SECTION 2: INDIVIDUALS WHO CURRENTLY HAVE COVERAGE OR AN OFFER OF COVERAGE FROM THEIR EMPLOYER

Section 2 covers enrollment issues for individuals who have coverage or an offer of coverage—whether through an employer-sponsored plan, individual plan, high-risk pool, retiree plan, or student health plan—and want to understand their options, including eligibility for premium tax credits through the marketplace.
Chapter 1: Employer Sponsored Coverage

Background

Most people who have private coverage in the U.S. have coverage through an employer. More than 56 percent of Americans under age 65 have coverage through an employer-sponsored plan. For most people enrolled in a plan sponsored by a large employer, the coverage is relatively affordable and comprehensive. As a result, the Affordable Care Act insurance reforms focus on coverage in the individual and small group markets, where historically there have been more problems with access to affordable, adequate coverage. However, some reforms apply broadly to all group health plans, including large employers.

For more information on consumer protections that apply to employer-sponsored coverage — based on factors such as the size of the company, whether the plan is self-insured or fully-insured, and whether the plan is a grandfathered plan or new — refer to Appendix B.

Premium Tax Credits and Employer-Sponsored Coverage. Most people enrolled in employer-sponsored coverage, or with an offer of employer-sponsored coverage, will not be eligible for premium tax credits and would have to forgo a contribution from their employer toward their health care premiums in order to buy coverage in a health insurance marketplace.

To be eligible for premium tax credits, the employer-sponsored coverage must be “unaffordable” or fail to meet minimum value standards (i.e., considered “inadequate”). To be unaffordable, the cost of self-only coverage in the employer’s lowest cost plan must be more than 9.5 percent of the individual’s household income. To fail to provide minimum value, the plan must have an actuarial value of less than 60 percent, meaning that the plan covers less than 60 percent of the total average costs for covered benefits. If the individual’s employer-sponsored coverage fails either test, the individual may be eligible for a premium tax credit for a plan purchased in a health insurance marketplace. See Section 1, Chapter 2, Eligibility for Premium Tax Credits and Cost-Sharing Reductions.

Enrolling in Employer-Sponsored Coverage. Employers cannot use health factors to determine eligibility for health benefits or premiums. However, employers are allowed to establish different health benefits or eligibility rules for different categories of employees (such as salaried workers vs. hourly workers). Under the Affordable Care Act, employers are allowed to impose a waiting period for health benefits for new employees of no more than 90 days.

Employers typically have an annual open enrollment period that gives employees an opportunity to change plans or add dependents. However, there are circumstances under which employees may enroll in coverage or add dependents outside an annual open enrollment period. For example, if a worker loses coverage under his or her spouse’s plan, or has a new child by birth or adoption, they can enroll in the employer-sponsored plan or add new dependents, so long as they do so within 30 days of their change of circumstances.

All health plans, including employer plans, must provide individuals with a Summary of Benefits and Coverage, which uses a standard format to outline the benefits, cost-sharing and coverage limits of plans. The Summary of Benefits and Coverage must also state whether the plan meets minimum value and counts as minimum essential coverage, although in 2014, that information may be provided separately in a cover letter. The Summary of Benefits and Coverage must be made available to consumers at open enrollment and upon
renewal of coverage, upon request, and whenever there is a significant change in the plan. This can be an important tool for consumers to understand their plan options in employer-sponsored coverage or who want to compare plan benefits and costs for employer coverage to coverage in a health insurance marketplace.

Employers must also provide each employee with a Summary Plan Description within 90 days after they become a participant in a plan. The Summary Plan Description must contain information on benefits, eligibility for benefits, plan limits, and whether the health plan is fully insured or self-insured. However, it doesn’t have to be presented in a standard format, and only has to be provided after the employee enrolls in the plan, so it is not useful for comparing plan choices prior to enrollment.

All non-grandfathered employer-based plans must cover recommended preventive services with no cost-sharing. Employer plans must have a cap on out-of-pocket costs ($6,350 for individuals in 2014, $12,700 for family coverage), although in 2014, plans that have separate limits for medical and prescription drug benefits can maintain those limits, so long as neither limit exceeds $6,350 for individuals and $12,700 for family coverage. In addition, employer plans cannot impose annual or lifetime dollar limits on covered “essential” health benefits. The scope of those essential health benefits is determined by what is covered under a typical employer-sponsored plan in the state, but would generally cover categories of services such as doctor visits, hospitalization, maternity and newborn care, prescription drugs, laboratory services, mental health and substance use disorder services, rehabilitative and habilitative services, and pediatric care. For more information on essential health benefits see FAQ #111.

Employers cannot set premiums for their employees based on their health status, although there is an exception to this prohibition for “non-discriminatory wellness programs.” Employers can modify premiums and/or cost-sharing in an amount up to 30 percent of the total premium (including the employer’s contribution to the premium) for workplace wellness programs, and up to 50 percent for programs that target tobacco cessation. The financial incentives can be applied as a discount (e.g., lower premiums or deductibles) or as a penalty (higher premiums and deductibles), as long as the programs meet federal rules for being non-discriminatory.

**Frequently Asked Questions**

149. I have an offer of employer-sponsored coverage, but the premiums are too expensive and I have to pay a lot out-of-pocket. Can I get premium tax credits in the health insurance marketplace?

If your premiums for self-only coverage in your employer’s plan are 9.5 percent or more of your household income and your income is between 100 percent and 400 percent of the federal poverty level (or between $11,490 and $45,960 for individuals in 2013), you may be eligible for a premium tax credit for coverage in your state’s health insurance marketplace (See Appendix A for more information on the federal poverty level for individuals and families). The coverage must also provide minimum value (meaning it covers at least 60 percent of the average costs of covered services).

The application for coverage in a health insurance marketplace includes questions your employer can answer to help determine whether your health benefits qualify you for a premium tax credit.
150. I want to add my spouse and/or children to my plan but I can’t afford the family premium. Can my spouse buy a more affordable plan on the health insurance marketplace?

It depends. If the premium for self-only coverage in the lowest cost plan is less than 9.5 percent of your household income, no one in your family who is eligible to join your employer’s plan can qualify for a premium tax credit, no matter how expensive the premiums are for a family plan. However, if family members forgo coverage because the employer plan premiums are too expensive, they may not be subject to the requirement that individuals purchase health insurance (the individual responsibility requirement or mandate). Specifically, if the premiums for family coverage through your employer’s plan are more than 8 percent of your household income, your family members will not be subject to a penalty for not enrolling in coverage. Your children may also be eligible for your state’s Children’s Health Insurance Program, depending on your income and the eligibility rules of your state.

151. When can I enroll in my employer plan?

Most employers have an annual open enrollment period, often in the fall of each year (for plan coverage that starts January 1st). In addition, there are special circumstances that trigger a “special enrollment period,” in which you can enroll in coverage outside the annual open enrollment period. These include loss of eligibility for coverage because of divorce or legal separation, loss of dependent status, or reduction in hours or loss of job, or certain life events such as gaining a dependent through marriage, birth or adoption. Be aware, your employer may require you to enroll within 30 days of your change in circumstances.

152. We just had a baby. Can I add my baby to my family plan?

Yes, having a baby is one of the special circumstances that allow you to add dependents outside the annual open enrollment period. You have 30 days from the date of your child’s birth to request enrollment in your employer-sponsored coverage.

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

Yes. Having a baby is one of the special circumstances that allows you to add dependents to your health plan, even outside of the regular open season. You have 30 days from the date of your child’s birth to notify your employer and request that your husband and your baby be enrolled in your coverage.
154. Is my employer required to offer and pay for coverage for my dependents?

