

The Patient Protection and Affordable Care Law of 2010, amended by the Health Care and Education Reconciliation Act of 2010, are referred to collectively as the “Affordable Care Act.” For the purposes of this presentation, we will refer to it as the “Health Care Law.”

This session focuses on the new Health Insurance Marketplace (sometimes called “Marketplace” or “Exchange”) and other provisions of the Health Care Law.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and the Health Insurance Marketplace.

The information in this module was correct as of July 2013.

To check for updates on health care reform, visit HealthCare.gov.

This CMS National Training Program product isn’t a legal document. Official legal guidance is contained in the relevant statutes, regulations, and rulings.

Objectives

This session will help you

- Explain the Health Insurance Marketplace
- Identify who will benefit
- Define who is eligible
- Explain the enrollment process
- Define options for those with limited income
- Locate resources

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- Explain the Health Insurance Marketplace
- Identify who will benefit
- Define who is eligible
- Explain the enrollment process
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- Locate resources

Session Topics

1. Health Insurance Marketplace
2. Eligibility and Enrollment
3. New way to lower costs
 - Monthly premiums, and
 - Out-of-pocket costs
4. Medicaid and the Children's Health Insurance Program (CHIP)
5. Personalized Assistance
6. Key Points

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This session will include the following topics:

1. The Health Insurance Marketplace
2. Eligibility and enrollment
3. New way to lower costs
 - Monthly premiums, and
 - Out-of-pocket costs
4. Medicaid and the Children's Health Insurance Program (CHIP)
5. Personalized Assistance
6. Key Points

Introduction

New way to buy health insurance when key parts of the health care law take effect

Health Insurance Marketplace

- Enrollment starts October 1, 2013
- Coverage begins as soon as January 1, 2014



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The Marketplace (also known as an Exchange) is for qualified individuals and employers to directly compare certain competitive private health insurance options, known as Qualified Health Plans, on the basis of price, quality, and other factors. The Marketplace will help enhance competition in the health insurance market, improve choice of affordable health insurance, and give small businesses similar advantages as large businesses.

When key parts of the health care law take effect, there'll be a new way to buy health insurance: the Health Insurance Marketplace.

- Enrollment starts October 1, 2013
- Coverage begins as soon as January 1, 2014

When you shop at the Health Insurance Marketplace, information about prices and benefits is written in plain language you can understand, so you don't have to guess about your costs. You get a clear picture of what you're paying and what you're getting before you make a choice.

1. Health Insurance Marketplace

- To provide qualified individuals and employers
 - Access to affordable coverage options
 - Ability to buy certain private health insurance
 - Access to health insurance information
- Allows apples-to-apples comparison of Qualified Health Plans



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The Health Insurance Marketplace is a new way to find and buy health insurance and apply for Medicaid and the Children's Health Insurance Program (discussed later). The Marketplace is designed to help you find health coverage that fits your budget, with less hassle. Qualified individuals and employers can shop for affordable, private coverage from Qualified Health Plans.

Qualified Health Plans in the new Marketplace will be sold and run by private companies, and every Qualified Health Plan will cover a core set of benefits called Essential Health Benefits. New and expanded programs will be directly linked. You will have guaranteed coverage and renewability, regardless of a pre-existing condition (like cancer or diabetes), sex, age, etc.

Choose a plan from the comfort of your home, or anywhere you can access the Web, and sign up right online.

Beginning October 1, 2013, you and your family can explore every Qualified Health Plan in your area. You may even be eligible for lower premiums and out-of-pocket costs. Coverage can begin as soon as January 1, 2014.

How the Marketplace Works

- Coverage to fit individual needs
- Marketplace affordability
 - May be able to get lower costs on premiums and out-of-pocket costs
- Unbiased help and customer support provided
- Quality health coverage
- Easy to use

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The Marketplace will make it easier to find insurance coverage that fits your needs by:

- Increasing affordability. Find out if you are eligible for advance payment of the premium tax credits, cost-sharing reductions, or public health coverage programs to make coverage more affordable.
- Offering personalized help. Each Marketplace can help you consider your coverage choices and answer your questions. Each Marketplace will offer help through a website, a call center, and community groups or individuals specifically designated as “Navigators” to help consumers. Other assisters, such as insurance agents and brokers may also be able to help consumers and small employers find coverage options in the Marketplace (if they meet criteria discussed later).
- Ensuring quality. The Marketplace will ensure that all Qualified Health Plans in the Marketplace meet basic standards, including quality standards, consumer protections, and access to an adequate range of doctors and clinicians.
- Making costs clear. When you shop at the Marketplace, information about prices and benefits is written in plain language you can understand, so you don’t have to guess about your costs. You get a clear picture of what you’re paying and what you’re getting before you make a choice.
- Increasing transparency. The Marketplace will post clear and detailed information about health plan prices, benefits, and quality so that you can make meaningful comparisons between plans.

How the Marketplace Works (Continued)

- One process to determine eligibility for
 - Qualified Health Plans through the Marketplace
 - New tax credits to lower premiums
 - Reduced cost sharing
 - Medicaid
 - Children's Health Insurance Program (CHIP)
- Offers choice of plans and levels of coverage
- Insurance companies compete for business

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Through the Marketplace, you'll be able to find out if you're eligible for the new premium tax credits (which you can choose to use to lower what you pay for your monthly health plan premium); cost-sharing reductions; or other health coverage programs, like Medicaid (a federal/state program which covers certain people with low income and resources) and the Children's Health Insurance Program (CHIP) (which covers certain children); and enroll promptly and easily in the appropriate program. The Marketplace offers competition, choice, and clout. Insurance companies will compete for business on a level and transparent playing field, driving down costs.

Marketplace Basic Rules

- Offer Qualified Health Plans that provide basic consumer protections
- Ensure high quality and choice of plans
- Provide information on plan premiums, deductibles, and out-of-pocket costs before you decide to enroll
- Allow you to compare costs and coverage between health insurance plans

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A Marketplace will offer only Qualified Health Plans that meet minimum standards, ensure high quality, and cover Essential Health Benefits like emergency services, hospitalization, prescription drugs, preventive and wellness services, and maternity and newborn care. Qualified Health Plans provide basic consumer protections. The Marketplace will provide information on plan premiums, deductibles, and out-of-pocket costs before you decide to enroll. This allows a comparison of the costs and coverage between the health insurance plans offered. These are the minimum Federal standards – but states have flexibility in establishing their own Marketplace standards.

