Health Insurance Marketplace: What is It?

Arizona Advisory Council on Indian Health Care

Learning Objectives

Learning Objectives:

Please note that this presentation pertains to health insurance programs. There are a large number of different health insurance options and models out there. However, for the purposes of this presentation, we will be limiting discussion to the Health Insurance Marketplace.

1. What is the Health Insurance Marketplace?
2. What is Open Enrollment?
3. What are Special Enrollment Periods?
4. Important Health Insurance Definitions
5. What is the Affordable Care Act?
6. Using the Health Insurance Marketplace to Browse Possible Health Plans
7. Applying for a Health Plan Using the Health Insurance Marketplace
8. Health Care and Indigenous Peoples
9. High level Overview of Medicaid and Medicare

Thank You

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- Anthony Enoch Jr. Office of Civil Rights
- Cassandra Peña, MSW, Tribal Liaison with Molina Healthcare
- Shaun Sellers, Tribal Liaison with UnitedHealthcare Community Plan

What *is* the Health Insurance Marketplace

What *is* the Health Insurance Marketplace?

The Health Insurance Marketplace is an online shopping site for health insurance.

- It is a service offered by the federal government, with a primary audience of individuals and families without health insurance, and small businesses.
- It fills the gap for those who do not have health insurance through their employer, a family member's employer, Medicare, Medicaid or the Children's Health Insurance Program (CHIP/Kid's Care).
- There are a variety of plans that are low cost, including $0 premium plans for qualifying incomes.
- It allows for easy comparison between health insurance plans, so you can compare them side-by-side, in a clear and transparent manner.

Source: https://www.healthcare.gov/quick-guide/
https://www.hhs.gov/answers/health-insurance-reform/what-is-the-health-insurance-marketplace/index.html

What *is* the Health Insurance Marketplace?

How to Access the Health Insurance Marketplace

- Website: www.Healthcare.gov
- Phone: 1-800-318-2596
  - Please note, that if you qualify to enroll in Marketplace coverage through a Special Enrollment Period, you need to **call the Marketplace Call Center t**o complete your enrollment. You cannot complete it online.

Where Can I Browse Plans Prior to Applying?

- https://www.healthcare.gov/see-plans/#/

What *is* the Health Insurance Marketplace?

What Can You Do on the Health Insurance Marketplace?

You will be able to do things like:

- Check if you are eligible to get new health insurance – you can only enroll in a new health plan during open enrollment or during special times of the year;
- Compare health insurance plans for coverage and affordability;
- Enroll in or change from your current health insurance plan to a new one;
- Find out about tax credits for private insurance or health programs like Medicaid or the Children's Health Insurance Program (CHIP); and
- Get answers to questions about health care insurance.

What *is* the Health Insurance Marketplace?

What Else Should I Know about the Health Insurance Marketplace?

- **Pre-Existing Conditions:** You cannot be disqualified or charged more due to a pre-existing condition.
- **4 out of 5 people find plans for under $10 a month** with the financial help option. The amount you pay is determined by your annual household income, your household size, age, and where you live.
- **What's Covered?** By law, these include annual check ups, regular healthcare provider visits, specialists visits, hospitalizations, emergency room visits, and prescription drug coverage.

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Source: https://www.healthcare.gov/see-plans/#/ andwww.Healthcare.gov

What is Open Enrollment?

And What is the Special Enrollment Period?

What *is* the Health Insurance Marketplace?

What is Open Enrollment?

Did you know that you **cannot enroll in health insurance at just *any time*** during the year?

As nice as that might be, you can only get health insurance at certain times in the year. This can be done during either:

1. **Open Enrollment**, or
2. If you have a Qualifying Life Event, which entitles you to a "**Special Enrollment Period**".
   - The Special Enrollment Period allows you a limited time frame in which you able to enroll in new health insurance.

Remember: TIME MATTERS!

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What *is* the Health Insurance Marketplace?

When and *What* is Open Enrollment?

Open Enrollment is the window of time (time frame) in which you can change or enroll in a private health insurance, through the Health Insurance Marketplace.

- During this time frame, you can sign up for health insurance, adjust your current plan (i.e. change deductibles by going to a higher tier plan), or cancel your plan altogether.
- Open Enrollment is November 1-January 15

Enroll by December 15th → **Coverage starts January 1st**

Enroll by January 15th → **Coverage starts February 1st**

Source: https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/ and https://www.healthcare.gov/quick-guide/

What *is* the Health Insurance Marketplace?

What Happens if You Miss Open Enrollment?

Unfortunately, unless you qualify for a Special Enrollment Period, you will be out of luck.

- Unless you can qualify for Medicaid, Medicare, CHIP, ALTCS, or can be covered under someone else's insurance plan, such as your spouse or parent's, you will have to wait until the next open enrollment period.

This is why it is so important to take action and look at options while you can!

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Source: https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/ and https://www.healthcare.gov/quick-guide/

What *is* the Health Insurance Marketplace?

Special Situations

In a few, very limited situations, you may be able to qualify under a different special enrollment period, that is different from the typical qualifying events. Examples I

Examples include:

If you were facing a serious medical condition that prevented you from enrolling.

- Examples include, unexpected hospitalization or temporary cognitive disability. You will be required to submit documentation.

You were involved in either a natural disaster or other national or state-level emergency that kept you from enrolling on time.

- Examples include, residing within a county that is eligible to apply for “individual assistance” or “public assistance” by the Federal Emergency Management Agency (FEMA).
- In these events, you will be required to submit documentation.
- You will only have 60 days from the end of the FEMA-designated incident period to complete your enrollment in Marketplace coverage.

Source: https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/ and https://www.healthcare.gov/quick-guide/

What *is* the Health Insurance Marketplace?

What is a Special Enrollment Period?

A special enrollment period is a time frame, outside of the typical open enrollment time frame of November 1st to January 15th, where you can still enroll in a new health insurance, change your health insurance, or adjust or cancel your health insurance.

Think of a Special Enrollment Period as a new window of opportunity to enroll in health insurance.

Qualifying Events Vary → **Time Frame is Typically 60 Days**

Source: https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/ and https://www.healthcare.gov/quick-guide/

What *is* the Health Insurance Marketplace?

Qualifying Events

These are examples of what can 'trigger' eligibility for a Special Enrollment Period. Other events may qualify. Call the **Marketplace Call Center** with questions about qualifying events.

- **Becoming a Member of a Federally-Recognized Tribe**
- **Becoming Recognized as an Alaska Native Claims Settlement Act (ANCSA) Corporation Shareholder**
- **Becoming a United States Citizen**
- **Loss of Health Coverage**
- **Changes in Household**
- **Changes in Residence**
- **Leaving Incarceration**
- **Victim of Domestic Violence/Abuse**
- **Serving in AmeriCorps and began or/ended service in last 60 days**
- **Inability to Find an In-Network Provider Nearby**
- **Employer Offers to Help with Health Insurance Costs**
- **Misrepresentation from Health Plan – This is when someone is misinformed about important plan aspects**

Source: https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/ and https://www.healthcare.gov/quick-guide/

What *is* the Health Insurance Marketplace?

