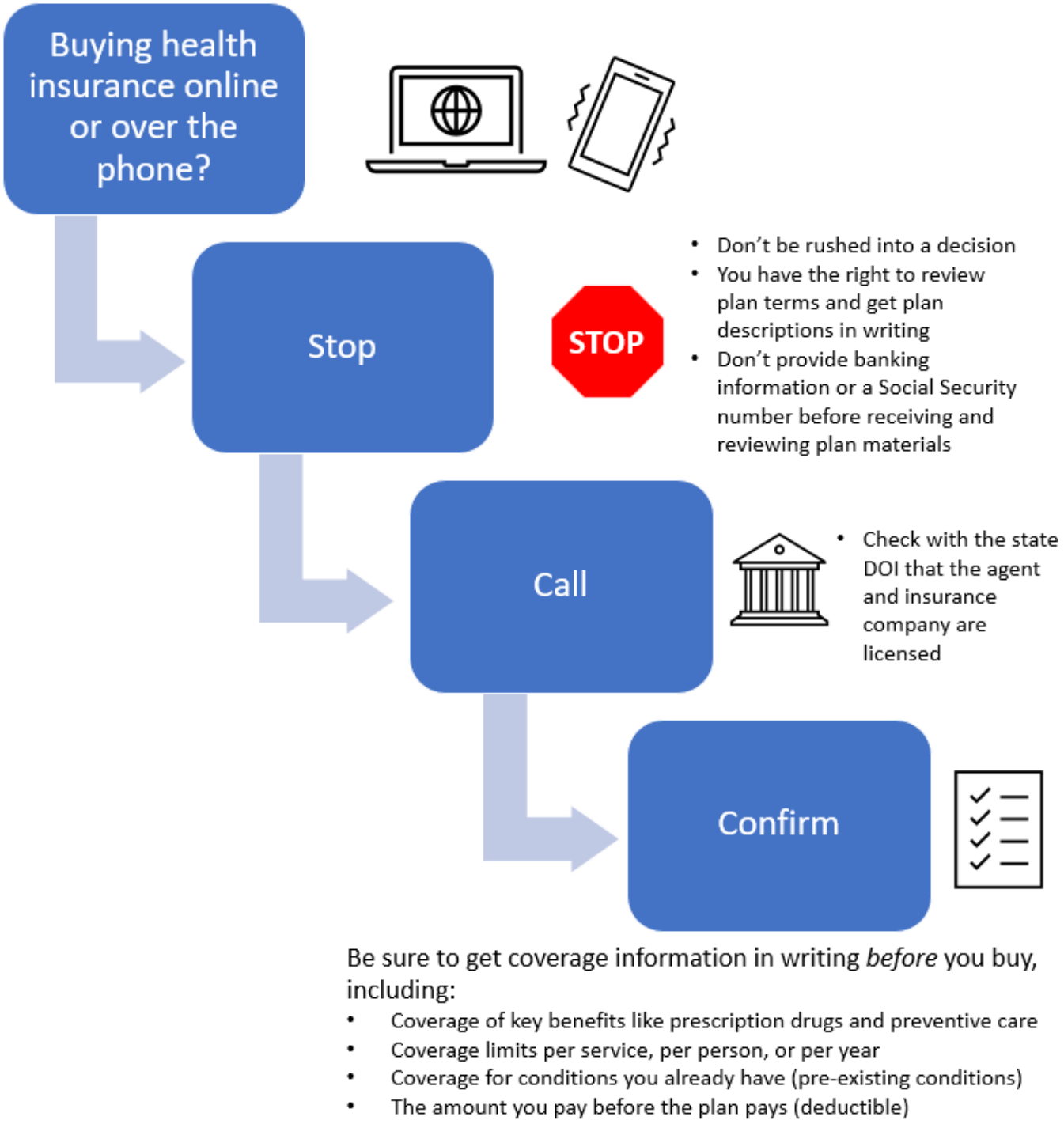

Get more help with these resources from the National Association of Insurance Commissioners

What to Ask When Shopping for Health Insurance

Health Insurance Shopping Tool

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Consumer Information (B) Subgroup
Conference Call
October 20, 2020

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call Oct. 20, 2020. The following Subgroup members participated: Mary Kwei, Chair (MD); Debra Judy, Vice Chair (CO); Weston Trexler (ID); Michelle Baldock (IL); Jenifer Groth (IN); LeAnn Crow, Brenda Johnson, Tate Flott, and Shannon Lloyd (KS); Judith Watters and Sherry Ingalls (ME); Candace Gergen (MN); Carrie Couch, Michelle Vickers, and Jessica Schrimpf (MO); Laura Arp and Martin Swanson (NE); Ingrid Marsh (NH); Kathy Shortt (NC); Cuc Nguyen (OK); Elizabeth Hart and Shannen Logue (PA); Gretchen Brodkorb, Candy Holbrook and Jill Kruger (SD); Jennifer Ramcharan and Vickie Trice (TN); Shelley Wiseman and Jaakob Sundberg (UT); Jennifer Stegall, Julie Walsh, Darcey Paskey, Rebecca Rebholz and Mary Kay Rodriguez (WI).