Large employers are not required to offer coverage to an employee’s dependent or spouse. If an employer’s plan does provide for dependent coverage, it must make that coverage available to dependents to age 26. However, there is no requirement that they contribute to the premiums for dependent coverage. If the employer does not contribute to premiums for dependent coverage, it may be too costly for your children to enroll, or for your spouse, if the employer’s plan includes them. Unfortunately, the fact that your dependents and/or spouse are eligible for this coverage, even though it is too expensive, makes them ineligible for premium tax credits through the health insurance marketplace. That’s because the test for “affordable” employer-sponsored coverage is based only on the premiums for self-only coverage. If the premium for self-only coverage in your employer’s lowest cost plan is less than 9.5 percent of your household income, no one who would be covered by a family plan at your work can qualify for a premium tax credit, no matter how expensive the family plan premiums are.

155. Is my employer required to offer benefits to part-time workers?

No. Under the Affordable Care Act, employers are not required to offer health benefits to employees who work on average fewer than 30 hours a week. If they aren't eligible for their employer’s plan, those workers are likely able to buy coverage in the health insurance marketplace, and may be eligible for premium tax credits, depending on their household income and their eligibility for other coverage programs, such as Medicaid.

156. Is my employer required to offer benefits to retirees?

No, there is no requirement to offer retiree health benefits. Retirees not yet eligible for Medicare may be eligible for coverage in a health insurance marketplace, possibly with a premium tax credit, depending on income and other factors. For more information on this, see Section 2, Chapter 3, Retiree Coverage.

157. I will start a new job next month with benefits. Can I enroll right away in my employer plan?

Maybe – ask your employer. Under federal law, employers can impose a waiting period for health benefits after you start your job, but the waiting period can be no more than 90 days. If you are concerned that your employer requires a waiting period longer than 90 days, you can contact the U.S. Department of Labor at 1-866-444-3272.

158. I work and am eligible for health benefits. Do I have to sign up for my job-based plan or will my employer do that for me?

You generally are responsible for enrolling in a health plan offered by an employer, so it’s up to you.
to sign up for coverage under the rules and procedures established by your employer health plan.

Some employers may use auto-enrollment, which means that your employer will enroll you in a plan and you must opt-out of the plan if you do not want to be covered. If your employer auto-enrolls you in the group health plan, you must be given the opportunity to disenroll if you want or to change plans if your employer offers more than one option. If you have concerns with the way auto-enrollment in health coverage is handled at your job, you can contact the U.S. Department of Labor at 1-866-444-3272.

159. My employer offers a workplace wellness program that increases premiums for employees who don’t participate and/or can’t meet certain targets for healthy behavior. I don’t think I’ll be able to afford the premiums if I don’t participate or miss the mark. Can I leave my employer-sponsored plan and get one on the health insurance marketplace?

It depends on how much your costs go up based on any premium increases you face due to the wellness program. If your premiums with the wellness penalty would be 9.5 percent of your income or more, or if your cost-sharing increases enough to lower the value of your plan below the minimum value standard (60 percent of average costs of covered services), then you may be eligible for premium tax credits. This test applies whether you are actually penalized or not, and in advance of the penalty being applied (for example, if your employer gives you time to try to meet the health standard that triggers a penalty or reward).

160. I have COBRA and it’s too expensive. Can I drop it during open enrollment and enroll in a marketplace plan instead?

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

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

No, voluntarily dropping your COBRA coverage or ceasing to pay your COBRA premiums will not trigger a special enrollment opportunity. You will have to wait until you exhaust your COBRA coverage or until the next open enrollment (whichever comes first) to sign up for other non-group coverage.
162. I’m leaving my job and will be eligible for COBRA. Can I shop for coverage and subsidies on the marketplace instead?

Yes, leaving your job and losing eligibility for job-based health coverage will trigger a special enrollment opportunity that lasts for 60 days. You can apply for marketplace health plans and (depending on your income) for premium tax credits and cost-sharing reductions during that period. If you enroll in COBRA coverage through your former employer, however, you will need to wait until the next marketplace open enrollment period if you want to switch to a marketplace plan.

163. I thought there was supposed to be a cap on my out-of-pocket costs, but when I look at my plan options, it looks like there is more than one cap, depending on what health care I use. How can that be?

All non-grandfathered group health plans must cap out-of-pocket costs at $6,350 for an individual plan and $12,700 for a family plan. The cap applies to essential health benefits obtained in-network. However, this requirement has been delayed for group health plans for one year. In 2014, plans can maintain separate out-of-pocket limits for benefits if they are separately administered. For example, sometimes prescription drug benefits are administered separately from medical benefits. In such a case, your group health plan is allowed to have separate out-of-pocket caps for each of those separately administered benefits, as long as each cap is no more than $6,350 for an individual plan and $12,700 for a family plan. However, there cannot be a separate out-of-pocket limit for mental health and substance use disorder benefits.

By 2015, group health plans will be allowed to have only one out-of-pocket spending cap.

164. I thought my employer plan couldn’t have any annual or lifetime limits on benefits but I heard that there may still be some limits in our plan. Is that allowed?

All non-grandfathered group health plans are prohibited from imposing annual or lifetime dollar limits on “essential health benefits” (see FAQ #111). There may be some benefits that your plan covers that aren’t considered “essential health benefits,” and for those services, your plan can include an annual or lifetime dollar limit. Plans can also include non-dollar limits on benefits, such as limits on the number of visits, or days in the hospital, even on “essential health benefits.”

Your Summary of Benefits and Coverage must include information on limitations and exceptions on services that are covered, as well as lists of excluded services and “other covered services,” which may include services that have greater restrictions and/or higher out-of-pocket costs than would apply to “essential health benefits.”
165. I'm eligible for health benefits at work. My employer didn’t provide my enrollment materials on time and as a result, I missed the company’s open enrollment. Can I apply for coverage in the marketplace now? Or is my employer required to give me a second chance to enroll at work?

If your employer failed to provide you enrollment materials on time and, as a result, you missed your opportunity to enroll in your employer’s plan, you can ask your employer for – and you must be offered – another opportunity to enroll.

166. My employer won’t fill out the form that asks about the affordability of our job-based health plan. I think my job-based plan is unaffordable and that’s why I’m not enrolled in it. Can I go ahead and apply for marketplace coverage and premium tax credits without that form?

Your employer is not required to fill out the form that asks about affordability of your job-based health plan. If for any reason you cannot obtain this information from your employer, you should report to the marketplace what you know yourself about your eligibility for employer-sponsored coverage, the cost of that coverage, and whether it meets minimum value. The marketplace may try to follow up with your employer and collect or verify this information. The marketplace will determine your eligibility for premium tax credits based on the information you provided or based on any information the marketplace was able to obtain.

167. I'm eligible for health benefits at work. However, unfortunately, I didn't turn in my enrollment papers on time during the company open season, so now I'm not covered. Can I get a policy in the marketplace instead? Can I apply for premium tax credits?

If you missed your opportunity to enroll in your employer plan during the company’s open enrollment season, you can still apply for coverage in the marketplace during open enrollment, which runs from October 1, 2013 to March 31, 2014. You can also apply for premium tax credits but you will have to provide information on the health coverage you are eligible for at work, even if you’re not enrolled in the plan. If the plan offered meets standards for affordability and minimum value, you will not be eligible for premium tax credits or cost-sharing reductions.

168. My large employer offers health benefits to me. My wife works and has coverage through her job. To figure out whether my coverage is affordable, do I just count my income or do I count my wife’s salary, as well?

If you are considering applying for premium tax credits for coverage in the marketplace, the test for whether your employer coverage is affordable is based on the cost of self-only coverage in the lowest cost plan your employer offers, compared to your household income (and not just your salary).
169. My employer offers a “mini-med” plan. It only covers preventive services and a few doctor visits each year. I want better coverage. Can I apply for coverage and premium tax credits in the marketplace?