Qualifying Events: Changes in Household or Residence

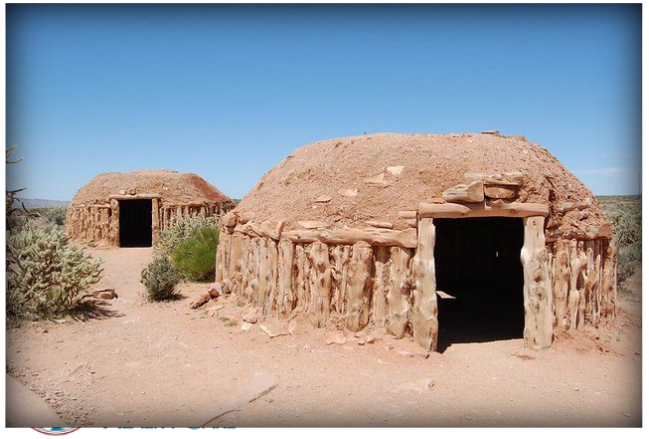
These are examples of what can 'trigger' eligibility for a Special Enrollment Period:

Changes in Household

- Marriage
- Having a baby, adopting a child, or foster care placement
- Divorce/Separation
- Death of Spouse

Changes in Residence:

- New home in a new ZIP code or county
- The U.S. from a foreign country or United States territory
- Place you attend school (if you're a student)
- Place you both live and work (if you're a seasonal worker)
- Shelter or other transitional housing



Source: https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/ and https://www.healthcare.gov/quick-guide/
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What *is* the Health Insurance Marketplace?

Qualifying Event: Employer Helps with Health Insurance

Loss of health coverage can result from a loss of job-based coverage, individual coverage, Medicaid/CHIP coverage, Medicare coverage, or coverage through a family member.

Employer Offers to Help with Health Insurance Costs

Job-Based Coverage

- Employers will sometimes change what options they offer their employees. You may qualify for a Special Enrollment Period if you (or anyone in your household) were offered an individual coverage HRA or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) within the past 60 days, or are expected to have this occur within the next 60 days.
- Please note that your employer may refer to an individual coverage HRA by a different name, like "ICHRA." Get details about offers for individual coverage HRAs and Qualified Small Employer HRAs.

What is an HRA?

- An HRA is a Health Reimbursement Arrangement (HRA), where an employer offers an employee a contract to reimburse medical expenses (like premiums, deductibles and copayments) instead of offering a traditional job-based health plan.

Source: https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/ and https://www.healthcare.gov/quick-guide/, https://www.healthcare.gov/job-based-help/ichra/, and https://www.healthcare.gov/job-based-help/qsehra/

What *is* the Health Insurance Marketplace?

Qualifying Event: Loss of Health Coverage

Loss of health coverage can result from a loss of job-based coverage, individual coverage, Medicaid/CHIP coverage, Medicare coverage, or coverage through a family member.

Loss of Health Coverage

Job-Based Coverage

- If you lose health coverage through your employer or the employer of a family member you qualify for a special enrollment period.
- If you lose health coverage through a parent or guardian because you're no longer a dependent or have aged out of their healthcare plan you also qualify for a special enrollment period.
- You do NOT qualify if you voluntarily elect to leave the health plan you were covered under.
  - The only time a voluntary election to leave the health insurance permits you to use a special enrollment period, would be if a sudden decrease in household income qualified you for savings on a Marketplace plan.

Individual Coverage

- Your individual plan or your Marketplace plan is discontinued (no longer exists).
- You lose eligibility for a student health plan.
- You lose eligibility for a plan because you no longer live in the plan's service area.
- Your individual or group health plan coverage year is ending in the middle of the calendar year and you choose not to renew it.
- Your household income decreased, and now you qualify for savings on a Marketplace plan.

Source: https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/ and https://www.healthcare.gov/quick-guide/

What *is* the Health Insurance Marketplace?

Qualifying Event: Loss of Health Coverage

Loss of health coverage can result from a loss of job-based coverage, individual coverage, Medicaid/CHIP coverage, Medicare coverage, or coverage through a family member.

Loss of Health Coverage

Other Coverage Situations

- You turn 26 (or the maximum dependent age allowed in your state) and can no longer be on a parent's plan.
- A family member loses health coverage or coverage for their dependents.
- A divorce or legal separation.
- The death of a family member.
- You're no longer a dependent.

Medicare Coverage

- If you lose a Premium-Free Medicare Part A plan, you can qualify for a special enrollment period.
  - You do not qualify for a special enrollment period if you lose your Medicare Part A, because you didn't pay your Medicare premium, or if you lose Medicare Parts B or D only

Source: https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/ and https://www.healthcare.gov/quick-guide/

What *is* the Health Insurance Marketplace?

Qualifying Event: Loss of Health Coverage

Loss of health coverage can result from a loss of job-based coverage, individual coverage, Medicaid/CHIP coverage, Medicare coverage, or coverage through a family member.

Loss of Health Coverage

Medicaid/CHIP Coverage

- Sometimes household income will change, and you and your family will no longer be eligible for Medicaid or the Children's Health Insurance Program (CHIP). If this occurs, you are eligible for the special enrollment period.
- If your family was removed from Medicaid or CHIP due to the return to regular renewals (verifying income for households) post Public Health Emergency, you are eligible for the special enrollment period.
- If your child ages out of the CHIP program, they are eligible for the special enrollment period.
- If you applied for Medicaid/CHIP or Marketplace coverage during Open Enrollment or with a different Special Enrollment Period and were told you might be eligible for Medicaid/CHIP, but were denied after Open Enrollment Period had ended, then you are eligible for a special enrollment period. You may be asked to provide documentation for this, such as the date of the denial for Medicaid/CHIP.

Source: https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/ and https://www.healthcare.gov/quick-guide/

What *is* the Health Insurance Marketplace?

Qualifying Event: Domestic Violence

There is guidance for individuals seeking coverage, who are victims of domestic violence.

DV/Abuse

Domestic Violence and Abuse

- It can be daunting to enter in information about your household when struggling in a domestic violence situation. The Health Insurance Marketplace has prepared specific instructions for victims of abuse to review, to help them in their health insurance journey.
  - https://www.healthcare.gov/income-and-household-information/household-size/#domesticabuse
- You can select “unmarried” on your application in these situations, even if you are still legally married. You can do this without fear of punishment or penalty for misrepresenting your marital status.

Source: https://www.healthcare.gov/income-and-household-information/household-size/#domesticabuse

Source: https://www.healthcare.gov/income-and-household-information/household-size/#domesticabuse

What *is* the Health Insurance Marketplace?

Qualifying Event: Domestic Violence

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DV/Abuse

Domestic Violence and Abuse

⊖ Do I have to file federal taxes and apply for insurance with my spouse if I'm a victim of domestic abuse, domestic violence, or spousal abandonment?

No, you don't have to file jointly — and you can still qualify for a premium tax credit and other savings.

If you're living apart from your spouse and are a victim of domestic abuse, domestic violence, or spousal abandonment and want to enroll in your own health plan separate from you abuser or abandoner, you can say you're "unmarried" on your Marketplace application without fear of penalty for mis-stating your marital status.

This will let you (and possibly your dependents) qualify for premium tax credits and other savings based on your income.

What *is* the Health Insurance Marketplace?

How Long Does a Special Enrollment Period Last?

Unfortunately, the answer is, ***it depends.***

- If you separated from your job, you have ***60 days*** from the date of separation to enroll in the Health Insurance Marketplace.
- If you were a part of a natural disaster, such as a flood or storm, you have ***60 days*** from the date of the event, and will have to show proof that you resided in the affected area on the day of the event.
- If you were told that you were eligible for Medicaid, so to apply for it, but were then later denied after Open Enrollment was over, then you have ***less than 90 days*** to apply.
- Some situations, such as domestic abuse situations, do not have a time frame. Just call as soon as possible.