Qualified Health Plans

- A Qualified Health Plan
 - Is offered by an issuer that is licensed by the state and in good standing
 - Covers Essential Health Benefits
 - Is offered by an issuer that offers at least one plan at the “silver” level and one at the “gold” level of cost sharing
 - Is offered by an issuer that agrees to charge the same premium rate whether offered directly through the Marketplace or outside the Marketplace

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Section 1301 of the Health Care Law defines Qualified Health Plans as follows:

(a) Qualified Health Plan.—In this title:

(1) IN GENERAL.—The term “Qualified Health Plan” means a health plan that—

- (A) has in effect a certification (which may include a seal or other indication of approval) that such plan meets the criteria for certification described in section 1311(c) issued or recognized by each Marketplace through which such plan is offered;
- (B) provides the Essential Health Benefits package described in section 1302(a); and
- (C) is offered by a health insurance issuer that—
 - (i) is licensed and in good standing to offer health insurance coverage in each state in which such issuer offers health insurance coverage under this title; H. R. 3590—45
 - (ii) agrees to offer at least one Qualified Health Plan in the silver level and at least one plan in the gold level in each such Marketplace (see slide 11);
 - (iii) agrees to charge the same premium rate for each Qualified Health Plan of the issuer without regard to whether the plan is offered through a Marketplace or whether the plan is offered directly from the issuer or through an agent; and
 - (iv) complies with the regulations developed by the Secretary under section 1311(d) and such other requirements as an applicable Marketplace may establish.

The Marketplace will only offer Qualified Health Plans, including stand-alone dental Qualified Health Plans that cover pediatric dental Essential Health Benefits. Each state has a benchmark plan that is the basis for what services a Qualified Health Plan must cover as Essential Health Benefits. The Exchange Establishment final rule requires a state’s base-benchmark plan that lacks pediatric dental or vision coverage to be supplemented with the FEDVIP pediatric vision/dental plan; or the state’s separate CHIP plan benefit if one exists. Pediatric services are services required to be covered for individuals under age 19, but states have the flexibility to require coverage for older individuals.

There are new consumer protections which end lifetime and annual dollar limits on coverage of Essential Health Benefits. Lifetime limits on Essential Health Benefits are banned for all comprehensive health insurance plans. Annual limits on your Essential Health Benefits are currently permitted to a limited extent and will be eliminated in 2014.

Essential Health Benefits

Qualified Health Plans cover Essential Health Benefits which include at least these 10 categories

Ambulatory patient services	Prescription drugs
Emergency services	Rehabilitative and habilitative services and devices
Hospitalization	Laboratory services
Maternity and newborn care	Preventive and wellness services and chronic disease management
Mental health and substance use disorder services, including behavioral health treatment	Pediatric services, including oral and vision care (pediatric oral services may be provided by stand-alone plan)

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The Health Care Law provides for the establishment of an Essential Health Benefit (EHB) package that includes coverage of EHBs (as defined by the Secretary of the Department of Health and Human Services (the Secretary)). The law directs that EHBs be equal in scope to the benefits covered by a typical employer plan and cover at least the following 10 general categories:

1. Ambulatory patient services (outpatient care you get without being admitted to a hospital)
2. Emergency services
3. Hospitalization
4. Maternity and newborn care (care before and after your baby is born)
5. Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
6. Prescription drugs
7. Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care (pediatric oral services may be provided by stand-alone plan, see notes on slide 9)

Plan Levels of Coverage

Levels of Coverage	Plan Pays On Average	Enrollees Pay On Average* <i>(In addition to the monthly plan premium)</i>
Bronze	60%	40%
Silver	70%	30%
Gold	80%	20%
Platinum	90%	10%

*Based on the aggregate cost under the plan when benefits are provided to a standard population. This may not be the same for every (or any specific) enrolled person.

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Actuarial value, or AV, in the aggregate for a standard population, can be considered a general summary measure of health plan generosity. For example, if a plan has an actuarial value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy. While premiums are not taken into account to calculate the actuarial value, generally plans with a higher actuarial value and more generous cost-sharing tend to have higher premiums.

The Health Care Law requires that plans meet certain levels of coverage referred to as “metal tiers.” Each of these levels of coverage is associated with an actuarial value, which section 1302(d) of the statute requires be calculated based on the provision of the Essential Health Benefits to a standard population (and without regard to the population the plan may actually provide benefits to).

The levels of coverage are as follows:

- Bronze level - is a health plan that has an AV of 60%.
- Silver level - is a health plan that has an AV of 70%. The second lowest cost silver plan is used for figuring the reductions in cost sharing and premium tax credits for eligible individuals.
- Gold level - is a health plan that has an AV of 80%.
- Platinum level - is a health plan that has an AV of 90%.

Catastrophic Plans

- Who is eligible?
 - Young adults under 30 years of age
 - Those who obtain a hardship waiver from the Marketplace
- What is catastrophic coverage?
 - Plans with high deductibles and lower premiums
 - Includes coverage of 3 primary care visits and preventive services with no out-of-pocket costs
 - Protects consumers from high out-of-pocket costs



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Catastrophic plans will generally have lower premiums, protect against high out-of-pocket costs, and cover recommended preventive services without cost sharing—providing affordable individual coverage options for young adults and people who qualify for certain hardship exemptions from the requirement to maintain health insurance coverage. Marketplace catastrophic plans cover 3 annual primary care visits and preventive services at no cost. After the deductible is met, they cover the same set of Essential Health Benefits that other Marketplace plans offer. If you enroll in a catastrophic plan, you cannot use a Premium Tax Credits to lower your monthly premiums.

In the Marketplace, catastrophic plans are available only to people under 30 and to people who have received certain “hardship exemptions.” Each member of the family must meet eligibility requirements to purchase.

Minimum Essential Benefits

- Starting in 2014, most people must have health coverage or pay a fee
 - If you don't have a certain level of health coverage (employer coverage, Medicare, Medicaid, CHIP, TRICARE, certain VA coverage, an individual policy, or a plan in the Marketplace) you may have to pay a fee with your tax return
 - Starting when you file your 2014 Federal tax return in 2015
 - Some people may qualify for an exemption

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When an uninsured person requires urgent—often expensive—medical care but doesn't pay the bill, everyone else ends up paying the price. That's why the Health Care Law requires all people who can afford it to take responsibility for their own health insurance by getting coverage or paying a fee (penalty, or shared responsibility payment). People who choose not to obtain health coverage will also have to pay the entire cost of all their medical care. They won't be protected from the kind of very high medical bills that can sometimes lead to bankruptcy.

The fee in 2014 is 1% of your yearly income or \$95 per person for the year, whichever is higher. The fee for uninsured children is \$47.50 per child. The most a family would have to pay is \$285. Amounts go up after 2014. But it's important to remember that someone who pays the fee won't get any health insurance coverage.

After open enrollment ends on March 31, 2014, people won't be able to get health coverage through the individual Marketplace until the next Annual Enrollment Period, unless they have a qualifying life event that provides for a Special Enrollment Period.

You pay the fee when you file your 2014 Federal income tax return in 2015, and thereafter. The IRS routinely works with taxpayers who owe amounts they cannot afford to pay. The law prohibits the IRS from using liens or levies to collect any payment you owe related to the individual responsibility provision, if you, your spouse or a dependent included on your tax return does not have minimum essential coverage.

You may get an exemption from the payment for reasons of religious conscience; if you are a member of a recognized health care sharing ministry; a member of a Federally recognized Indian tribe; you have no tax filing requirement (household income below minimum threshold); if you have a short coverage gap (less than 3 consecutive months); you suffered a hardship; you have unaffordable coverage options (minimum amount you must pay for premiums is more than 8% of your household income), you are incarcerated; or if you are not lawfully present (neither a U.S. citizen, a U.S. national, nor an alien lawfully present in the U.S.).