1. Discussed Updates to FAQ about Health Care Reform

The Subgroup discussed updates to the Frequently Asked Questions (FAQ) about Health Care Reform document. Ms. Kwei pointed out questions in the FAQ document with unresolved comments. Brenda Cude (University of Georgia) asked about notices for transitional plans. Ms. Shortt said there is no harm in keeping it, even if it has outlived its usefulness. Ms. Cude suggested revised language, which the Subgroup agreed to accept. The Subgroup discussed whether to add a question on when Medicare is a primary or secondary payer to employer coverage. The Subgroup agreed to add one such a question. The Subgroup also agreed to add a question on the interaction between Medicare and health reimbursement arrangements (HRAs). The Subgroup discussed Question 91, which concerned Medicare inquiries. Bonnie Burns (California Health Advocates—CHA) agreed to work with other NAIC consumer representatives to develop revised language and forward the revised language for the Subgroup's consideration.

The Subgroup agreed to review an updated version of the FAQ document and vote on approval by e-mail in the week of Oct. 26.

2. Discussed a Consumer Guide on Short-Term Plans

Ms. Judy brought up the consumer guide titled "Before You Buy That "Low Cost" Health Insurance." The Subgroup discussed adding a reference to off-exchange plans being available during open enrollment and agreed to remove a reference to marketplace plans so that off-exchange are also included. Ms. Ramcharan said that many state insurance regulators cannot regulate health care sharing ministries (HCSMs) and Tennessee published information to say it cannot help consumers with them. Ms. Judy said that state authority concerning HCSMs vary. She recommends that the language remain unchanged and the states can edit the language to reflect their authority over such plans. The Subgroup discussed limiting the warning on phone and internet sales to outside open enrollment. After discussion, the Subgroup decided to retain the existing language because limited benefit plans are sometimes marketed during open enrollment as well. Ms. Rodriguez suggested adding a warning not to provide banking or social security numbers until a consumer has reviewed plan materials. The Subgroup accepted her suggestion.

The Subgroup agreed to review an updated version of the guide and vote on approval by e-mail in the week of Oct. 26.

Having no further business, the Consumer Information (B) Subgroup adjourned.

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Draft: 11/30/20

Health Innovations (B) Working Group
Virtual Meeting (*in lieu of meeting at the 2020 Fall National Meeting*)
November 9, 2020

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met Nov. 9, 2020. The following Working Group members participated: Marie Ganim, Chair (RI); Martin Swanson, Vice Chair, and Laura Arp (NE); Andrew R. Stolfi, Vice Chair, and TK Keen (OR); Anthony L. Williams and William Rodgers (AL); Sarah Bailey, Lori K. Wing-Heier and Jacob Lauten (AK); Howard Liebers (DC); Doug Ommen, Andria Seip and Cynthia Banks Radke (IA); Kim Collins, Claire Szpara and Karl Knable (IN); Brenda Johnson, Craig Van Aalst and Julie Holmes (KS); Robert Wake (ME); Camille Anderson-Weddle, Carrie Couch, Jessica Schrimpf, Michelle Vickers, Chlora Lindley-Myers and Amy Hoyt (MO); Jon Godfread, Colton Storseth and Chrystal Bartuska (ND); Tyler Brannen and Maureen Belanger (NH); Philip Gennace (NJ); Colin Baillio and Paige Duhamel (NM); Mark Garratt (NV); Jessica K. Altman and David D'Agostino (PA); Valerie Brown, Doug Danzeiser, Rachel Bowden, David Bolduc and Barbara Snyder (TX); Shelley Wiseman and Jaakob Sundberg (UT); Molly Nollette and Jane Beyer (WA).

1. Adopted its July 30 Minutes

Commissioner Stolfi made a motion, seconded by Ms. Arp, to adopt the Working Group's July 30 minutes (*see NAIC Proceedings – Summer 2020, Health Insurance and Managed Care (B) Committee, Attachment Six*), which covered presentations related to telehealth and cost control. The motion passed unanimously.