The easiest way to determine how long you have for enrollment, is to call the Marketplace Call Center and say “Special Enrollment Period” when prompted to state the reason for your phone call.

The phone number is 1-800-318-2596

Important Terms to Know

Important Health Insurance Terms

Before you start shopping…it's important to know what you are looking at. In order to do so, it's important to understand some basic health insurance terms.

- Monthly Premium
- Copay
- Deductible
- Coinsurance
- Out-of-Pocket Max

Important Health Insurance Terms

What is a Premium?

Your premium is the amount of money you pay each month to your health insurance company, so that you can keep your health insurance coverage.

- Premium costs can vary *wildly* based on:
  - How many people are covered (1 person, a couple, or a family plan);
  - The location you are in;
  - Your age;
  - Whether or not you use tobacco; *and*
  - Your plan category (for example, if your plan has only a $500 a year deductible, the premium will cost more than that charged to those with a $2000 deductible).

Note: Your health history, like pre-existing conditions, and gender *cannot affect your premium.*

Source: https://www.healthcare.gov/see-plans/#/aptc

Important Health Insurance Terms

What is a Copay?

Sometimes you'll pay a small fee, called a copay or copayment, when you check out.

- Generally, copays are for doctor's office, urgent care and emergency room visits, and prescription drugs. But read your health plan details to be sure.
- Example copays can look like this:
  - PCP Visit: $20
  - Specialist Visit: $40
  - Urgent Care Visit: $60
  - ER Visit: $200
  - Hospitalization Daily Copay: $200 per day

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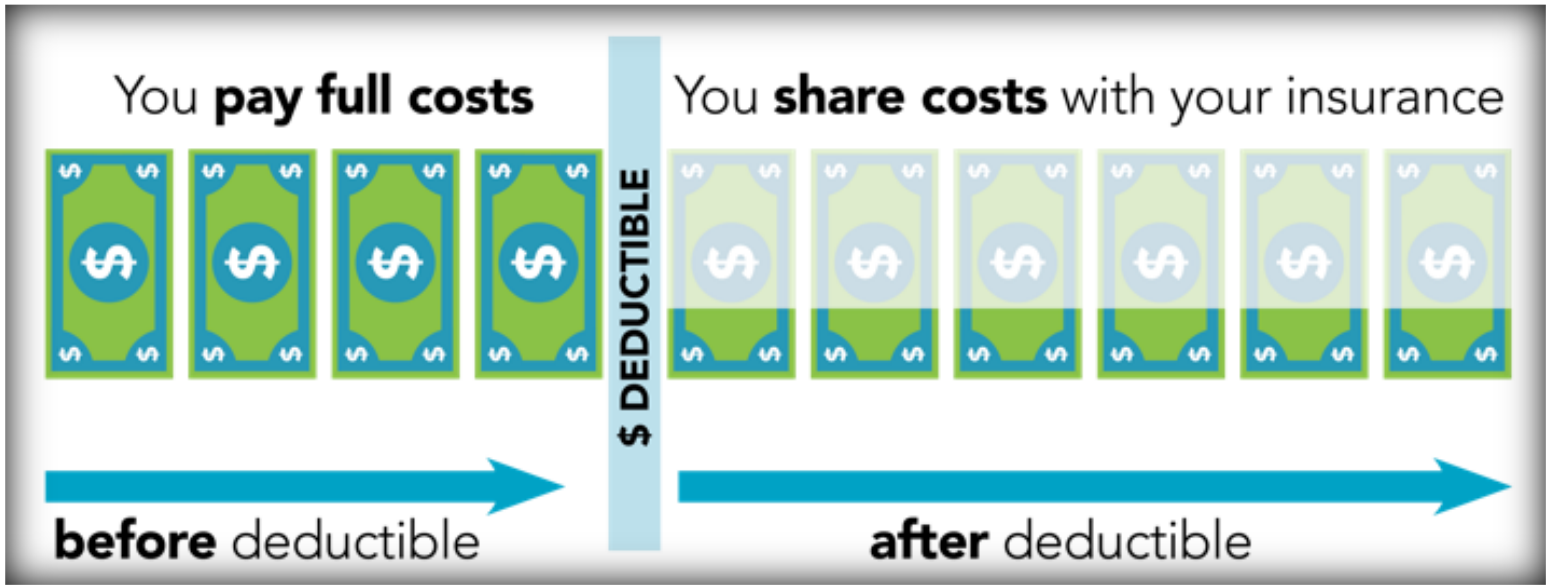
Source: https://www.healthcare.gov/see-plans/#/aptc

Important Health Insurance Terms

What is a Deductible?

A deductible is the amount you pay for covered health care services before your insurance plan starts to pay.

- For example, with a $2,000 deductible, you pay the first $2,000 of covered services yourself.
- After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest.
- Each year you'll pay your deductible. (Copays don't count toward paying your deductible.) You'll pay for any services or supplies not covered by a copay, when you check out, until you've met your deductible for the plan year.



Important Health Insurance Terms

What is Coinsurance?

This is where we get “fancy”.

(I’ll let you in on a secret…this is just another way of saying more complicated!!!)

The first thing you need to know…is that not all health insurances will have a coinsurance.

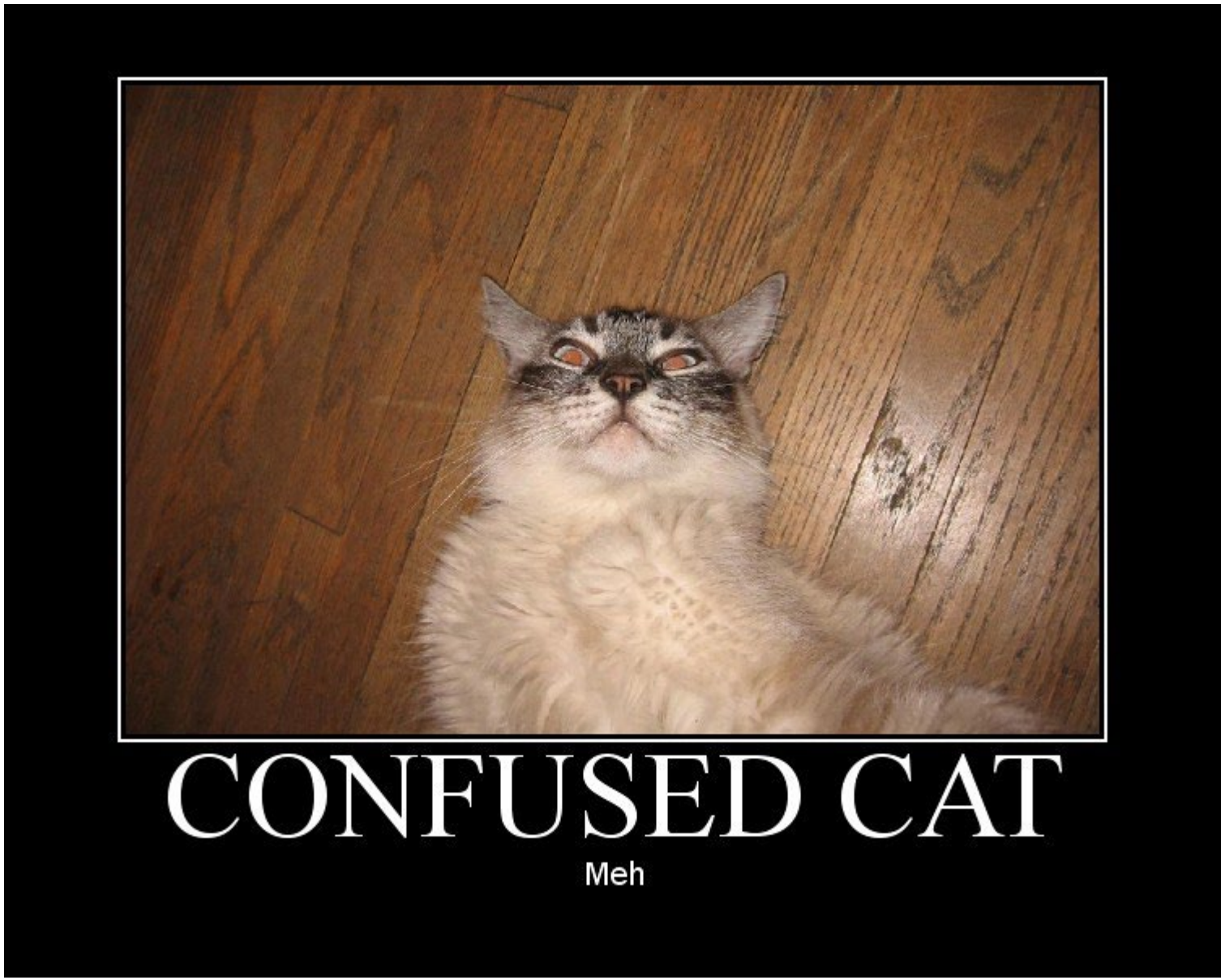
If you do have a Coinsurance, they are another type of **cost sharing payment** that you may have to make out-of-pocket when receiving certain health care services or medications.