Small Business Health Options Program (SHOP)

- The Small Business Health Options Program is a Marketplace for small businesses and their employees
 - Beginning 2014, small businesses will have more choice and control over health insurance spending
 - Choices among Qualified Health Plans to meet every budget
 - Access to tax credits for eligible employers
 - New consumer protections

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Today, small employers have a tough time finding and affording coverage that meets the needs of their employees. Starting in 2014, they'll have more choice and control over health insurance spending through the Small Business Health Options Program (SHOP). Eligible employers can define how much they'll contribute toward their employees' coverage, have access to a small business tax credit, and benefit from new protections that help them get real value for their premium dollars.

The Small Business Health Care Tax Credit was created to help small employers of lower wage workers afford a significant contribution to those workers' premiums. This credit is already available to employers with fewer than 25 low-to-moderate wage employees, when the employer contributes at least 50% of the cost of single (not family) health care coverage for each employee. Low-to-moderate wage employees means that their average wages are less than \$50,000 per year. The limit on employer size applies to "full-time-equivalent (FTE)" employees. That means that small employers with more than 25 lower-to-moderate wage part-time employees may still be eligible for the credit. For example, two half-time employees equal one full-time-equivalent employee.

Employers can visit the IRS website or consult their tax preparers for more details. Starting in 2014, the credit will be available **only** to employers who purchase insurance through SHOP. Right now, the credit is worth up to 35% of an employer's premium contribution (up to 25% for tax-exempt employers). Starting in 2014, the value of the credit increases to as much as 50% of an employer's premium contribution (up to 35% for tax exempt employers). The number of small businesses benefiting from the small business tax credit doubled to 360,000 in tax year 2011.

NOTE: Reporting and the employer fee (shared responsibility payment) have been delayed to January 1, 2015.

How SHOP Works

- Small employers with fewer than 100 FTE employees can qualify
 - Most states will keep upper limit of 50 FTEs for 2014/2015
 - Employer will access SHOP where its principal business office is located or through its employee's primary work sites
 - Employer must offer coverage to all full-time employees
- Sole proprietors
 - May buy through the individual Marketplace rather than through SHOP

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Small employers must have 100 FTE or fewer employees to be eligible to participate in the SHOP, although states may define a small employer eligible to participate in SHOP as one with 50 or fewer employees until 2016. Then all states will use the 100 employee limit.

§ 155.710 Eligibility standards for SHOP.

- (b) Employer eligibility requirements. An employer is a qualified employer eligible to purchase coverage through a SHOP if such employer—
- (1) Is a small employer;
 - (2) Elects to offer, at a minimum, all full-time employees coverage in a QHP through a SHOP; and
 - (3) Either—
 - (i) Has its principal business address in the Marketplace (Exchange) service area and offers coverage to all its full-time employees through that SHOP; or
 - (ii) Offers coverage to each eligible employee through the SHOP serving that employee's primary worksite.
- (c) Participating in multiple SHOPS. If an employer meets the criteria in paragraph (b) of this section and makes the election described in (b)(3)(ii) of this section, a SHOP shall allow the employer to offer coverage to those employees whose primary worksite is in the SHOP's service area.

Those who are sole proprietors are considered individuals and **may** buy through the individual Marketplace, but not through SHOP.

Marketplace Establishment

- Each state can choose to
 - Create and run its own Marketplace
 - Partner with the Federal government to run some Marketplace functions
 - Have a Marketplace established and operated by the Federal government

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A state has substantial flexibility in establishing a Marketplace that meets the needs of its citizens. States across the country have received grants to establish new Marketplaces. States may create and operate their own Marketplace. The Federal government will establish and operate a Marketplace in those states that do not establish their own. In states where the Federal government is operating a Marketplace, the state can opt to partner with the Federal government. A Partnership Marketplace allows states to make recommendations for key decisions and help tailor a Marketplace to local needs and market conditions. States may also choose to run a SHOP.

States that decided to operate their own Marketplace submitted a letter of intent and an application to HHS. States applied to participate in a State Partnership Marketplace with the Federal government by February 15, 2013. A state may apply at any time to run its own Marketplace in future years.

U.S. territories can decide whether to create their own Marketplace or expand Medicaid coverage. Residents of a U.S. territory aren't eligible to apply for health insurance using the federal or state Marketplace; you must be a resident of the state in which a Marketplace is operating in order to be eligible to enroll in coverage through the Marketplace.

Check with your territory's government offices to learn about these options.

State Establishing a Marketplace

- State-based Marketplace can be operated by
 - Non-profit entity
 - Independent governmental agency
 - Existing state agency
 - State Medicaid agency
 - Department of Insurance
 - Other

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A state can operate a Marketplace as a non-profit entity established by the state, as an independent public agency, or as part of an existing state agency. A Marketplace that is run by independent agencies or non-profits must have a governing board that is administered under a formal charter, that holds regular meetings, that include consumer representatives, that ensures that board members have relevant experience, ensures freedom from conflicts of interest and promote ethical and financial disclosure standards.

State Not Establishing a Marketplace

- If state does not establish a Marketplace
 - The Marketplace will be established by the Federal government
 - States can work in partnership with the Department of Health and Human Services (HHS) to perform activities in the
 - Plan management, and/or
 - Consumer assistance, education, and outreach
- A state may seek approval in subsequent years to establish and operate its own State Marketplace

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If a state chooses not to create and run its own Marketplace:

- The Marketplace will be established by the Federal government.
- The state can work with the Department of Health and Human Services to perform the following activities:
 - Plan management, and/or
 - Consumer assistance, education, and outreach
- States may apply at any time to run their own Marketplace in future years. A state electing to seek approval of its Marketplace later than January 1, 2013, must have in effect, an approved, or conditionally approved, Marketplace Blueprint and operational readiness assessment at least 12 months prior to the Marketplace first effective date of coverage, and develop a plan jointly with HHS to facilitate the transition to a state Marketplace.

Marketplace Establishment Funds

- Federal support for initial costs
 - Federal grants available to states to plan for and establish Marketplace
 - Grants must be awarded before January 1, 2015
 - After January 1, 2015
 - No grants awarded for operational costs
 - Marketplace will be financially self-sustaining

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The costs to states for establishing a Marketplace and testing Marketplace operations during 2014 may be funded by grants under section 1311(a) of the Health Care Law. Additionally, grants under section 1311 may be awarded until December 31, 2014, for approved establishment activities that fund first year start-up activities (i.e., activities in 2014 within the applicable grant award). See

<http://www.cms.gov/ccio/resources/marketplace-grants/> for grant information for your state.

A state may also receive grants for activities to establish and test functions that the state performs in support of a Marketplace established by the Federal government, including for a State Partnership Marketplace. By law, states operating a Marketplace in 2014 must ensure that their Marketplaces are financially self-sustaining by January 1, 2015.

NOTE: Navigators may not be paid through these grants, but through operational funds. Navigators are discussed later in this presentation.