You can apply for coverage in the marketplace and if your employer plan doesn’t meet the Affordable Care Act’s standard for minimum value, you may qualify for premium tax credits. To meet the minimum value standard, the plan must cover at least 60 percent of covered services for an average population. If your employer plan only covers preventive services and a few doctor visits, it is likely it doesn’t meet the minimum value standard (which means it would be considered inadequate and you could be eligible for premium tax credits to help buy a marketplace plan). However, if your employer offers another plan or plans, in addition to the mini-med plan, that is found to be adequate and the premiums for self-only coverage in that plan would be considered affordable for you, you will not qualify for premium tax credits in the marketplace.

Chapter 2. Coverage for Employees of Small Businesses

Background

Most people who have private coverage in the U.S. have coverage through an employer. More than 56 percent of Americans under age 65 have coverage through an employer-sponsored plan. However, because of high costs and limited options, many small businesses have struggled to offer health insurance to their workers, and the number of small businesses doing so has declined over time. Currently, the states define a small business to include at least one but no more than 50 employees. However, by 2016, the Affordable Care Act will expand the definition of small business to include those with up to 100 employees.

The Affordable Care Act builds on a prior federal law – HIPAA – to improve the accessibility, adequacy and affordability of health insurance for small businesses through a series of reforms. Many of the Affordable Care Act’s reforms apply to small business health insurance but not to large businesses.

NOTE: States can enact stronger consumer protections. Specific reforms include:

• Modified community rating. Insurers are no longer allowed to charge higher premiums based on the health status or claims experience of an employer group. However, insurers may charge more if the employer group is older than average (up to three times more) or if a number of employees use tobacco products and the employer doesn’t offer tobacco users services to help them quit.
• Prohibition on pre-existing condition exclusions. Prior to the Affordable Care Act, some small employer plans would refuse to cover care for employees’ pre-existing conditions. In
many states this period could last for up to 12 months. Under the Affordable Care Act, health insurers are no longer allowed to exclude pre-existing conditions from covered benefits under the plan.

- Minimum essential benefit standard. Insurers are required to cover a minimum set of benefits within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

- Minimum generosity of coverage. Small employer coverage must provide a minimum level of financial protection for health costs, at least 60 percent of total average costs for covered benefits. Further, the Affordable Care Act requires plans to be offered at specified coverage levels, so that employers and employees can more easily compare them. The lowest level of coverage (60 percent) is called the bronze level. A silver level plan will cover 70 percent of total average costs for covered benefits, a gold plan covers 80 percent, and a platinum plan covers 90 percent.

- Maximum out-of-pocket costs. Insurers are required to limit how much consumers can pay in out-of-pocket costs (including deductibles, co-payments, and co-insurance) for covered benefits in a given year. In 2014, the limits are $6,350 for individuals and $12,700 for families. However, some employer-sponsored plans may have higher limits in the first year, to provide a transition period for employers that use one company to administer its primary medical benefits and another company to administer certain benefits, such as prescription drugs. In these cases, the maximum out-of-pocket limit will apply to the primary set of medical benefits but a separate limit – or in some cases no limit at all – will apply to any benefits administered by another company.

- Creation of a Small Business Health Options Program (SHOP), designed to simplify the process of buying health insurance for small business. In the SHOP, employers can compare health plans online and may qualify for a small business health care tax credit worth up to 50 percent of premium costs.

**Frequently Asked Questions**

170. I have an offer of coverage from my employer, but the premiums are too expensive and I have to pay a lot out-of-pocket. Can I get financial help in the health insurance marketplace?

If your premiums for self-only coverage in your employer plan are 9.5 percent or more of your
household income and your income is between 100 percent and 400 percent of poverty, you may be eligible for a premium tax credit for coverage in a health insurance marketplace (see Appendix A for more information on the federal poverty level for individuals and families). The coverage must also provide minimum value (at least 60 percent of average costs of covered services).

The application for coverage in a health insurance marketplace includes questions your employer can answer to help determine whether your health benefits qualify you for a premium tax credit.

171. My employer just told us we are enrolling in the “SHOP.” What is the SHOP?

The SHOP, or Small Business Health Options Program, is a new marketplace in which small employers can go online to compare health plans on an “apples-to-apples” basis. Depending on the size of employer and average employee salaries, your employer may also qualify for federal premium tax credits to help pay for employees’ coverage.

All health plans offered on the SHOP have been certified to meet minimum standards for the adequacy and quality of coverage. All plans also must cover a similar set of benefits, and each plan will be assigned to a precious metal level of coverage – bronze, silver, gold, or platinum – that reflects how much protection against cost-sharing the plan provides to the average enrollee. Bronze plans expose the average consumer to the greatest amount of cost-sharing, while platinum plans provide the most protection. Bronze plans will tend to have lower monthly premiums, while the premiums for platinum plans will be more expensive.

On the SHOP website, depending on your state, you may be able to select and enroll in a health plan. In some states, your employer may only provide one plan choice; in other states, your employer may be able to offer you a range of plans to choose from. Either way, you can see standardized information about your plan options online so you can better understand the coverage you are purchasing. If you need additional assistance picking a plan or understanding how to enroll in coverage, in-person and telephone assistance is also available.

172. The company I work for is buying coverage through the SHOP. Can I choose any plan I want?

In most states in 2014, if you are purchasing coverage through the SHOP, your employer will select your plan options for you. However, certain states running their own health insurance marketplaces may allow your employer to provide you with greater choice. For example, your employer may allow employees to pick any plan at a given precious metal level of coverage (for example, any silver level of coverage plan); or to pick between multiple plans offered by a selected insurer (for example, any metal level of coverage offered by a particular insurer). In some states, employers also may allow their employees to pick from a wider selection of plans. Typically, if your employer chooses to provide greater choice to you and your co-workers, they will select a “reference plan” to calculate
how much they will contribute to your premium. If you choose to purchase a more expensive plan than the “reference plan,” you may be responsible for the additional cost. If you choose to purchase a less expensive plan, you may be able to reduce your portion of premium expenses compared to what you would owe if you selected the reference plan. In 2015, all SHOPs will at least allow employers to let their employees pick any plan at a given actuarial value.

173. My employer’s plan is changing and they’ll now pay a pre-set dollar amount toward my coverage. What does this mean for the coverage I buy?

Your employer is shifting to a defined contribution plan, meaning that the employer defines in advance the dollar amount he or she is willing to contribute to employees’ premiums. This is different from the more traditional defined benefit approach to employer-sponsored coverage, in which the employer chooses the benefit package and agrees to pay a percentage of the premiums. With a defined benefit approach, if the plan’s premiums go up, so does the employer’s contribution.

If your employer is shifting to a defined contribution approach, and offers only one plan option, your coverage may not look very different to you in the first year. However, over time, your employer’s level of contribution may not keep pace with increases in the cost of health insurance – leaving you to make up the difference.

If your employer is offering more than one plan option, your employer may peg the amount of their contribution to one of the options – often referred to as a “benchmark” or “reference plan.” If you choose to purchase a more expensive plan than the “reference plan,” you may be responsible for the additional cost. If you choose to purchase a less expensive plan, you may be able to reduce your portion of premium expenses compared to what you would owe if you selected the reference plan. However, if your employer’s level of contribution does not increase at the same rate as premiums, over time, you will be responsible for a greater portion of costs regardless of your plan selection.