- These are usually expressed in the form of a percentage.
  - For instance, let’s say you have a 10% coinsurance for a doctor’s visit that costs $100.
  - You will pay $10 for every $100 your insurance pays for a doctor’s visit.

Coinsurance kicks in *after you have paid your deductible.*

Source: https://www.healthcare.gov/see-plans/#/aptc

Important Health Insurance Terms



Important Health Insurance Terms

How Coinsurance Works

- You have a $1,500 deductible.
- You have a Max-OOP (see definition of Maximum Out-of-Pocket) of $7,500.
- Your coinsurance is 30%.
- You have paid $1,500 in health care expenses and met your deductible.
- The next time you go to the doctor, instead of paying all costs, you and your plan share the cost. So if your coinsurance is 30%, then you will pay for 30% of the costs of your doctor's visit, and your health insurance will pay for 70% of it. The 30% that you pay is your coinsurance.
- Once you have paid a total of $7,500 in health care costs *total* (the amount towards your deductible and all your coinsurance payments count) your health insurance will then pay 100% of your costs.

Important Health Insurance Terms

How Coinsurance Works with Medicare and Medicaid

- Medicaid is often responsible for paying the Medicare deductibles, copayments and *coinsurance* for Medicare-covered items and services.
- How this works can vary from plan-to-plan. We will cover this in a later training series specific to Medicare enrollment and plan specifics.
- For now, all you need to know is that sometimes Medicaid will cover these for Medicare plans. Coinsurance works for private health plans the Health Insurance Marketplace plans, the way outlined in the previous slide.
- See why the cat is so confused?

Important Health Insurance Terms

What is an Out-of-Pocket Max? (OOP Max?)

At some point in healthcare history, someone decided to be merciful and set a limit on the maximum amount of money that someone could possibly pay out of pocket. Prior to this, individuals could face hundreds of thousands of dollars in medical expenses if they were severely injured or fell badly ill.

Now, the OOP Max is the cap on how much you'll have to pay out of pocket for health care in one year.

Things to Know about the OOP Max:

After you reach this amount your insurer will pay for your covered care in full for the rest of the year!

- For the 2024 plan year, the OOP Max limit for a Marketplace Plan (private insurance purchased through the state or federal insurance marketplace) cannot be higher than $9,450 for an individual and $18,900 for a family. It can, however, be lower.
- For example, say you have purchased a plan that has a you have a $1,500 deductible, and a $7,500 out-of-pocket limit and you've met your $1,500 deductible, and paid $6,000 in other cost-sharing payments (like copays or coinsurances), then you have you've met your limit and your insurance company will pay for any covered care for the rest of the year.

Source: https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit

Important Health Insurance Terms

What is an Out-of-Pocket Max? (OOP Max?)

Affordable Care Act compliant plans require all major medical health insurance plans to have an annual out-of-pocket maximum for each beneficiary

- When shopping for an insurance plan, pay close attention to an OOP Max.

What counts towards your OOP Max?

- Copays
- Deductible
- Coinsurance

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The Affordable Care Act (ACA)

What is the Affordable Care Act (ACA)?

What is the Affordable Care Act?

The Affordable Care Act (ACA), also known as the Patient Protection and Affordable Care Act (PPACA) or Obamacare, is a comprehensive health insurance reform law, enacted in 2010, that increases health insurance coverage for the uninsured and implements reforms to the health insurance market.

The ACA changed things, by allowing those who were uninsured due to preexisting conditions or limited finances to secure affordable health plans through the health insurance marketplace in their state.

Source:
https://www.healthinsurance.org/glossary/essential-health-benefits/ and
https://www.healthinsurance.org/glossary/affordable-care-act/

What is the Affordable Care Act (ACA)?

What is the Affordable Care Act?

A radical change, and benefit, for people in the U.S. was that insurers were no longer legally able to ban someone from their health insurance due to a preexisting condition, or to charge them a premium (or an additional amount) for having one.

Prior to the ACA, many individuals with things like asthma, type II diabetes, or even minor heart arrythmias, could not get coverage.

- If they did get coverage, they were charged very large monthly premiums, that were almost impossible to paying many cases.
- Prior to the ACA, people who were uninsured would wind up in extreme debt, and would tragically suffer unnecessary medical complications or deaths due to fear of doctor's visits. Additionally, the U.S. number one reason for filing for bankruptcy prior to the ACA was due to medical debt!

But like all good things in life…there was a trade off. The trade off was to mandate that everyone buy health insurance or pay a monetary penalty. This trade off was how the ACA managed to pass through Congress.

Source: https://www.healthinsurance.org/glossary/essential-health-benefits/ and https://www.healthinsurance.org/glossary/affordable-care-act/

What is the Affordable Care Act (ACA)?

What is the ACA?

The ACA required health insurers to:

- Accept all applicants, regardless of pre-existing conditions;
- Accept all applicants without charging extra based on pre-existing conditions or demographic status (except for age). Prior to this, women of pregnancy age could be charged higher premiums;
- Cover a list of essential health benefits for all enrolled members of their health plan;
- Eliminate waiting periods that employer-sponsored plans previously were allowed to impose before covering pre-existing conditions (and imposed a 90-day cap on the allowable waiting period employers could require before offering new employees coverage at all);
- Eliminate lifetime and annual benefit maximum payments (from the health insurance, not the patient) for essential health benefits. Prior to the ACA, if someone was in a serious car accident, the cost of treatment could result in them 'maxing out their lifetime benefit' and then force the person to pay for all future health costs, since insurers were allowed to decline covering them!; and
- Cover preventative health care services at no cost to the patient (so no cost sharing – including no copays, deductibles, or coinsurance), if they wanted to be considered an ACA-compliant health plan.