2. Eligibility and Enrollment

- Marketplace eligibility requires you to
 - Live in its service area, and
 - Be a U.S. citizen or national, or
 - Be a non-citizen who is lawfully present in the U.S. for the entire period for which enrollment is sought
 - Not be incarcerated
 - Can apply for Marketplace if pending disposition of charge
 - Can apply for Medicaid/CHIP at any time

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A Marketplace must determine an applicant eligible for enrollment in a Qualified Health Plan (QHP) through the Marketplace if he or she meets the following requirements:

- Meets the applicable residence standard—lives in the state served by the Marketplace, or if different, the service area of the Marketplace.
- Citizenship, status as a national, or lawful presence. Is a citizen or national of the United States, or is a non-citizen who is lawfully present in the United States, and is reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought.
- Is not incarcerated, other than incarceration pending the disposition of charges. It is important to note that if someone is incarcerated, they can still apply for Medicaid or the Children’s Health Insurance Program (CHIP) directly to their appropriate state agency.

If you meet the eligibility requirements you are considered a “qualified individual.”

If a person does not meet the citizenship, status as a national, or lawful presence requirement they cannot be a qualified individual. There is no waiting period such as in Medicaid that will provide eligibility after a set period of time.

Eligibility status will be determined through electronic data checks with the IRS, SSA, the Department of Homeland Security, and other electronic data sources approved for eligibility verification.

People with a student visa may be eligible for the Marketplace, but they are not eligible for Medicaid or the Children’s Health Insurance Program.

When You Can Enroll in the Individual Market

- Marketplace Initial Open Enrollment Period Starts October 1, 2013 and ends March 31, 2014
- Annual Open Enrollment Periods after that start on October 15 and end on December 7
- Special Enrollment Periods available in certain circumstances during the year

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The Marketplace may only permit a qualified individual to enroll in a Qualified Health Plan (QHP) or an enrollee to change QHPs during the Initial Open Enrollment Period (October 1, 2013 – March 31, 2014), the Annual Open Enrollment Period, or a Special Enrollment Period for which the qualified individual has been determined eligible.

Annual Open Enrollment Period

For the 2015 benefit period and beyond, the Annual Open Enrollment Period begins October 15 and extends through December 7 of the preceding calendar year. For example, on October 15, 2014, qualified individuals can begin enrolling in coverage that will start on January 1, 2015.

Automatic enrollment

The Marketplace may automatically enroll qualified individuals, at such time and in such manner as HHS may specify, and subject to the Marketplace demonstrating to HHS that it has good cause to perform such automatic enrollments.

Notice of Annual Open Enrollment Period

Starting in 2014, the Marketplace must provide a written Annual Open Enrollment notification to each enrollee no earlier than September 1, and no later than September 30.

NOTE: Later in the presentation we will discuss Medicaid and the Children's Health Insurance Program (CHIP). You can apply for these programs at any time.

Initial Open Enrollment Period for the Individual Market

- October 1, 2013 – March 31, 2014

Enroll during the Initial Open Enrollment Period	Your coverage is effective
On or before December 15, 2013	January 1, 2014
Between the 1st and 15th day of January - March	First day of the following month
Between the 16 th and the last day of December - March	First day of second following month

- Some exceptions may allow for earlier effective dates

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The Initial Open Enrollment Period begins October 1, 2013 and extends through March 31, 2014. If the Marketplace receives a Qualified Health Plan (QHP) selection from a qualified individual from October 1 to December 15, 2013, the Marketplace must ensure an effective date of coverage of January 1, 2014. If you enroll between the first and fifteenth day of any subsequent month during the Initial Open Enrollment Period, the Marketplace must ensure an effective date of coverage of the first day of the following month. If you enroll between the sixteenth and last day of the month for any month between December 2013 and March 31, 2014, the Marketplace must ensure an effective date of coverage of the first day of the second following month.

The Marketplace has an option to allow for earlier effective dates. Subject to the Marketplace demonstrating to HHS that all of its participating QHP issuers agree to effectuate coverage in a timeframe shorter than mentioned above, the Marketplace may do one or both of the following for all applicable individuals:

- For a QHP selection received from a qualified individual the Marketplace may provide an earlier effective date, provided that either—(A) The qualified individual has not been determined eligible for advance payments of the new tax credit or cost-sharing reductions; or (B) The qualified individual pays the entire premium for the first partial month of coverage as well as all cost sharing.
- For a QHP selection received by the Marketplace from a qualified individual on a date set by the Marketplace after the fifteenth of the month for any month between December 2013 and March 31, 2014, the Marketplace may provide an effective date of coverage of the first of the following month.

NOTE: Your first premium payment must be received before enrollment begins.

Special Enrollment Period

- May enroll or change Qualified Health Plan
 - Within 60 days in individual market and 30 days in small group market from triggering event

Special Enrollment Period Qualifying Events

Loss of minimum essential coverage	Material contract violations by Qualified Health Plans
Gaining or becoming a dependent	Gaining or losing eligibility for premium tax credits or cost-sharing reductions
Gaining lawful presence	Relocation resulting in new or different Qualified Health Plan selection
Enrollment errors of the Marketplace	Exceptional circumstances

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The Marketplace must allow qualified individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events: (1) A qualified individual or dependent loses minimum essential coverage; (2) A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption; (3) An individual, who was not previously a citizen, national, or lawfully present individual gains such status; (4) A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Marketplace or HHS, or its instrumentalities as evaluated and determined by the Marketplace. In such cases, the Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction; (5) An enrollee adequately demonstrates to the Marketplace that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee; (6) An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP. The Marketplace must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; (7) A qualified individual or enrollee gains access to new QHPs as a result of a permanent move; (8) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; and (9) A qualified individual or enrollee demonstrates to the Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Marketplace may provide. (e) *Loss of minimum essential coverage*. Loss of minimum essential coverage includes those circumstances described in 26 CFR 54.9801-6(a)(3)(i) through (iii). Loss of coverage does not include termination or loss due to—(1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or (2) Situations allowing for a rescission as specified in 45 CFR 147.128. The SEP lasts 60 days from the triggering event.

Special Enrollment Period for Members of Federally-Recognized Indian Tribes

- May enroll in a Qualified Health Plan (QHP)
 - One time per month
- May change from one QHP to another
 - One time per month