2. Heard a Presentation on Hospital Prices

Christopher Whaley (RAND Corporation) gave a presentation on the RAND Corporation's most recent study on the prices charged by hospitals to private health plans. He described the changes to the study since the last version, including that it now includes 49 states, six all-payer claims databases, professional fees, and facility fees. He said commercial prices relative to Medicare have increased steadily, and they were 247% of Medicare prices, on average, in 2018. He said hospital prices vary widely across the states, within the states, and within health systems. The study found some link between price and quality, but there are many high-quality hospitals with low prices. He suggested policy changes, such as support for all-payer claims databases, policies that promote competition and eliminate gag clauses, limits on out-of-network charges, and all-payer or global budget programs.

Commissioner Stolfi asked what resources might be available to help employers use the data from the study in their negotiations with health plans. Mr. Whaley said employers can form coalitions to rethink benefit designs in ways that take advantage of lower priced providers. He also said states can use their leverage as large employers to direct enrollees to lower priced providers and implement reference-based pricing. Commissioner Stolfi asked how the Medicare comparison rate was determined. Mr. Whaley said his study makes all of the same adjustments as Medicare does for payments, including geographic adjustments and teaching hospital adjustments.

Commissioner Godfread asked Mr. Whaley to respond to hospitals' argument that they are rate takers, not rate setters. Mr. Whaley said different markets have different dynamics, so this may be true in some places; but rates of growth, like 10% per year above Medicare rates, do not seem to indicate rate taking.

3. Heard Presentations on Hospital Costs

Marilyn Bartlett (National Academy for State Health Policy—NASHP) explained a hospital cost tool that her organization developed. She said information on hospital prices is more available, but data on the costs that hospitals have is harder to find. She said using the tool does not take much work, just gathering a Medicare cost report for a hospital and entering information into a Microsoft Excel spreadsheet. She said the tool could be used in health insurance rate review, hospital merger evaluations, and discussions around global health care budgets. She showed how the tool can be used to compare hospitals in different categories, such as not-for-profit, for-profit health system, and university-based and by payer mix, showing how much profit hospitals make from Medicare and Medicaid patients. She said the tool also allows calculation of a hospital's breakeven point for different payers.

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4. Heard a Presentation on Costs and Coverage Requirements for Coronavirus Tests

Karen Pollitz (Kaiser Family Foundation—KFF) presented on prices for coronavirus tests and issues related to the federal requirement for insurers to cover the cost of tests. She described the different types of tests in the market and those under development. She explained federal law and guidance on insurer coverage, which says that testing for surveillance need not be covered and providers must post their cash prices online. She added that states may impose additional standards or requirements if they do not prevent the application of federal law. She discussed pricing information based on Medicare payment rates, the prices posted on hospital websites, and in advertising from retailers and test manufacturers. She shared media stories of the amounts insured and uninsured individuals have been charged for tests. She suggested ways for state insurance regulators to address testing prices, including enhancing price transparency; coordinating to report complaints; auditing a sample of claims; adapting surprise billing protections; and communicating with federal officials, other state agencies like attorneys general, and local public health departments.

Commissioner Stolfi asked how the states can clarify coverage for tests when an individual is notified by a contact tracer that there was a possible exposure. Ms. Pollitz said in her view, such a test would be diagnostic and not for surveillance.

5. Heard Presentations from Consumer Representatives on Health Care Prices and Coronavirus Test Prices

Eric Ellsworth (Consumer's Checkbook) outlined ways in which price transparency efforts are not working for consumers. He noted that consumers are not aware of existing tools, the information they provide is not actionable, and providers often make care decisions, not consumers. He said consumers need accurate, real time information. He recommended that state insurance regulators push for public network data and standards for clarity in user experiences.

Amy Killelea (National Alliance of State and Territorial AIDS Directors—NASTAD) spoke on coronavirus test prices. She suggested that there is no such thing as a purely surveillance test. She said for other diseases like hepatitis, insurers cover routine screening as well as diagnostic testing. She said public health funding should be more consistent, rather than increasing only when there is a public health emergency. She said given cuts to public health funding, insurers have a role to play in funding testing in the current emergency. She said state insurance regulators could more broadly define recent exposure to allow more coverage for testing.

Jackson Williams (Dialysis Patient Citizens) addressed the issue of hospital prices and the role of insurers and state insurance regulators in pushing back on high prices. He suggested that state insurance commissioners act as coordinators to facilitate more effective negotiation between payers, both insurers and employers, and providers. He said there is also a role for state attorneys general and consumer advocates. He suggested that state insurance regulators could withhold permission to increase rates and potentially impose a duty on insurers to get the best price for consumers. He shared a law review article he authored that further describes these ideas.

Having no further business, the Health Innovations (B) Working Group adjourned.

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