Additionally, the ACA required that large employers offer affordable, minimum value health plans for Full-Time employees working 30 or more hours a week, or face a significant financial penalty.

Source: https://www.healthinsurance.org/glossary/essential-health-benefits/ and https://www.healthinsurance.org/glossary/affordable-care-act/

What is the Affordable Care Act (ACA)?

What are the 10 Essential Health Benefits Mandated by the ACA?

1. **Hospitalization**
2. **Ambulatory services** (visits to doctors and other healthcare professionals and outpatient hospital care)
3. **Emergency services**
4. **Maternity and newborn care**
5. **Mental health and substance abuse treatment**
6. **Prescription drugs** (including brand-name drugs and specialty drugs)
7. **Lab work**
8. **Preventive care services**
9. **Pediatric dental and vision care** (there is some flexibility on the inclusion of pediatric dental if the plan is purchased within the exchange)
10. **Rehabilitative and habilitative services**

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Source: https://www.healthinsurance.org/glossary/essential-health-benefits/ and https://www.healthinsurance.org/glossary/affordable-care-act/

What is the Affordable Care Act (ACA)?

A Note on Preventative Care

The services included under the preventative care provision are ones recommended by the U.S. Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the CDC's Advisory Committee on Immunization Practices (ACIP).

This includes things like:

- Contraception
- Blood pressure screening
- Breast cancer screening
- Breastfeeding counseling
- Colorectal cancer screening
- Obesity screening and counseling
- Tobacco use counseling and interventions
- Recommended Vaccinations

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Source: https://www.healthinsurance.org/glossary/essential-health-benefits/ and https://www.healthinsurance.org/glossary/affordable-care-act/

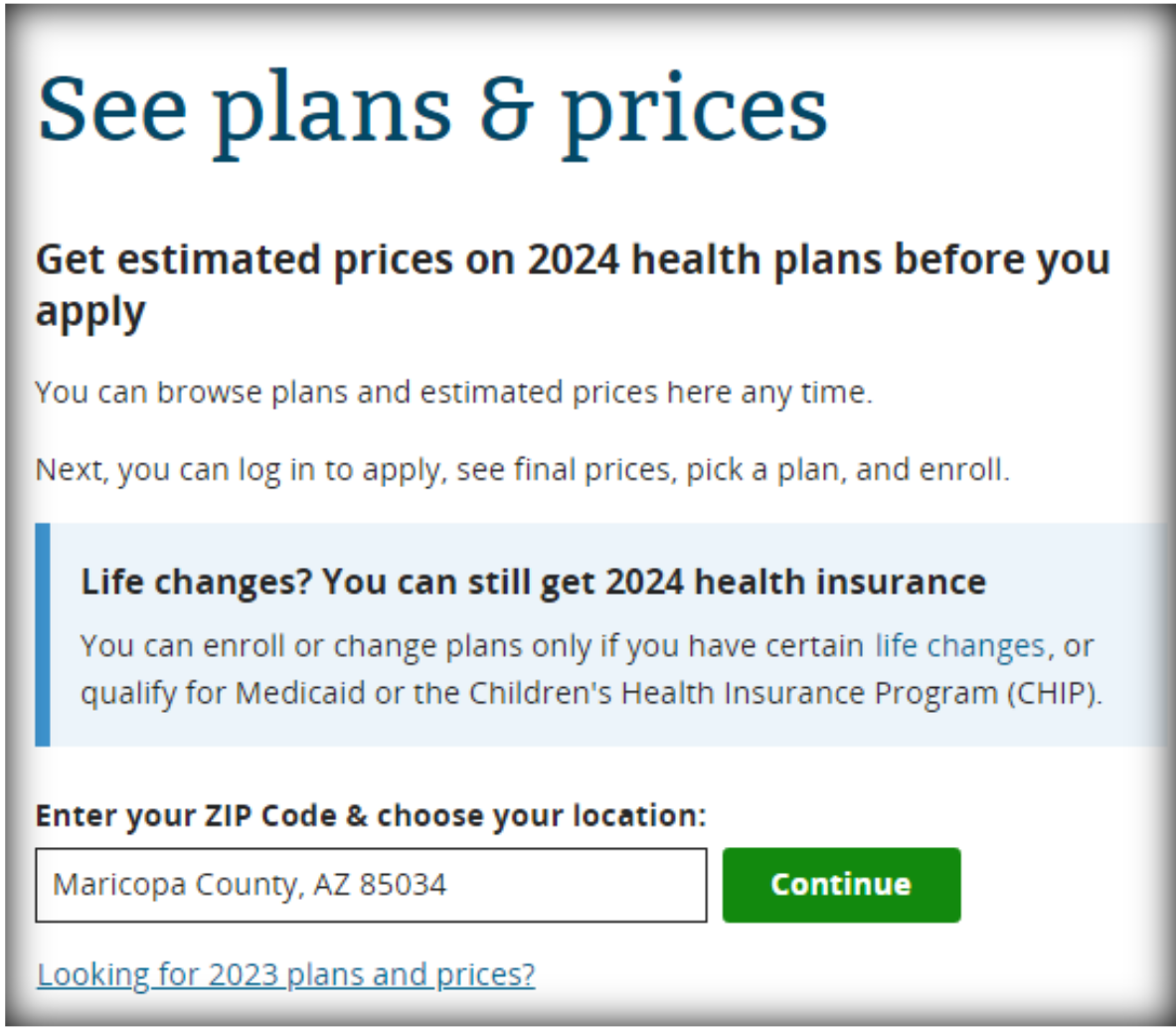
Browsing Possible Health Plans, Setting Up an Account, and Starting an Application

What *is* the Health Insurance Marketplace?

Prior to Applying, You May Want to Browse

Everyone likes to “window shop”

- To do so, go to https://www.healthcare.gov/see-plans/#/
- Enter in your Zip Code/Choose your Location
- Hit Continue
- You will then be prompted to enter in some basic information to help you ‘estimate’ your cost. But don’t worry! If you don’t want to enter that information in quite yet, you can skip it.



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Source: https://www.healthcare.gov/see-plans/#/aptc

What *is* the Health Insurance Marketplace?

Preview 2024 plans & prices

Answer a few questions to see plans and prices available in your area. Or, skip the questions and see full priced plans.

1 Enter your ZIP code

✔ Completed
Restart

You'll see plans available in the ZIP code you enter. If you change the ZIP code you'll restart your search.

2 Tell us about you & your household

Start

Answer questions about your current plan, household, and income to see more accurate prices and estimated savings.