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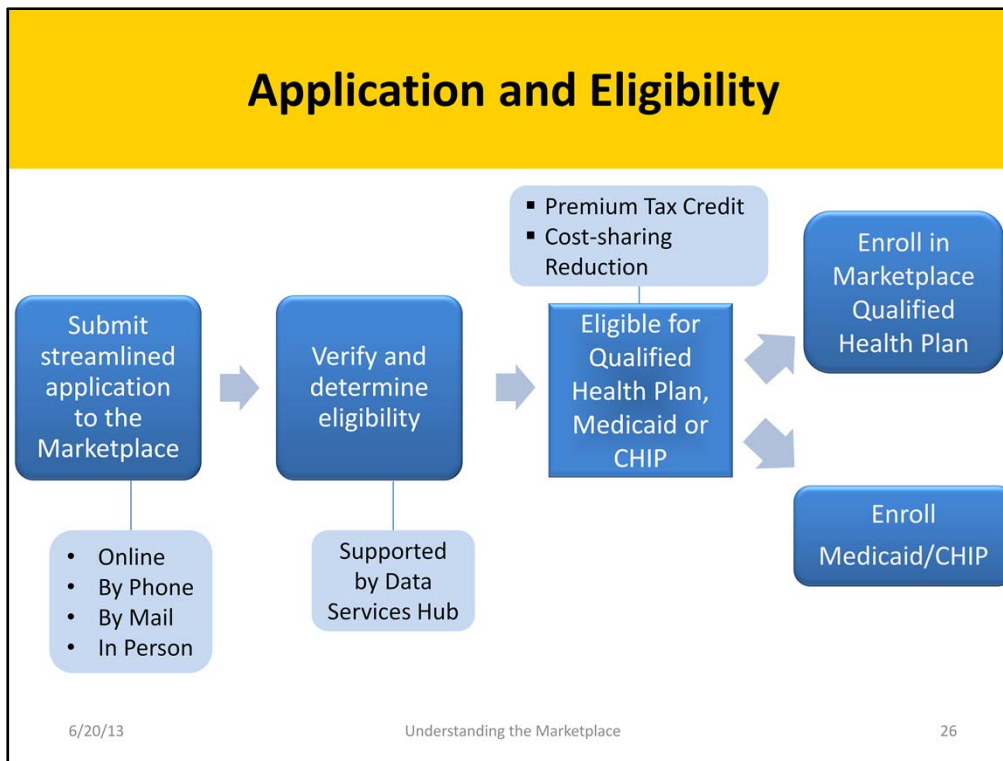
The Health Care Law also includes the permanent reauthorization of the Indian Health Care Improvement Act (IHCA), which extends current law and authorizes new programs and services within the Indian Health Service (IHS), and provides unique provisions for Indians, including Special Enrollment Periods. An Indian, as defined by Section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified Health Plan (QHP) or change from one plan to another one time per month.



There are four steps to using the Marketplace.

1. **Create an account.** You'll provide some basic information to get started, like your name, address, and email address. Sign up for Marketplace emails now at HealthCare.gov/subscribe and we'll let you know when you can set up a Marketplace account. We'll also keep you up-to-date on other key information.
2. **Apply.** Starting October 1, 2014, you'll provide information about you and your family, like income, household size, current health coverage information, and more. This will help the Marketplace find options that meet your needs.
3. You'll be able to see all the options you qualify for, including Qualified Health Plans and free and low-cost coverage through Medicaid and the Children's Health Insurance Program (CHIP). The Marketplace will tell you if you qualify for lower costs on your monthly premiums and out-of-pocket costs on deductibles, copayments, and coinsurance. You'll see details on costs and benefits before you choose a plan.
4. **Enroll.** After you choose a plan, you can enroll online and decide how you pay your premiums to your insurance company. If you or a member of your family qualify for Medicaid or CHIP, a representative will contact you to enroll.

If you have any questions, there's plenty of live and online help along the way.



You will submit a streamlined application to the Marketplace. You can apply online, by phone, via mail or in person.

Then your application is verified (supported by a data services Hub between SSA, the IRS, Homeland Security, and other approved data sources for verification).

You may be determined eligible for the Marketplace (to purchase and enroll in a Qualified Health Plan through the Marketplace), Medicaid, or the Children's Health Insurance Program (CHIP). If you are eligible to enroll in a Qualified Health Plan in the Marketplace, you also find out if you are eligible for the Premium Tax Credit and the cost-sharing reduction.

You then enroll in the program you are eligible for.

The Application

- Available electronically and on paper
 - English and Spanish
- Federal form
 - Dynamic online version (asks only relevant questions based on your prior responses)
 - Streamlined paper version
- State-run Marketplace may have own version
- Help will be available to complete application

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When you complete the application, information will be verified including: residency; that you live in the service area of that Marketplace; your incarceration status; Indian status; household income; household size; and eligibility for other essential coverage including employer coverage or government programs like Medicare, Medicaid, CHIP, VA, and TRICARE. This information is checked electronically against the data of Social Security, the IRS, DoD, Homeland Security, and other approved electronic data sources for verification. Someone submitting an incomplete application will receive a notice and have 90 days to provide the needed information. The paper application is available on Marketplace.cms.gov.

Applying for insurance affordability programs is optional. If you choose to apply only for eligibility to purchase a Qualified Health Plan through the Marketplace, you will be required to provide only limited information on residency, immigration status, and incarceration status, and no household income information will be required.

NOTE: There is a question about foster care on the application. This only needs to be answered for those age 18-25 as it relates to a new Medicaid category for people aging out of foster care.

3. Marketplace Affordability

- Financial help available for working families includes
 - Tax credits to lower the premiums qualified individuals pay
 - Premium Tax Credits
 - Advanced Premium Tax Credits
 - Reduced cost sharing to lower out-of-pocket spending for health care

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Coverage will be more affordable for some consumers through the new tax credits (Premium Tax Credits and Advance Premium Tax Credits) and reduced cost sharing. This financial assistance will help low income consumers who are not eligible for other programs to buy insurance.

A New Way to Lower Premium Costs

- A new refundable or Advanced Premium Tax Credit (APTC) that lowers the cost of Qualified Health Plans
- Eligibility is based on
 - Household income, and family size (at end of year)
 - Income between 100% to 400% of the Federal Poverty Level (FPL) (\$23,550 – \$94,200 for a family of four in 2013)
 - Obtaining qualified health insurance through the Marketplace
 - Ineligibility for government-sponsored coverage, affordable employer-sponsored insurance, or certain other minimum essential coverage

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The premium tax credit is generally available to individuals and families with incomes between 100% and 400% of the Federal Poverty Level (\$23,550 – \$94,200 for a family of four in 2013) who do not have access to certain other types of minimum essential coverage, which will make coverage much more affordable for the middle class. Minimum essential coverage includes government-sponsored coverage (like Medicare, Medicaid, CHIP, some VA coverage, and TRICARE, affordable employer-sponsored insurance [meaning the cost for the employed individual is no more than 9.5% of their income], and certain other coverage). With most tax credits, you have to wait until you file your taxes to get the credit. But the new Advanced Premium Tax Credit (APTC) available through the Marketplace lets you reduce your premiums right away or wait to receive the Premium Tax Credit (PTC) until tax time.

The Congressional Budget Office estimates that when the Affordable Care Act is fully phased in, the PTC will help 20 million Americans afford health insurance.

NOTE: Any changes in financial circumstances or family size should be reported immediately. When you apply for coverage in the Marketplace, it's important to double-check the information you put on your application. If the amount of your expected 2014 income you report isn't accurate, you may not get the right amount of savings. If you earn more income than the household income amount above, the amount of PTC for which you are eligible will be lower when you file your tax return. In this case, you might owe money at the end of the year. But if you make less than you expected, you may be eligible to receive a refund based on a higher PTC at the end of the year. You would do this on your next tax return. If you think a mistake was made when you get your savings decision determination in the Marketplace, you have the right to appeal. The Marketplace application will explain how to do this.

There are special rules in case of divorce. If you get married, the amount is computed by month.

How much is the Premium Tax Credit?