174. I’ve heard there is a tax credit if my employer buys through the SHOP. Can I get it?

Since 2010, certain small businesses – specifically, those that cover at least 50 percent of premiums for their employees (not including dependents) and have fewer than 25 full-time employees whose average annual wages are less than $50,000 – have been able to receive a small business health care tax credit. Beginning January 1, 2014, the maximum value of this sliding scale tax credit will increase significantly – from 35 percent to 50 percent of premiums paid by small businesses. To qualify, they must purchase coverage through the SHOP. The amount of the tax credit is only based on your employer’s contribution to premiums, and it is up to your employer to determine how to use the money. However, if your offer of employer-sponsored health insurance is unaffordable or does not provide adequate protection against cost-sharing, you may be eligible for premium tax credits and cost-sharing reductions if you purchase coverage in the health insurance marketplace. For more information, see FAQ #44.
175. Does my employer have to offer these essential health benefits or other consumer protections in the Affordable Care Act?

That depends. Some employer-sponsored plans may be exempt from many of the Affordable Care Act’s requirements, including the essential health benefit rules. If your plan is “grandfathered,” for example, your employer does not have to comply with the essential health benefits standard. For more on grandfathered plans, see Appendix B.

In addition, if you are covered by a “self-insured” or “self-funded” plan, your employer is exempt from many of the Affordable Care Act’s rules, including the requirement to cover the essential health benefits. Under such an arrangement, your employer acts as the insurer, rather than purchasing a plan from a health insurance company. Sometimes these plans can look very similar to traditional health insurance – for example, your employer may still pay an insurance company to administer your benefits. Self-funded plans must comply with certain federal rules, including bans on annual and lifetime limits and rescissions, and requirements to cover recommended preventive health services without cost-sharing and extend dependent coverage to age 26.

Lastly, if your plan year started in 2013, many of the Affordable Care Act’s protections, including essential health benefits, will not go into effect until your plan renews later in 2014.

176. When can I enroll in my small employer plan?

Your employer can choose to begin offering coverage at any point during the year. If your employer is purchasing coverage through the SHOP, you will have an annual open enrollment period lasting no less than 30 days during which you can compare your options and enroll in coverage. If you are a new employee, the SHOP must provide you an enrollment period to seek coverage beginning on the first day of your eligibility for coverage. For more information, see FAQ #157.

Outside of your employer’s annual open enrollment period, there may be changes in your coverage or circumstances, known as “triggering events,” that allow you or your dependent to enroll in or change a plan during a special enrollment period. Special enrollment periods will be provided if you or a dependent (if your employer covers dependents):

- Lose minimum essential coverage (for example, if you or your dependent were previously covered by your spouse’s health plan, but are dropped from that coverage; or if the insurer providing the plan you were enrolled in through your employer discontinues the plan)
- Gain a dependent or become a dependent through marriage, birth, adoption or placement for adoption
- Were erroneously enrolled in the wrong health plan or not enrolled in a health plan
due to administrative error by the SHOP

• Demonstrate that the health plan you or your dependent are enrolled in violated its contract with you
• Gained access to new health plans as a result of a permanent move
• Lose eligibility for coverage under Medicaid or Children’s Health Insurance Program coverage
• Become eligible for assistance with your employer-sponsored plan through Medicaid or Children’s Health Insurance Program coverage
• Meet other exceptional circumstances as the SHOP may provide

In most instances, you will have 30 days from the triggering event to select and enroll in a plan through the SHOP. However, if your special enrollment period relates to the gain or loss of Medicaid or Children’s Health Insurance Program eligibility, you will have 60 days to select and enroll in a health plan. Your coverage will become effective on the first day of the following month if you make your selection between the first and fifteenth day of the month. If you make your selection later in the month, your coverage will typically not become effective until the first day of the second following month. However, exceptions are provided in certain circumstances. First, coverage is effective on the date of birth, adoption, or placement for adoption. Second, if you get married or lose minimum essential coverage, the SHOP must ensure your coverage is effective on the first day of the following month. In addition, if you are an American Indian/Alaska Native, you may enroll in a health plan or change from one health plan to another one time per month.

When it’s time to renew your coverage, you will remain in the health plan you selected the previous year, unless you choose to terminate your coverage in that plan, you enroll in another health plan through the health insurance marketplace, or the plan is no longer available to you.

177. My employer offers a workplace wellness program that increases premiums for employees who don’t participate and/or can’t meet certain targets for healthy behavior. I don’t think I’ll be able to afford the premiums if I don’t participate or miss the mark. Can I leave my employer-sponsored plan and get one on the health insurance marketplace?

It depends on how much your costs go up based on any premium increases you face due to the wellness program. If your premiums with the wellness penalty would be 9.5 percent of your income or more, or if your cost-sharing increases enough to lower the value of your plan below the minimum value standard (60 percent of average costs of covered services), then you may be eligible for premium tax credits. This test applies whether you are actually penalized or not, and in advance of the penalty being applied (for example, if your employer gives you time to try to meet the health standard that triggers a penalty or reward).
178. I work for a small business who buys health insurance in the marketplace and I smoke. Will my company be charged more because of me?

Yes, assuming your coverage is purchased in a state that allows the tobacco surcharge. An insurer can adjust the premiums of health plans sold to small businesses based on the number of workers who use tobacco, unless your employer offers tobacco users services to quit.

Chapter 3. Retiree Coverage

Background

Retirees who are not yet eligible for Medicare may have a plan sponsored by their former employer as their primary source of health coverage. If the retiree is enrolled in Medicare, the retiree benefits serve as a secondary source of coverage, supplementing Medicare by reducing cost-sharing or covering benefits like prescription drugs.

For pre-Medicare retirees with employer-sponsored coverage, the Affordable Care Act may provide new protections. If the plan in which the retirees are enrolled also covers active workers, the consumer protections will apply, including limits on out-of-pocket costs and coverage of recommended preventive services without cost-sharing. However, if the plan only covers retirees, as is more often the case, the coverage does not have to comply with the Affordable Care Act consumer protections. Retiree health coverage is considered “minimum essential coverage,” which means no individual mandate penalty applies to those who have retiree health benefits. However, individuals with an offer of retiree health benefits are only eligible for the premium tax credit as long as they are not enrolled in retiree coverage.

Frequently Asked Questions

179. I have retiree coverage from my former employer, but the premiums are too expensive and I have to pay a lot out-of-pocket. Can I drop my retiree plan and get financial help in the health insurance marketplace?

Yes, as long as you drop your retiree health plan, you may be eligible for coverage in a health insurance marketplace, and depending on your income, for premium tax credits. There are a few important considerations to keep in mind:

• You must apply for coverage during the annual open enrollment period. If you drop your plan expecting to enroll at another time, you will have to wait.
• In order to avoid a gap in coverage, be sure to coordinate the date your retiree coverage will
end with the date your health insurance marketplace coverage will begin.

- If you are eligible for premium tax credits, you will be able to shop for coverage and see the premiums you would pay, taking into account the tax credit.
- If you want to compare benefits and cost-sharing under your retiree plan to those you would get in a plan in a health insurance marketplace, keep in mind that plans that cover only retirees (and not active workers as well) don’t have to comply with the same consumer protections as plans in a health insurance marketplace.


Yes, Social Security benefits are counted as income in determining eligibility for premium tax credits in the marketplace.

181. I’m a retired veteran collecting VA pension benefits. Are those benefits counted in determining my eligibility for subsidies in the marketplace?

Yes, VA pension benefits, like Social Security benefits, are counted as income in determining eligibility.

182. Does my retiree health coverage count for the individual responsibility requirement (individual mandate), or will I have to change my coverage?

Yes, retiree health coverage counts as “minimum essential coverage,” so you won’t have to pay a tax penalty or change plans.