- Your household
- Your household income
- View estimated savings

3 View health & dental plans

Optional

- Estimate your total yearly costs
- See if doctors, facilities, & drugs are covered

Source: https://www.healthcare.gov/see-plans/#/aptc

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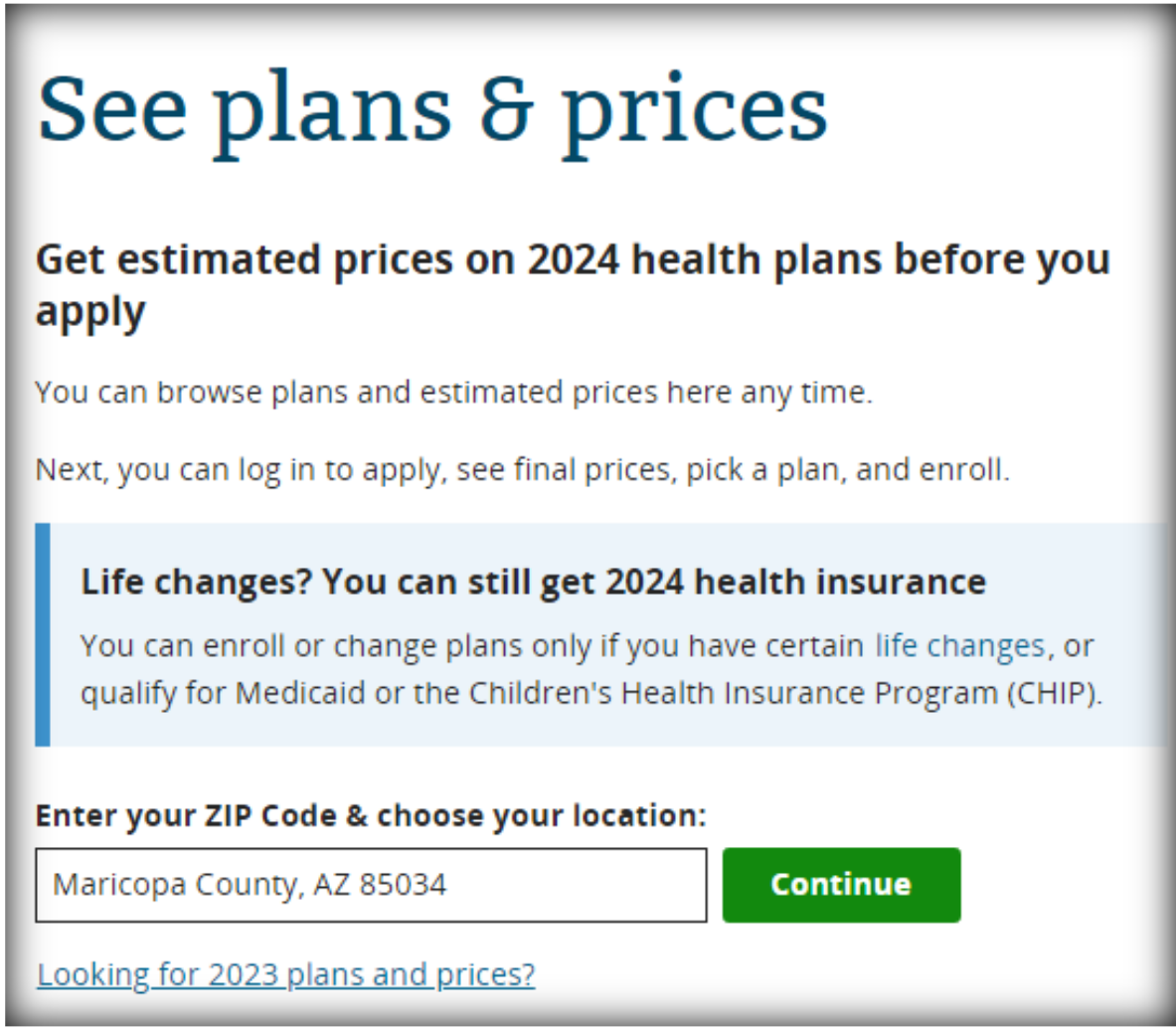
Prior to Applying, You May Want to Browse

Everyone likes to “window shop”

- To do so, go to https://www.healthcare.gov/see-plans/#/
- Enter in your Zip Code/Choose your Location
- Hit Continue
- You will then be prompted to enter in some basic information to help you ‘estimate’ your cost. But don’t worry! If you don’t want to enter that information in quite yet, you can skip it.



Arizona Advisory Council on Indian Health Care

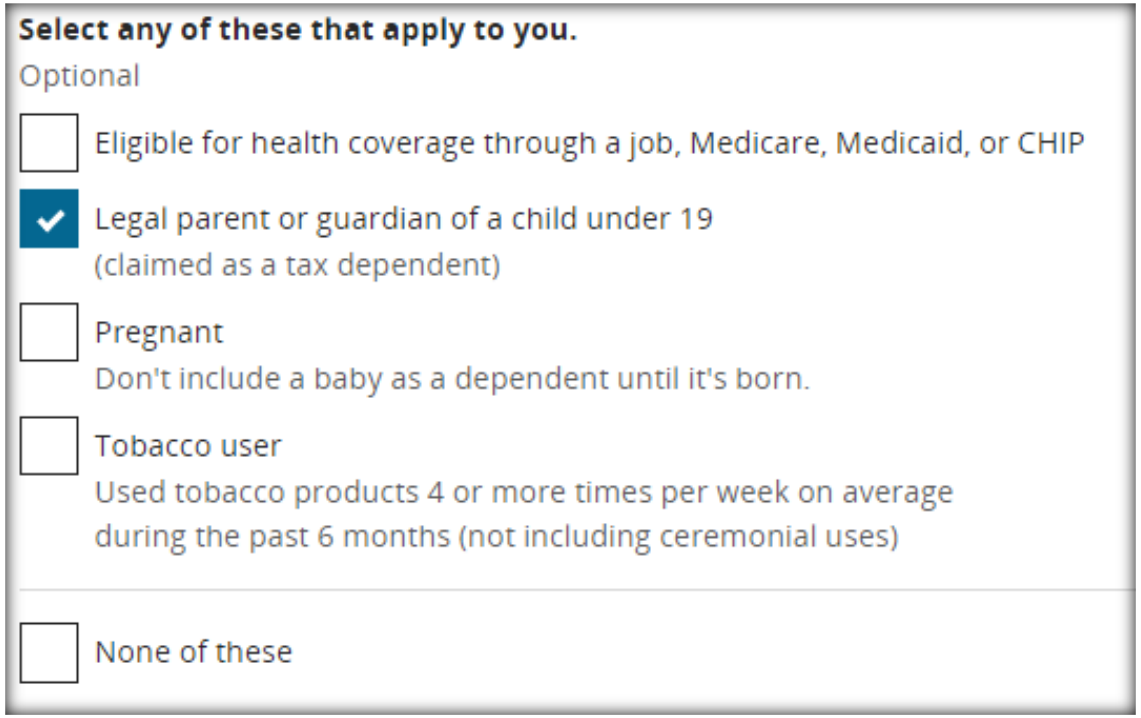
Source: https://www.healthcare.gov/see-plans/#/aptc

What *is* the Health Insurance Marketplace?

Prior to Applying, You May Want to Browse

If you do go through the questions, it will ask you for things like:

- Your martial status
- Whether or not you have dependents.
  - Dependents can be children or grandchildren or even nieces and nephews that you are financially responsible for.
- Your age
- Your sex
- Whether or not additional requirements apply to you, such as if you have health insurance through work, smoke, are pregnant, or a legal guardian of a child under 19.