- The amount of the Premium Tax Credit (PTC) depends on
 - **Actual** household income as a percentage of the Federal Poverty Level (FPL) and family size
 - The premium for the second lowest cost silver level Qualified Health Plan, referred to as the benchmark plan, adjusted for the age of the covered person
 - A sliding scale that increases the taxpayer's own contribution towards the premium cost as household income as a percentage of the FPL increases

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The Premium Tax Credit can vary based on the following:

- The amount of your household income as a percentage of the Federal Poverty Level (FPL) and family size. It is based on a sliding scale. The higher the household income, the higher your contribution.
- The amount of the premium for the second lowest cost silver level Qualified Health Plan in your Marketplace.

The amount of the Premium Tax Credit is based on your actual household income as reported on your income tax returns.

Do I have to wait until I file my taxes to get the tax credit?

- You can reduce your premium amount up front
 - You can choose an Advance Premium Tax Credit (APTC)
 - You choose the amount (up to the maximum)
 - Advance payments are paid directly to the insurer on your behalf
- The amount is based on **projected** household income
 - Reconciled at tax time against the actual Premium Tax Credit amount you are eligible for
 - Report income changes immediately to avoid an overpayment and balance due

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The advance payments of the premium tax credit will be applied when you sign up for QHP coverage through the Marketplace and the payment will go directly to the insurance company. When you apply, you will provide your household income, identification to show that you are in the U.S. legally and other information. The Marketplace will determine what affordability programs you are eligible for (Medicaid, Children's Health Insurance Program, or lower costs for premiums and cost-sharing amounts). You will compare the Qualified Health Plans that are offered, each with a clear description of benefits and cost. You will buy the plan and the advance payment of the premium tax credit will be applied at the time you pay your premium to lower your cost. Age-based increases in premiums are included when the premium tax credit is calculated. The advance payment of premium tax credits is reconciled at the end of the tax year. It limits the premium payments as a percentage of income.

Since the APTC is based on projected household income, there is the possibility that you could receive an overpayment and have a balance due on your income tax return. It is important that you report any changes to income or family size to reduce the possibility of owing a balance.

Who is Eligible for a Cost-Sharing Reduction?

- Eligibility for reduced cost sharing is based on
 - Incomes at or below 250% of the FPL (\$58,875 annually for a family of four in 2013)
 - Receiving the Premium Tax Credit
 - Enrolling in a Marketplace silver-level plan
- Members of Federally-recognized Indian Tribes
 - No cost sharing if income is <300% FPL

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Cost-sharing reductions are available to help reduce out-of-pocket expenses.

To be eligible for cost-sharing reductions, you must have a household income that is less than or equal to 250% of the Federal Poverty Level (FPL) which is \$58,875 annually for a family of four in 2013; meet the requirements to enroll in a health plan through the Marketplace and receive the new tax credit; and enroll in a silver-level plan through the Marketplace.

Members of a Federally-recognized Indian tribe may also be eligible for special cost-sharing reductions. Certain American Indians and Alaska Natives who purchase health insurance through the Marketplace do not have to pay co-pays or other cost sharing if their income is under 300% of the Federal Poverty Level, which is roughly \$70,650 for a family of four in 2013 (\$88,320 in Alaska).

4. Medicaid and CHIP

- Medicaid and the Children's Health Insurance Program (CHIP)
 - Eligibility for health coverage extended under the new law
- Simplifies eligibility
- Coordinated with new Qualified Health Plan coverage
 - No wrong door if you apply through the Marketplace
 - Streamlined application for affordability programs
 - New website with program information and option to enroll

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The Health Care Law establishes a seamless system of health coverage across the Marketplace. Medicaid and the Children's Health Insurance Program (CHIP) will serve as the foundation for this new system, providing coverage for most low income adults and children, with Qualified Health Plans in the Marketplace serving individuals with slightly higher incomes. The new eligibility rules for all three programs will be aligned and easier to understand for families, and everyone will have an opportunity to enroll in coverage using a unified application.

You may qualify for Medicaid now by contacting your state's Medicaid office. If you don't qualify now, your state may be expanding Medicaid in 2014 and you may qualify then. Fill out a Marketplace application starting October 1, 2013, to find out if you'll qualify in 2014.

Many states have separate CHIP, which provides health benefits for children who don't qualify for Medicaid. (Some children will qualify for Medicaid.) In some states, parents and pregnant women qualify for CHIP coverage too.

CHIP will not be expanding in 2014. You can find out if you qualify right now by contacting your state's CHIP program.

Medicaid Eligibility in 2014

- Creates new opportunities for states to expand Medicaid eligibility to
 - Adults ages 19 – 64 with incomes up to 133% of the Federal Poverty Level (FPL) (\$15,282/year for an individual, \$31,322/year for a family of 4 (2013 amounts))
- Ensures Medicaid coverage for all children
 - With incomes up to 133% of the FPL
- Shifts to simplified way of calculating income to determine Medicaid/CHIP eligibility
 - Known as Modified Adjusted Gross Income (MAGI)-based method

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The Health Care Law fills in current gaps in coverage for the poorest Americans by creating new opportunities for states to have minimum Medicaid income eligibility levels across the country. Beginning in January 2014, individuals under age 65 with incomes up to 133% of the Federal poverty level (FPL) will be eligible for Medicaid in those states that implement the Medicaid expansion. In addition, all children with incomes up to 133% of the FPL will be eligible for Medicaid. Those states that previously covered these children through the CHIP program will continue to receive the enhanced CHIP matching rate.

In addition, the rules for counting income for purposes of determining Medicaid and CHIP eligibility will be much simpler and easier for families to understand.

The Health Care Law makes coverage accessible to millions who would have otherwise remained uninsured.

When you apply for Medicaid through the Marketplace, the information you provide is “data matched” against the information the IRS and SSA have in their systems. When submitting your information, you will have three attempts to verify. If the data doesn’t match, you will have to provide proper paper documentation to complete your application.

In states that don’t implement Medicaid expansion, people between the state’s Medicaid ceiling (it varies by state) and 100% of the FPL will not be eligible for Medicaid or the new tax credit. However, these individuals will not be subject to a fee (penalty) if they do not obtain coverage through the Marketplace. People with income above 100% of the FPL will be eligible for the tax credit.

Simplifying Medicaid and CHIP

- Eligibility process to rely primarily on electronic data
 - Reduce need for paper documentation
- Apply on-line, by phone, by mail, or in person
- 12-month eligibility period for
 - Adults
 - Parents
 - Children
- Simplified process for renewing coverage



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The new rule simplifies the Medicaid and CHIP eligibility, enrollment and renewal process in the following ways:

- Modernizes eligibility verification procedures to rely primarily on electronic data sources while providing states flexibility to determine the usefulness of available data before requesting additional information from applicants, and simplifying verification procedures for states through the operation of a Federal data services “Hub” that will link states with Federal data sources (e.g. Social Security and Homeland Security).
- Codifies current Medicaid policy so that eligibility is renewed by first evaluating the information available through existing data sources and limits renewals for the people enrolled through the simplified, income-based rules to once every 12 months unless the individual reports a change or the agency has information to prompt a reassessment of eligibility. For more information see Section 1413 of the Affordable Care Act.

There are two models for Medicaid eligibility determinations when an application is submitted through the Marketplace.