183. Does my retiree coverage have to comply with the Affordable Care Act?

It depends. If the plan in which the retirees are enrolled also covers active workers, the consumer protections will apply, including limits on out-of-pocket costs and coverage of recommended preventive services without cost-sharing. However, if the plan only covers retirees, as is more often the case, the coverage does not have to comply with the Affordable Care Act consumer protections. Your former employer can tell you which type of plan you have.

184. My spouse is covered under my plan at work. If I retire and sign up for my retiree plan, will my husband be eligible to buy a plan on the marketplace?

Probably. Most people are eligible to buy a plan on the health insurance marketplace. However, depending on your household income and his access to other coverage options, he may not be eligible for premium tax credits to lower the cost of a marketplace plan. For example, if he is eligible
for Medicare and doesn’t sign up for your retiree plan, he would not be eligible for premium tax credits. However, if he’s not eligible for Medicare and doesn’t enroll in your retiree health plan, he could be eligible for premium tax credits, assuming your household income is less than 400 percent of the federal poverty level ($62,040 for a couple in 2013).

185. I’m 63 and about to retire. I’ll be offered a retiree health plan. Can I look for better coverage and subsidies in the marketplace instead?

Yes. Most early retiree health plans are considered minimum essential coverage, and thus meet an individual’s requirement for coverage. However, if you want to obtain coverage through the marketplace, you may do so, and if your income is at or below 400 percent of the federal poverty level, you are eligible for premium tax credits. Eligibility for retiree coverage will not affect your eligibility for marketplace coverage and subsidies. See Appendix A for more information on the federal poverty level for individuals and families.

186. My spouse is an early retiree with affordable retiree health benefits from his former employer, but I’m not eligible to be on his plan. Can I apply for coverage and subsidies in the marketplace?

Yes, assuming you meet the other requirements, you can apply for health plans and premium tax credits in the marketplace. Your spouse’s eligibility for early retiree coverage will not affect your ability to seek coverage and financial help in the marketplace.

187. I’m 63 and my husband is 65 and on Medicare. Our income is less than 400 percent of the FPL so I need help affording the premium in the marketplace. Can we count what my husband has to pay for his Medicare premiums and supplemental and Part D premiums against what I will be required to contribute toward coverage in the marketplace?

No. Your eligibility for premium tax credit subsidies and the amount of your premium tax credit will be based on your family income. The amount your husband pays for his Medicare, Part D and supplemental insurance premium costs will not be taken into account.

Chapter 4: Individual Health Insurance

Background

The Affordable Care Act creates new health insurance marketplaces that will exist in each state. These marketplaces will enable consumers to shop for and compare health plans, and access premium tax credits and cost-sharing reductions to make health insurance more affordable. In most states, consumers will continue to be able to buy health coverage outside the marketplace.
For the most part, health insurers selling this coverage outside the health insurance marketplace coverage will have to provide many of the same consumer protections that insurers inside the health insurance marketplace provide. However, some types of coverage sold outside the marketplace are exempted from the new rules, and consumers should fully review the terms of their coverage to ensure it provides adequate protection. In addition, not all coverage sold outside the marketplace meets the federal standard for “minimum essential coverage” and consumers could face a tax penalty if they do not have this minimum coverage.

**Health insurance marketplace.** Consumers are eligible to purchase health insurance coverage through the marketplace if they:

- Live in the state in which they are applying;
- Are a citizen of the U.S. (or are lawfully present); and
- Are not currently incarcerated.

Consumers will need to go through additional eligibility screening to determine whether they are eligible for premium tax credits or cost-sharing reductions to help make their marketplace plan more affordable.

**Premium tax credit.** Starting in January 2014, individuals may qualify for financial help with premiums and out-of-pocket costs for coverage purchased through a health insurance marketplace. Financial help is available in two forms: a premium tax credit and cost-sharing reductions.

To be eligible for the premium tax credit, the individual must meet all of the following criteria:

- Be enrolled in a health plan through the health insurance marketplace
- Is not eligible for minimum essential coverage, other than coverage offered in the individual market (see FAQ #45), and
- Has household income between 100 percent and 400 percent of the federal poverty level (i.e., between $11,490 and $45,960 for an individual in 2013). See Appendix A for more information on the federal poverty level for individuals and families.

**Getting more information about your coverage options.** All health plans must provide individuals with a Summary of Benefits and Coverage, which uses a standard format to outline the benefits, cost-sharing and coverage limits of plans. The Summary of Benefits and Coverage must also state whether the plan meets minimum value and counts as minimum essential coverage, although in 2014, that information may be provided separately in a cover letter. The Summary of Benefits and Coverage must be made available to consumers at open enrollment and upon renewal of coverage,
Upon request, and whenever there is a significant change in the plan.

**Comparing plans and understanding options.** Beginning in 2014, all non-grandfathered plans sold to individuals and small businesses must meet federal standards for the adequacy and affordability of coverage. The federal rules establish minimum standards for benefits and cost-sharing, limit the factors that may be used to set premiums, and require plans to be standardized so that it’s easier for consumers to make apples-to-apples comparisons of plans.

See also Appendix B for a chart outlining how rules apply to different insurance markets and types of coverage.

All non-grandfathered plans sold to individuals and small businesses, including those sold through a health insurance marketplace or SHOP, must meet the following requirements:

(NOTE: States may enact stronger laws or rules to protect consumers)

- **Minimum essential benefit standard.** Insurers are required to cover a minimum set of benefits within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
- **Access to key services.** Health plans must cover recommended preventive care at no cost-sharing (co-payments, coinsurance and deductible); allow individuals to designate any participating pediatrician to be their child’s primary care doctor; and use emergency services without prior authorization or higher cost-sharing for out-of-network emergency room care.
- **Prohibition on discrimination based on health status.** Prior to the Affordable Care Act, insurers could refuse to accept applicants. Under the Affordable Care Act, health insurers can no longer do this.
- **Prohibition on pre-existing condition exclusions.** Prior to the Affordable Care Act, some insurers would refuse to cover care for an individual’s pre-existing conditions for up to 12 months. Under the Affordable Care Act, health insurers are no longer allowed to exclude pre-existing conditions from covered benefits under the plan.
- **Minimum generosity of coverage.** Individual coverage must provide a minimum level of financial protection for health costs, at least 60 percent of total average costs for covered benefits. Further, the Affordable Care Act requires plans to be offered at specified coverage levels, so that individuals can more easily compare them. The lowest level of coverage (60
percent) is called the bronze level. A silver level plan will cover 70 percent of total average costs for covered benefits, a gold plan covers 80 percent, and a platinum plan covers 90 percent. Individuals under age 30 or who cannot find “affordable” coverage are eligible to purchase catastrophic coverage.

- Modified community rating. Insurers are no longer allowed to charge higher premiums based on the health status or claims experience of an individual. However, insurers may charge more if the individual is older than average (up to three times more) or if he or she uses tobacco products. Premiums can also vary by geography.

- Prohibition on annual and lifetime limits. Prior to the Affordable Care Act, health plans could limit how much they paid toward benefits, for example, no more than $100,000 in a year or $1 million in a lifetime of coverage. Under the Affordable Care Act, health plans can no longer impose annual or lifetime dollar limits on benefits.

- Limits on out-of-pocket costs. Health plans must limit out-of-pocket costs for essential health benefits to no more than $6,350 for an individual or $12,700 for a family in 2014 (this amount will grow each year to track increases in medical costs). Depending on household income, the limits may be lower for individuals and families that qualify for cost-sharing reductions in a health insurance marketplace.

- Covers young adults up to age 26. Health plans must allow families to keep their adult children on the family plan up to age 26. This applies even if the child isn’t a student, doesn’t live at home or is not financially dependent on his or her parents.

- Sufficient access to providers. In addition to the above rules, plans offered in a health insurance marketplace must also meet federal standards for network adequacy, ensuring access to primary care doctors, specialists, and “essential community providers” such as community health clinics without unreasonable delay.