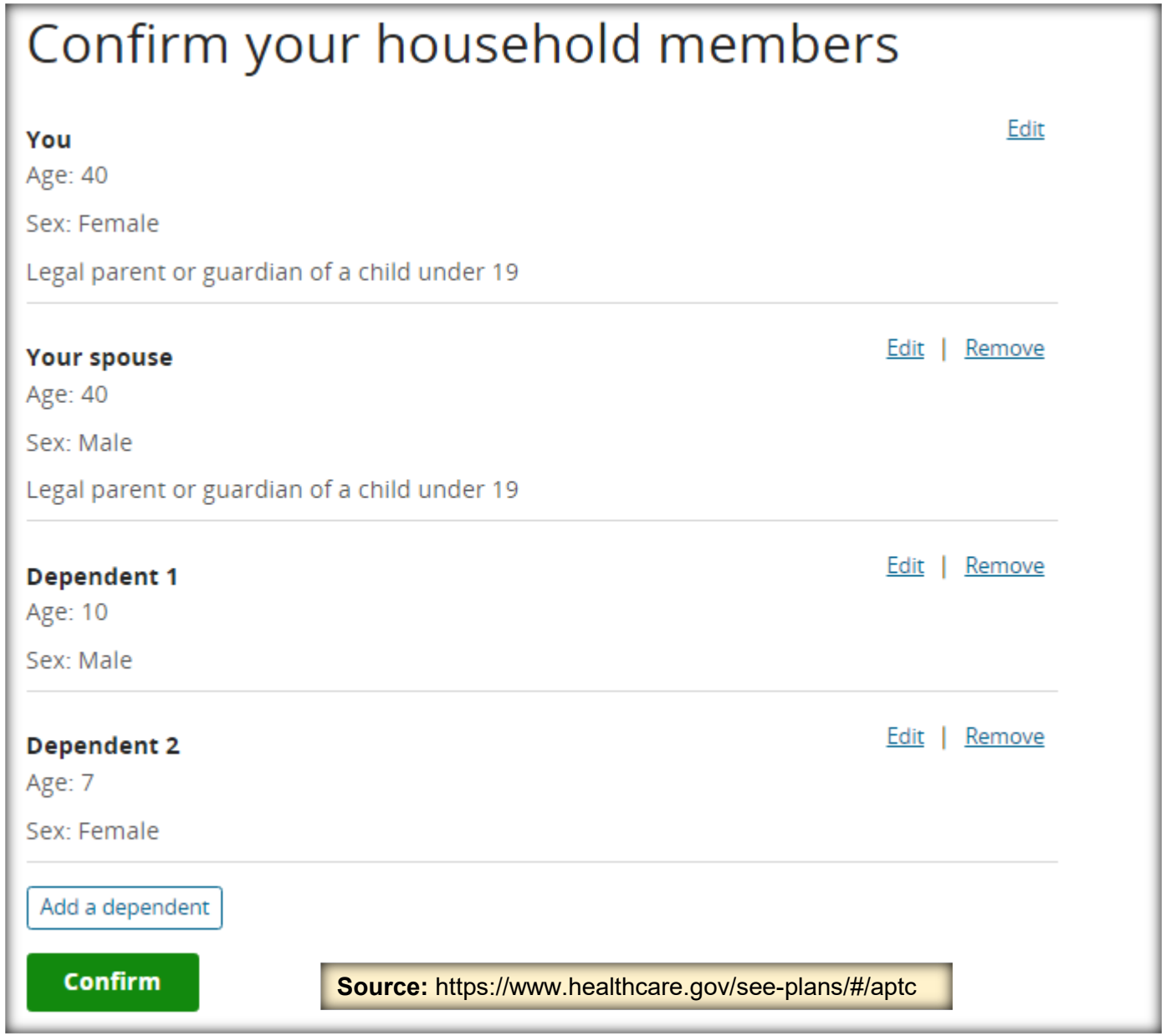
Source: https://www.healthcare.gov/see-plans/#/aptc

What *is* the Health Insurance Marketplace?

Prior to Applying, You May Want to Browse

It will ask you the same questions for other members of your household, including children.

- Once done, it will give you a summary of your responses.
- See our example family to the right.

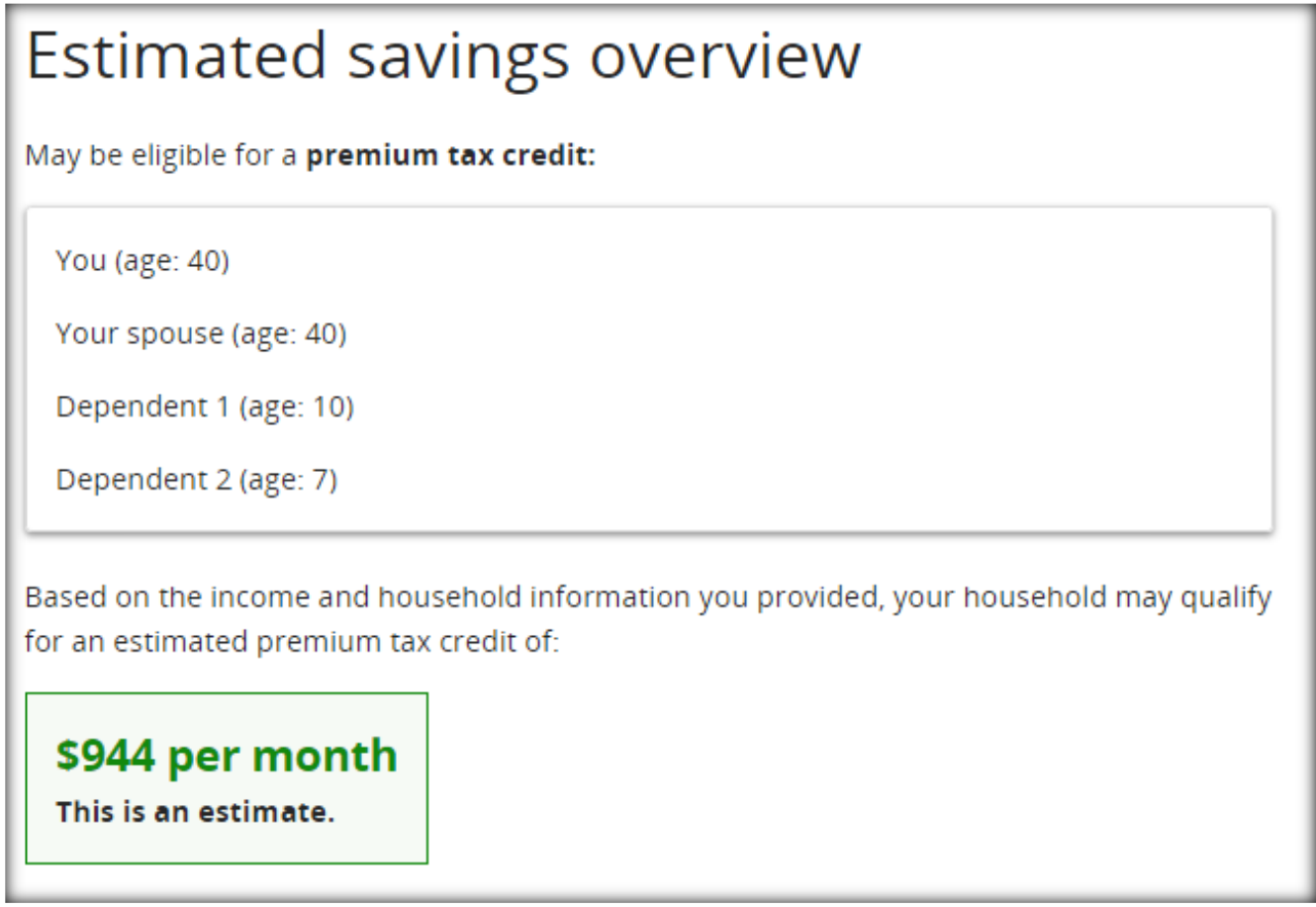


What *is* the Health Insurance Marketplace?