- In the Assessment model, in a state with a Federally Facilitated Marketplace, the state Medicaid or CHIP agency will make the determination. You could be assessed eligible for Medicaid by the Marketplace and then determined ineligible by the state Medicaid/CHIP agency. The account will get transferred back to the Marketplace to determine eligibility for tax credits/cost-sharing reductions. The Marketplace in this case would not handle a Medicaid or CHIP redetermination.
- In the Determination model, the authority is delegated to a state’s Federally Facilitated Marketplace, and the state must accept that determination.

States can take up to 45 days to determine Medicaid/CHIP eligibility, but enrollment may be retroactive up to 3 months.

5. Enrollment Assistance

- Help available in Marketplaces
 - The Marketplace Toll-Free Call Center
 - Certified Assisters
 - Navigators program
 - Non-Navigator in-person assisters
 - Agents and brokers
 - HealthCare.gov and state Marketplace websites

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If you have questions or need help applying, there are several resources that will be available, including a toll-free call center and website with plan comparison tools. There are also several programs to help you through the process of enrolling and using health insurance, including the Navigator program.

Other assistance personnel such as Navigators, non-Navigator assistance personnel, agents and brokers, and certified application counselors will also play a large role in helping people apply for health insurance coverage.

It is important to note that some of the assistance resources (Marketplace call centers and websites, and Navigators) are required to provide unbiased and impartial advice, while others (such as some agents and brokers and issuer web sites and call centers) are not.

For information about enrolling in Medicaid or the Children's Health Insurance Program (CHIP), check with your State Medical Assistance (Medicaid) office. Call 1-800-MEDICARE (1-800-633-4227) to get their phone number. TTY users should call 1-877-486-2048. Or, visit www.medicare.gov/contacts and search for your state Medicaid office's contact information.

National Marketplace Toll-Free Call Center

for Federally Facilitated and State-Partnership Marketplaces

- 1-800-318-2596 (TTY 1-855-889-4325)
 - Customer service representatives - 24/7
 - English and Spanish
 - Language line for 150 additional languages
- June – September
 - Provide general information to individuals in the Marketplace and **employees** of SHOP employers
 - SHOP call center for **Employers** – opens in August
- Starting October
 - Eligibility, enrollment and referral assistance



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A toll-free call center is going live in June. The number for this National Health Insurance Marketplace Call Center is 1-800-318-2596. TTY users should call 1-855-889-4325.

Customer Service Representatives will be available 24 hours a day, 7 days a week, including New Year's Day. The call center is closed on Thanksgiving, Christmas, Labor Day, Memorial Day, and the Fourth of July.

The call center will provide objective information in English and in Spanish. It will also use language lines for 150 additional languages.

From June through September, callers can get general information about the Marketplace. Once Open Enrollment begins on October 1, 2013, the Customer Service Representatives will be able to help consumers go through the eligibility and enrollment process, and refer them to local in-person help.

When you call, you will be asked what state you live in. If you live in a state operating a State-Based Marketplace, you will be provided with the number to that state's Marketplace call center.

Navigator Program

- Grant program administered by each Marketplace
 - Navigators will
 - Maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities
 - Distribute fair, accurate, and impartial information about enrollment in Qualified Health Plans (QHP) and other health programs such as Medicaid and CHIP
 - Facilitate selection of a QHP
 - Refer consumers to other programs
 - Provide information in a manner that is culturally and linguistically appropriate and accessible for people with disabilities

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Each Marketplace must establish a grant program to fund entities or individuals called “Navigators” that will provide consumer assistance. Navigators will help you understand your new health insurance options available through the Marketplace and will help you select a health plan.

Each Navigator must be trained to perform all of the listed duties in §1311(i)(3) and 45 CFR §155.210(e):

- Maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities
- Distribute fair, accurate, and impartial information about enrollment in Qualified Health Plans (QHP) and other health programs such as Medicaid and CHIP
- Facilitate selection of a QHP –Refer consumers to Consumer Assistance Programs (CAPs) (proposed) or other ombudsmen programs
- Provide information in a manner that is culturally and linguistically appropriate and accessible for people with disabilities

To ensure that Navigators provide unbiased and accurate information, each Marketplace must develop conflict of interest standards and training programs for its Navigators.

Agents and brokers may serve as Navigators as long as all other Navigator standards are met. They can also help consumers with other enrollment functions that Navigators are not able to provide, as is set forth in 42 CFR 155.220. However, during their term as a Navigator, agents/brokers may not receive compensation from health insurance issuers related to enrollment in Qualified Health Plans or non-Qualified Health Plans.

Navigator Program – Continued

for Federally Facilitated and State-Partnership Marketplaces

- Navigators must
 - Be certified
 - Must take initial web-based training
 - Must take required on-going training
 - Be recertified annually
 - Not accept direct or indirect compensation from issuers related to enrollment in QHPs or non-QHPs
 - Meet reporting requirements – progress, financial, and performance
- Mid-August – Notification of grant approval
- Starting in September, find Navigators and other assisters through the Call Center or on HealthCare.gov

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Navigators in Federal Facilitated and State-Partnership Marketplaces must be certified. To receive certification, they must take the initial web-based training (up to 30 hours) which we expect will be available online in August. They must also take required on-going training and be recertified annually. As federal grantees, they must also meet reporting requirements, including progress reports, financial reports, and performance reports.

Those who are approved to be Navigators in Federally-Facilitated and State-Partnership Marketplaces will be notified of their grant approval on or around August 18.

In Federally Facilitated and State-Partnership Marketplaces, you will be able to locate Navigators and other assisters by calling the National Health Insurance Marketplace Call Center or on HealthCare.gov under “Find Someone Local (in October).” State-Based Marketplaces will have their own training requirements. You will have to check the state’s call center or website (which will be linked from HealthCare.gov).

NOTE: Ten population centers will have special enrollment assisters contracted to help uninsured young and healthy people.

Texas: Dallas, Houston, San Antonio, Austin, McAllen, El Paso

Florida: Miami, Tampa, Orlando

Georgia: Atlanta

New Jersey: North Jersey

Arizona: Phoenix

Pennsylvania: Philadelphia

Indiana: Indianapolis

Louisiana: New Orleans

North Carolina: Charlotte

Ohio: Cleveland, Columbus, Cincinnati

Agents and Brokers

- Agents or brokers may be a Navigator if all Navigator standards are met
 - Can't be receive direct or indirect compensation by issuer related to enrollment in QHPs and non-QHPs
- Agents and brokers may help
 - In providing information on QHPs
 - In helping people enroll
- Agent and broker training will be available in August
 - Must be appropriately registered to conduct business in the Marketplace

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Agents and brokers can help employers find, choose, and enroll in coverage. If an agent or broker meets all the Navigator standards, they can be a Navigator. However, if they are a Navigator they cannot receive direct or indirect consideration from an issuer related to enrolling people into the issuers plan(s). We expect online training for Agents and Brokers in the individual market will be available in mid-August for Federally-Facilitated and State Partnership Marketplaces. They must be appropriately registered to conduct business in the individual Marketplace.