Frequently Asked Questions

188. I have my own health insurance. Why should I consider shopping for a new plan on the health insurance marketplace?

If you use the health insurance marketplace, you can compare plans and shop with confidence that all the plans displayed have been certified as meeting a minimum standard for coverage and quality, and will qualify as “minimum essential coverage” to avoid the tax penalty. If you shop for a plan outside the health insurance marketplace, you will need to do your own research to determine whether the plan provides the kind of financial protection and access to providers that is right for you and your family.
Second, premium tax credits and cost-sharing reductions to help lower the cost of coverage are only available through plans purchased in a health insurance marketplace. In addition, even if you are not currently eligible for premium tax credits, if you have a change in household income that may make you eligible for premium tax credits and cost-sharing reductions later, you can only enroll in the subsidies outside the annual open enrollment period if you already have coverage through a health insurance marketplace.

189. Can I buy or change private health plan coverage outside of open enrollment?

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

- Loss of eligibility for other coverage (for example, if you lose your employer-sponsored coverage because you quit your job, were laid off, or if your hours were reduced, or if you lose student health coverage when you graduate). Note that loss of eligibility for other coverage because you didn’t pay premiums does not trigger a special enrollment opportunity
- Gaining a dependent (for example, if you get married or give birth to or adopt a child). Note that pregnancy does NOT trigger a special enrollment opportunity
- Divorce or legal separation
- Loss of dependent status (for example, “aging off” a parent’s plan when you turn 26)
- Moving to another state or within a state if you move outside of your health plan service area
- Exhaustion of COBRA coverage
- Losing eligibility for Medicaid or the Children’s Health Insurance Program
- For people enrolled in a marketplace plan, income increases or decreases enough to change your eligibility for subsidies
- Change in immigration status
- Enrollment or eligibility error made by the marketplace or another government agency or somebody, such as an assister, acting on their behalf

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

When you experience a qualifying event, your special enrollment opportunity will last 60 days from
the date of that triggering event.

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

191. An agent offered to sell me a policy that pays $100 per day when you’re in the hospital. Does that count as minimum essential coverage?

No. Some types of coverage do not qualify as minimum essential coverage. These include hospital indemnity policies (that pay a fixed dollar amount per day when you are hospitalized), discount plans, short-term nonrenewable policies, or plans that provide coverage only for a specific disease (i.e., cancer-only policies). Companies that sell these products, also called “excepted benefits,” are required to notify you if they don’t qualify as minimum essential coverage. If you receive such a notice, and don’t obtain other coverage that is minimum essential coverage, you may have to pay a tax penalty.

191. What is a grandfathered plan? How do I know if I have one?

Grandfathered plans are those that were in existence on March 23, 2010 and have stayed basically the same. If you buy coverage on your own and you first purchased your policy prior to March 23, 2010, it may be a grandfathered plan. If you first purchased the policy after that date, it is not grandfathered. As your non-grandfathered policy comes up for renewal in 2014, it will have to change to follow all the new rules required of other health plans. If you currently are covered under a non-group policy – whether it is grandfathered or not – starting October 1, 2013, you can also explore other qualified plans offered through the marketplace and, if you prefer, you can switch to one of the new plans during open enrollment. To be eligible for a tax credit to help pay your premium – which will be based on your income – you would have to switch to a plan offered through the marketplace.

Some group plans offered by employers may also be grandfathered plans. A grandfathered group plan also must have been first established prior to March 23, 2010. To retain grandfather status, the group plan cannot be significantly changed (that is, the employer can’t significantly change covered benefits or cost-sharing, or the share of the plan premium that you are required to contribute). Because employer plans tend to change from year to year, most have already lost grandfather status or will lose it over time. Meanwhile, however, grandfathered plans are not required to provide all of the benefits and consumer protections required of other health plans. For example, a grandfathered health plan might not cover preventive health services. Employers with grandfathered group health plans are allowed to enroll new employees in the grandfathered plan. So even if you first joined a group health plan after March 23, 2010, you should ask about its grandfathered status. Your employer or your insurer must let you know if your health plan is grandfathered.
192. My insurance company is offering me the option to renew my current policy before the end of year. What are the pros and cons of doing that?

Some individuals may find that their insurer is offering lower rates if they renew early. However, doing so would exempt your coverage from many of the new protections going into effect in 2014, including modified community rating and the essential health benefit standard. In addition, because you will not be insured through the health insurance marketplace, you would be ineligible for the premium tax credit and cost-sharing reduction. Some insurers are asking individuals to decide to early renew before they have the opportunity to learn about what their plan options and rates would be if they buy through the health insurance marketplace or wait to renew on schedule. Individuals should take the time to compare all of their options before making a decision.

NOTE: Some states have enacted protections for individuals who are in coverage that renewed before the Affordable Care Act consumer protections take effect January 1, 2014.

193. What if I sign up for a plan and change my mind. Can I switch my plan during open enrollment?

Once you enroll in coverage, you can change plans prior to the coverage effective date. Once the coverage takes effect, you cannot change plans again until the next annual open enrollment period, or you have a change in circumstances that qualifies you for a special enrollment period. See FAQ #36 for more on events that trigger a special enrollment period.

194. How do I know that the coverage I have counts for purposes of the individual responsibility requirement (individual mandate)?

All health insurers and employer-sponsored group health plans must provide people with a Summary of Benefits and Coverage, which uses a standard format to outline the benefits, cost-sharing and coverage limits of plans. The Summary of Benefits and Coverage must also say whether the plan meets minimum value and counts as minimum essential coverage, although in 2014, that information may be provided separately in a cover letter.

195. I'm in a grandfathered plan that doesn't cover prescription drugs. Does that count as minimum essential coverage?

Yes, grandfathered plans count as minimum essential coverage.

196. If I switch plans, how do I make sure I can keep my doctor?

All health insurers must provide individuals with a Summary of Benefits and Coverage, which uses a standard format to outline the benefits, cost-sharing and coverage limits of plans. The Summary of Benefits and Coverage must also include information on how applicants and enrollees can obtain
a list of participating, or “in-network” providers. However, these lists can quickly become out of date and may not contain the most current and accurate list of participating providers. Furthermore, you can incur significantly higher out-of-pocket costs if you obtain services outside your plan’s network. Therefore, if you have a provider that you really want to keep seeing, you should contact the provider and confirm that they participate in the plans you’re considering.

197. If I switch plans, how do I make sure the drug I am taking is covered under the new plan?

All health insurers must provide individuals with a Summary of Benefits and Coverage, which uses a standard format to outline the benefits, cost-sharing and coverage limits of plans. The Summary of Benefits and Coverage must also include information on how applicants and enrollees can obtain a list of covered prescription drugs, known as the plan’s formulary.

198. When I graduated from college I bought a short-term policy that will help fill the gap until I get a job with health benefits. Does my short-term plan satisfy the individual responsibility requirement (individual mandate)?

No, short term policies are not required to meet the Affordable Care Act consumer protections and do not count as minimum essential coverage. Therefore, if you remain enrolled in the short term policy, you may face a tax penalty. However, you can enroll in a plan on the health insurance marketplace during the open enrollment period and drop that plan if and when you become eligible for employer-sponsored coverage. Be aware that if you don’t enroll in a plan on the health insurance marketplace and wait until your short-term policy expires, you will not be entitled to a special enrollment opportunity and will have to wait until the next open enrollment period to enroll.

199. I have health insurance through an association. How do I find out if my coverage qualifies as minimum essential coverage?

It is likely you have minimum essential coverage, because association health plans should meet the same standards as those required of an individual health insurance policy. If you are not sure whether your association’s plan qualifies as minimum essential coverage, contact your plan administrator.