People with Medicare

- Medicare isn't part of the Marketplace
- If you have Medicare you're already covered and don't have to make any changes

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Medicare isn't part of the Health Insurance Marketplace. If you have Medicare, you're already covered and don't need to make any changes.

The Marketplace won't affect your Medicare choices, and your benefits won't be changing. No matter how you get Medicare, whether through Original Medicare or a Medicare Advantage Plan, you'll still have the same benefits and security you have now.

- If you become eligible for Medicare while enrolled in the Marketplace, your eligibility for Premium Tax Credits and cost-sharing reduction will end, and you may want to terminate your coverage through the Marketplace and enroll in Medicare.

Pre-existing Condition Insurance Plan (PCIP) Transition

- Temporary program covering those with pre-existing conditions
 - PCIP program ends December 31, 2013
- Marketplace coverage can begin January 1, 2014
- PCIP enrollees who want coverage in the Marketplace
 - Need to apply by December 7, 2013, for no break in coverage
 - No automatic transition

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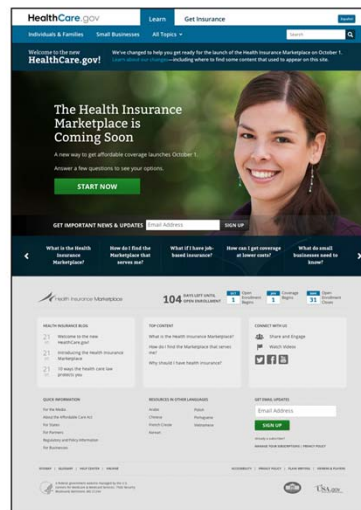
The Health Care Law established the Pre-existing Condition Insurance Plan (PCIP) program in every state and the District of Columbia. There are about 110,000 people currently in PCIP nationwide. PCIP provides temporary coverage to people with pre-existing conditions. This program ends December 31, 2013.

If you are enrolled in a PCIP, and you want to ensure no break in coverage by enrolling in the Marketplace, you must enroll by December 7, 2013. The PCIPs will send notices to their enrollees to make them aware and encourage them to take action. Notices will be sent in August, late September, and in late October/early November. Enrollment in the Marketplace begins October 1, 2013. Some PCIP enrollees may be eligible for Medicaid or other sources of coverage.

There are the 17 state-based PCIPs that transitioned to the federally-run PCIP on July 1: Arkansas, California, Colorado, Illinois, Iowa, Kansas, Michigan, Missouri, New Hampshire, New York, North Carolina, Ohio, Oregon, Pennsylvania, South Dakota, Utah, and Washington.

HealthCare.gov

- Cuidadodesalud.gov for Spanish
- The consumer site for info now, application and plan comparison in Oct
- Social media connections
- Responsive design
- Accessible for those with visual disabilities



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HealthCare.gov is a can help you identify your options for health insurance. The website is also available in Spanish at Cuidadodesalud.gov. It is in responsive design and can be used on smart phones and tablets. This website is also accessible for those with visual disabilities.

Marketplace.cms.gov

Get the latest resources to help people apply, enroll, and get coverage in 2014

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You can get up-to-date information to help you counsel people who may benefit from the Health Insurance Marketplace at Marketplace.cms.gov. There is access to consumer materials, training materials, research and more. You can sign up for updates as well.

A Look Ahead	
August 2013	October 1, 2013
<ul style="list-style-type: none"> • Expect training to begin for consumer assisters like Navigators as well as for agents and brokers • SHOP (Employer) Call Center live 	<p>Open enrollment in the Health Insurance Marketplace begins</p>
January 1, 2014	
<ul style="list-style-type: none"> ▪ Coverage through Health Insurance Marketplace begins (as early as) ▪ Discrimination due to pre-existing conditions or gender is prohibited ▪ Annual Limits on Insurance Coverage will be eliminated ▪ Advanced Premium Tax Credits will be available ▪ The Small Business Tax Credit will increase ▪ More people will be eligible for Medicaid (in some states) 	
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Here is a look ahead at what you can expect in the near future. In August 2013, we expect training for consumer assistance personnel like Navigators, as well as agents and brokers to begin. The Call Center for employers regarding SHOP is also expected to go live in August. Consumers may begin to select Qualified Health Plans on October 1, 2013, with coverage beginning as early as January 1, 2014.

Also, effective as early as January 1, 2014:

- Discrimination due to pre-existing conditions or gender will be prohibited
- Annual Limits on Insurance Coverage will be eliminated
- Advanced Premium Tax Credits will be available
- The Small Business Tax Credit will increase
- More people will be eligible for Medicaid (in some states)

6. Key Points to Remember

- ✓ The Marketplace is a new way to find and buy health insurance
- ✓ Qualified individuals and employers can shop for health insurance that fits their budget
- ✓ States have flexibility to establish their own Marketplace
- ✓ Individuals and families may be eligible for lower costs on their monthly premiums and out-of-pocket costs
- ✓ There is assistance available to help you get the best coverage for your needs

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Here are some key points to remember:

- The Marketplace is a new way to find and buy health insurance
- Individuals and small businesses can shop for health insurance that fits their budget
- States have flexibility to establish their own Marketplace
- Individuals and families may be eligible for lower costs on their monthly premiums and out-of-pocket costs
- There is assistance available to help you get the best coverage for your needs

Key Points to Remember

- ✓ You have choices
- ✓ Employer-based coverage will continue
- ✓ Insurance will continue to be sold outside of the Marketplace
 - Purchase from Marketplace not required
- ✓ The Marketplace is the only place to get the
 - New premium tax credits
 - Cost-sharing reductions

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You have choices. No one will be required to buy coverage in the Marketplace. Enrolling through the Marketplace is voluntary, employer-based coverage will continue, and insurance will continue to be sold outside of the Marketplace.

The Marketplace will be the only way to access the new tax credit and cost-sharing reductions to help you with health care costs.

5 Ways to Connect With the Marketplace

1. Sign up for email or text updates:
HealthCare.gov/subscribe
2. [Twitter.com/HealthCareGov](https://twitter.com/HealthCareGov) - Follow @HealthCareGov
3. [Facebook.com/HealthCareGov](https://facebook.com/HealthCareGov)
4. [Youtube.com/HealthCareGov](https://youtube.com/HealthCareGov)
5. The Health Insurance Blog:
<http://www.healthcare.gov/blog/>

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Don't miss key dates and information about the Health Insurance Marketplace. Here's how to stay connected:

5 ways to connect with the Marketplace

1. Sign up for email or text updates at HealthCare.gov/subscribe. Get updates in your inbox or on your mobile phone.
2. Twitter: [Twitter.com/HealthCareGov](https://twitter.com/HealthCareGov). Follow @HealthCareGov
3. Facebook: [Facebook.com/HealthCareGov](https://facebook.com/HealthCareGov). Join the conversation. Like, share, and respond to our latest posts.
4. YouTube: [Youtube.com/HealthCareGov](https://youtube.com/HealthCareGov). Watch and share videos about the Marketplace.
5. The Health Insurance Blog on <http://www.healthcare.gov/blog/>. Find tips for consumers and small businesses, top things to know about the Marketplace, frequently asked questions, and more. Make comments to continue the discussion.