200. I own my own business and have no employees, what are my options?

While you are not eligible to purchase small group health insurance through the SHOP marketplace, you can purchase individual market coverage and may be able to qualify for financial assistance through the health insurance marketplace for individuals.
Chapter 5. High-Risk Pools

Background

Thirty-five states operate high-risk pools for individuals who cannot get coverage on their own because of pre-existing conditions. Premiums are typically 150 percent or more of what an individual would pay for a private health insurance, and the coverage often comes with limits on benefits. The Affordable Care Act prohibits insurers from denying individuals coverage, or charging more or limiting benefits because of a pre-existing condition. As a result, individuals with pre-existing conditions will no longer need to rely on high-risk pools as a last-resort option for coverage. Therefore, some states are developing plans to close their high-risk pools and transition enrollees to other coverage.

The Affordable Care Act’s consumer protections don’t apply to high-risk pool coverage. For example, high-risk pools can:

- Set rates based on factors other than those that are required by the Affordable Care Act, including gender, and can charge more based on age than is required under the health reform law
- Retain annual and lifetime limits on benefits
- Impose greater cost-sharing than is allowed under the out-of-pocket maximum that applies to all insurance sold to individuals
- Impose cost-sharing for recommended preventive services
- Cover a more limited set of benefits than required under the Affordable Care Act

If the high-risk pool remains open, and an individual chooses to remain enrolled in a high-risk pool plan, their coverage will be considered minimum essential coverage in 2014 and they won’t be subject to a tax penalty under the individual responsibility requirement (individual mandate). However, high-risk pool coverage won’t automatically be considered minimum essential coverage in 2015 unless they provide consumer protections similar to those required by the Affordable Care Act.

NOTE: These high-risk pools are separate from the Pre-existing Condition Insurance Plan (PCIP) operated in each state under a temporary program established by the Affordable Care Act. Those pools will terminate coverage on December 31, 2013, in anticipation of individuals with pre-existing conditions gaining coverage under the new insurance rules and coverage options.
**Frequently Asked Questions**

201. I got a notice from my insurance company that the high-risk pool is phasing out by the end of the year and I should sign up for coverage through the health insurance marketplace. What should I do?

You can sign up for coverage through a health insurance marketplace during the open enrollment period that runs from October 1, 2013 through March 31, 2014. However, to maintain coverage without a gap between your high-risk pool coverage and coverage in a health insurance marketplace, be sure to sign up in time for the coverage effective date to coordinate with the end of your high-risk pool coverage. For example, if your high-risk pool coverage will end on December 31, 2013 and you need coverage beginning January 1, 2014, you must enroll in a health insurance marketplace by December 15. This process includes applying for coverage and any premium tax credits or cost-sharing reductions you might be eligible for, selecting a plan and paying your first month’s premium.

202. I got notice that my high-risk pool plan is continuing into next year. Should I change plans or stick with my high-risk pool?

It depends. You may want to stay in your high-risk pool plan if you are in the middle of a course of treatment, or wish to continue to see a particular provider. However, staying in a high-risk pool has significant downsides that you’ll want to carefully consider:

- High-risk pools don’t have to comply with the consumer protections of the Affordable Care Act. That means they can maintain annual and lifetime limits on benefits, don’t have to limit out-of-pocket costs, can limit benefits based on pre-existing conditions, and don’t have to comply with the minimum benefits standard required by the Affordable Care Act – all of which can mean individuals with significant health needs may be getting less from their coverage than they would under a plan that must comply with the Affordable Care Act rules.
- Only those enrolled in a plan on the health insurance marketplace can qualify for financial assistance to reduce the cost of premiums and out-of-pocket costs. That can be a critical benefit for individuals in high-risk pool plans with high premiums and cost-sharing.

203. If I keep my high-risk pool coverage, does that count as coverage for purposes of the individual responsibility requirement (individual mandate)?

Yes, at least for 2014. Coverage through a high-risk pool will be considered minimum essential coverage in 2014 so you won’t be subject to an individual mandate penalty. However, high-risk pool coverage won’t automatically be considered minimum essential coverage in 2015 unless the high-
risk-pool in which you are enrolled provides consumer protections similar to those required by the Affordable Care Act.

Chapter 6: Issues For Young Adults: Student Health Plans And Coverage On Parent’s Health Plans

Background

In recent years, many colleges have begun requiring proof of health insurance for students. Coverage options include insurance through family policies, Medicaid, and coverage through school-sponsored student health plans. Approximately 60 percent of all colleges currently offer student health plans. In addition, many students will soon be able to purchase coverage through the new health insurance marketplaces, and most will qualify for premium tax credits and cost-sharing reductions to make that coverage more affordable. While historically there has been a wide variation in the cost and benefits provided by school-sponsored plans, under the Affordable Care Act most student plans are required to provide some important consumer protections, such as:

- Student plans are no longer allowed to impose an annual cap on prescription drugs and other health coverage, meaning they can’t cut off paying for students’ care if they get really sick.
- Student plans are now required to provide free preventive care, such as free STD testing and birth control.

However, some types of student plans offered by colleges and universities are exempt from consumer protections under the Affordable Care Act. These are called “self-funded” student plans, in which the sponsoring college or university bears the financial risk for the health costs of enrollees. Students should be aware that there can be significant differences in the cost and benefits of these plans, and some plans may not provide adequate financial protection if a student gets sick or injured.

Frequently Asked Questions

Student Health Plans

204. What is a student health plan?

“Student health plan” refers to a special policy of health coverage that colleges and universities make available to their enrolled students. Typically the student health plan is different from the employer-sponsored group coverage that colleges and universities offer their faculty and staff.
205. Does a student health plan count as minimum essential coverage?

Yes.

206. Does a student health plan have to cover essential health benefits?

It does if it is a “fully insured” student health plan. A fully insured plan is one that your college or university purchases from a health insurance company. If your student health plan is fully insured, it must cover essential health benefits, which include:

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

However, if the student health plan is “self-insured,” it might not be required to cover essential health benefits. It’s up to states to regulate self-insured student health plans. Check with your college or university to find out what type of student health plan they offer, or check with your state insurance regulator to find out what rules apply to your student health coverage.

207. Does my student health plan have to cover contraceptives?

Generally, yes it does, if it is a fully insured plan. A fully insured plan is one that your college or university purchases from a health insurance company. These plans are required to provide, without cost-sharing, access to all FDA-approved contraceptive methods, sterilization procedures, patient education and counseling prescribed by a health care provider. Exceptions are made for religious institutions of higher education that have religious objections to providing contraceptive services. If you attend such a college or university, you will be able to seek contraceptive coverage at no cost directly from the health insurance company.

If your student health plan is a self-insured plan, it might not be required to cover contraceptive services. It’s up to states to regulate self-insured student health plans. Check with your college or university to find out what type of student health plan they offer, or check with your state insurance regulator.
regulator to find out what rules apply to your student health coverage.

208. I'm a part-time student. Does my college have to let me enroll in the student health plan?

It is up to the college or university to establish eligibility rules for student health plans.

209. I'm eligible for the student health plan but haven't signed up yet. Do I have to take that or can I apply for coverage and subsidies in the marketplace?

Eligibility for a student health plan does not make you ineligible for marketplace coverage and subsidies. Even if you are eligible for student health coverage, you can get coverage through the marketplace. In addition, if your income is between 100 percent and 400 percent of the federal poverty level and you meet other requirements, you can qualify for premium tax credits; if your income is between 100 percent and 250 percent of the federal poverty level, you can also qualify for cost-sharing reductions. See Appendix A for more information on the federal poverty level for individuals and families.

In addition, eligibility for a student health plan does not make you ineligible for Medicaid. Check with your state to find out if you meet the income and other eligibility standards to enroll in Medicaid coverage.

210. I'm enrolled in student health coverage now, but I think I can get a better deal in the marketplace. Can I drop student health plan coverage and go to the marketplace instead?

If you are currently enrolled in a student health plan, you can still qualify for marketplace policies and subsidies if you apply during open enrollment. During open enrollment, you can sign up for a marketplace plan and, if your income is between 100 percent and 400 percent of the poverty level you can also apply for premium tax credits (See Appendix A for more information on the federal poverty level for individuals and families). You will have to drop your student health coverage by December 31, 2013 in order to remain eligible for premium tax credits in 2014.

Outside of open enrollment, you cannot voluntarily drop your student health plan coverage in order to qualify for coverage and premium tax credits. However, if you involuntarily lose eligibility for student health plan coverage mid-year – for example, if you drop out of school and so lose eligibility for the student health plan – you will qualify for a special enrollment opportunity and be able to apply for marketplace coverage and premium tax credits. The special enrollment opportunity will last 30 days, so be sure to contact the marketplace promptly to notify them of your qualifying event.
211. I'm a foreign student studying in the U.S. Does the requirement to have health coverage apply to me?

In general, yes. There is no group exemption for international students to the individual responsibility to have health coverage. However, you might qualify for another exemption to the requirement.

212. I'm an American college student and I plan to study abroad next semester. Am I required to have U.S. health insurance while I'm living in another country?

Yes, unless you qualify for another exception. In general, U.S. citizens with a tax home outside the U.S. and who are residents of a foreign country for the entire taxable year are exempt from the requirement to have health insurance in the U.S. But if you are a student temporarily living abroad for part of the year, and don't qualify for any other exceptions, you would be required to have health insurance or else pay a penalty.

**Coverage on a Parent’s Health Plan**

213. I'm about to turn 19 and I'm covered under my parent’s health plan as a dependent. How long can I stay covered as a dependent?

Health plans that offer dependent coverage must cover dependents up to their 26th birthday.

214. I'm going to a college that offers a student health plan. Can I stay covered as a dependent on my parent’s policy or do I have to take the student health coverage?

Yes. Eligibility for student health coverage does not make you ineligible to be covered as a dependent on your parent’s policy up to the age of 26.

215. I just got a job that offers health benefits, but my parent’s policy is better and less expensive to me. Can I stay on my parent’s policy?

Generally, yes. Eligibility for group health benefits through your own job does not make you ineligible to be covered as a dependent on your parent’s policy up to the age of 26. One exception to this rule applies to grandfathered group health plans. These are plans offered by employers that were established prior to March 23, 2010 and that have not significantly changed since that date. If your parent’s policy is a grandfathered group health plan, it can refuse to cover you as a dependent if you are eligible for health benefits through your own job. However, this exception ends in 2014 as the grandfathered plan year renews. You will have to ask your parent’s health benefits administrator to find out about the grandfather status of the plan.
216. I'm 24 and I used to be covered as a dependent on my parent's policy. I dropped off last year when I found other coverage, but now I've lost that other coverage and want to get back on my parent’s policy. Can I do that?

Yes. You are still eligible to be covered as a dependent. Your parent’s plan must offer you a special opportunity to re-enroll because you lost other coverage. That special enrollment opportunity must last at least 30 days from the date you lost other coverage.

217. Do my parents have to claim me as a tax dependent for me to be on their health plan to age 26?

No. You do not need to be a tax dependent of your parents to continue to be covered as a dependent on their health plan.

218. Do I have to live in my parent’s home to be covered as a dependent under their policy?

No, living in your parent’s home is not a requirement for eligibility to be covered as a dependent under their policy.

219. I’m covered under my parent’s policy but I’m moving to another state. Can I remain covered as a dependent?

Yes, you are eligible to be covered as a dependent up to age 26 regardless of where you actually live. However, your parent’s health plan probably has a network of participating providers and it may be difficult for you to find in-network care when you are living in another state. If you find that your parent’s plan doesn’t cover health providers in the state where you live, you can also explore the option of signing up for coverage on your own. Moving will qualify you for a special enrollment opportunity to enroll in other coverage. Check the marketplace website in your state for more information about qualified health plan options and your eligibility for premium tax credits.

220. My wife and I want to cover our 25-year-old son as a dependent on our policy. We have no other children. We don’t claim him as a dependent, he doesn’t live with us, and he has a job. We also have modest income and hope we can qualify for premium tax credits in the marketplace. Do we have to count our son as a member of our household when we apply? Do we have to count his income when we apply?

No. You and your husband will be counted as a household of two and the income you and he report on your joint tax return will be counted for purposes of determining your eligibility. Your son will be counted separately as a household of one, and his income will be counted separately to determine his eligibility. After the marketplace decides the amount of premium tax credit each of your “households” are eligible for, the three of you can apply for a family policy offered on the marketplace and you can apply your combined premium tax credits to reduce what your family has to pay for that policy.
221. Can I be covered under my parent’s plan if I’m married?

Yes, as long as you are younger than 26. Being married does not affect your eligibility to be covered as a dependent under your parent’s plan.

222. I’m under age 26, covered on my parent’s plan as a dependent, and I’m getting married. Does my parent’s plan have to cover my spouse?

No. Your parent’s plan is not required to cover your spouse.

223. I’m covered as a dependent under my parent’s plan and I’m pregnant. Will my parent’s plan cover my prenatal care and delivery? Will my parent’s plan cover my baby after he’s born?

Your parent’s plan is required to cover your maternity care and delivery. However, after that, the plan is not required to cover your child as a dependent. You will be responsible for obtaining coverage for your baby. Depending on your income, your child may be eligible for coverage under the Medicaid/CHIP program in your state. Or, you can buy a child-only policy through the marketplace and, depending on your income, you may be eligible for a premium tax credit to reduce your cost of that coverage.

224. I’m covered as a young adult dependent on my parent’s policy now, but my 26th birthday is next summer, at which point I won’t be eligible for dependent coverage any longer. Should I apply for marketplace health plans and subsidies now, during open enrollment?

You can remain covered as a dependent on your parent’s policy until you turn 26. Once you lose eligibility as a dependent, you will qualify for a special enrollment opportunity. At that point, you will also be able to apply for health coverage and assistance through the marketplace, even though it won’t be during a regular open enrollment period.

225. My parents are self-employed and buy coverage through the marketplace. They earn too much to qualify for subsidies. I’m 24 and only earn $30,000 a year (about 260 percent of FPL.) My parents don’t claim me as a tax dependent, I file my own return. Can I be covered as a dependent under their marketplace policy? If so, can I qualify for a premium tax credit and apply that to their premium?

Yes, you can be covered as a dependent up to age 26 on your parent’s marketplace policy. If your parents don’t claim you as a tax dependent (and you file independently), then your eligibility for premium tax credits will be based on your income alone. With your income at 260 percent FPL, you will qualify for a premium tax credit. Once you know the amount, you can decide to sign up for a marketplace policy on your own, or be covered as a dependent on your parent’s policy until you are 26. If you enroll in your parent’s plan, you can elect to have your premium tax credit paid directly to your parent’s insurer each month, or you can claim it on your tax return later when you file.
226. My son goes to college in another state but we want him on our family plan in the health insurance marketplace. Can we do that?

Yes. If your son or daughter is a member of your tax household, they can join your family plan on the health insurance marketplace, even if they live out of state. However, your child may need to return home in order to access care within your plan’s network. If he or she gets health care services in another state, the providers may be outside your plan’s network and you may have to pay high co-payments or coinsurance. Your son or daughter is also likely eligible to buy coverage in the state where they attend school. If they do so, they would have a greater choice of in-network providers.