Prior to Applying, You May Want to Browse

The next screen will provide you the system's "best guess" as to whether or not you and your family will qualify for a premium tax credit.

- This will include the estimated amount per month.
- A premium tax credit is the amount you can use to lower your monthly premium each month. It's not the premium itself. When you view plans, the premium will be reduced by this amount.
- You'll get your exact premium tax credit amount when you complete an application.



Source: https://www.healthcare.gov/see-plans/#/aptc

What *is* the Health Insurance Marketplace?

Prior to Applying, You May Want to Browse

You will then be taken to the plans you qualify for, with estimated monthly premiums, based on the information you entered.

- You can search medical and dental plans, and do side-by-side comparisons of the estimated monthly premiums, deductibles, out-of-pocket maximums, and the estimated total yearly costs.
- You can even see how highly the plan is rated!

Source: https://www.healthcare.gov/see-plans/#/aptc

What *is* the Health Insurance Marketplace?

Source: https://www.healthcare.gov/see-plans/#/aptc

How to Apply?

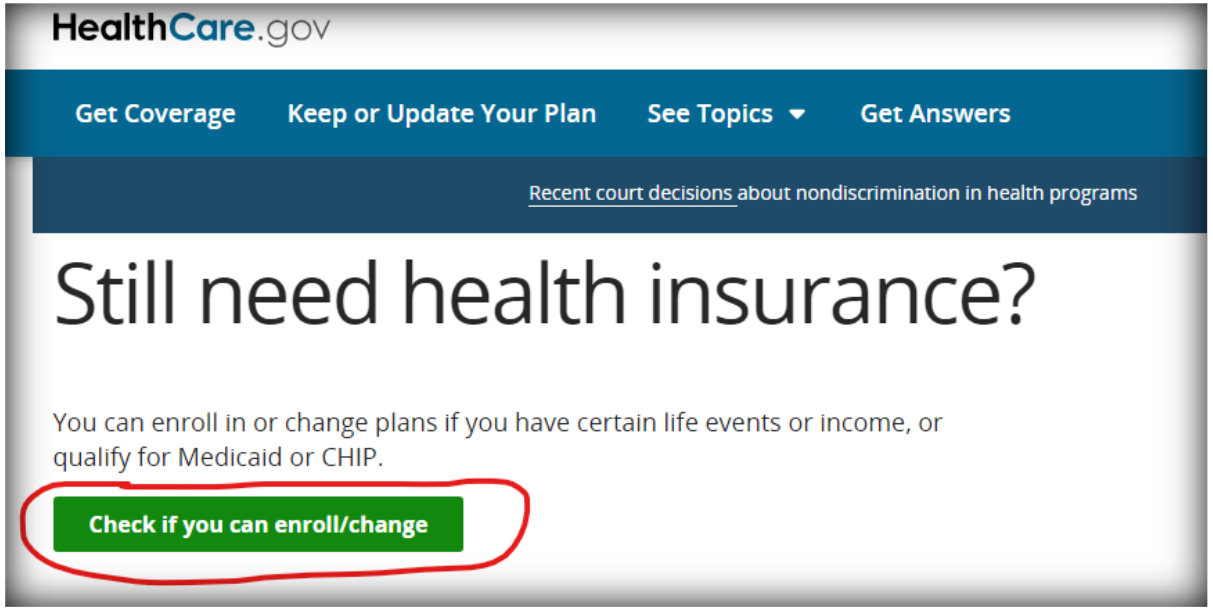
Time to Apply!

Ready to apply? Let’s get started!

What *is* the Health Insurance Marketplace?

How to Access the Health Insurance Marketplace

- Go to www.Healthcare.gov
- You can then choose a plan if it is either during the Open Enrollment Period, or if you qualify for a Special Enrollment Period.
- Click on “Check if You Can Enroll/Change”



- This will walk you through steps to see if you can enroll, and it will present you with your health insurance options.

How to Apply?

Step 1: Create an Account

How to Apply?

Step 2: Verify Your Email Address

Verify your email address

Your account information has been saved!

Verify your email address to finish creating your account

We sent an email to [redacted]
You should get the email within a few minutes.

Select the button in the email to verify your email address. Once you verify your email address, you can log into your account.

Didn't get the email?
Make sure you entered the correct email address, and check your spam or junk folder.

Still can't find it? **Request to re-send your email verification.**

Need help?
Get troubleshooting tips
Call the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

How to Apply?

Step 2: Verify Your Email Address

HealthCare.gov

Thanks for taking the first step toward getting health coverage!

To finish creating your HealthCare.gov account, verify your email address now.

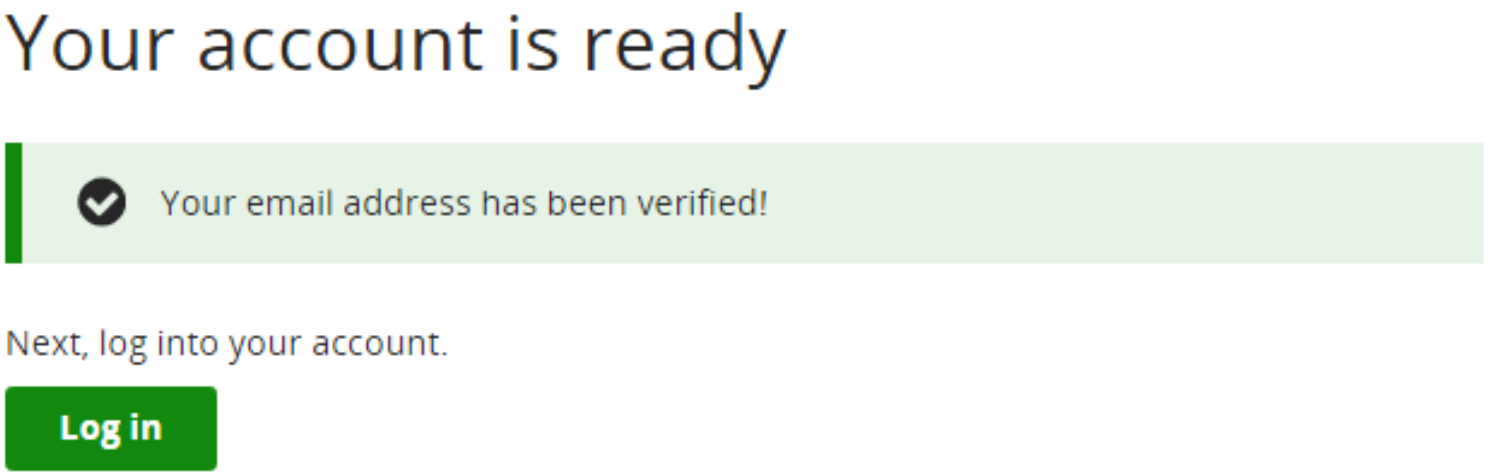
Verify my email address

The Health Insurance Marketplace

This email was created and distributed by the Centers for Medicare & Medicaid Services. To stop receiving important messages and reminders about your application or health coverage, log in to your Marketplace account and visit the Communications Preferences page.

How to Apply?

Step 2: Verify Your Email Address



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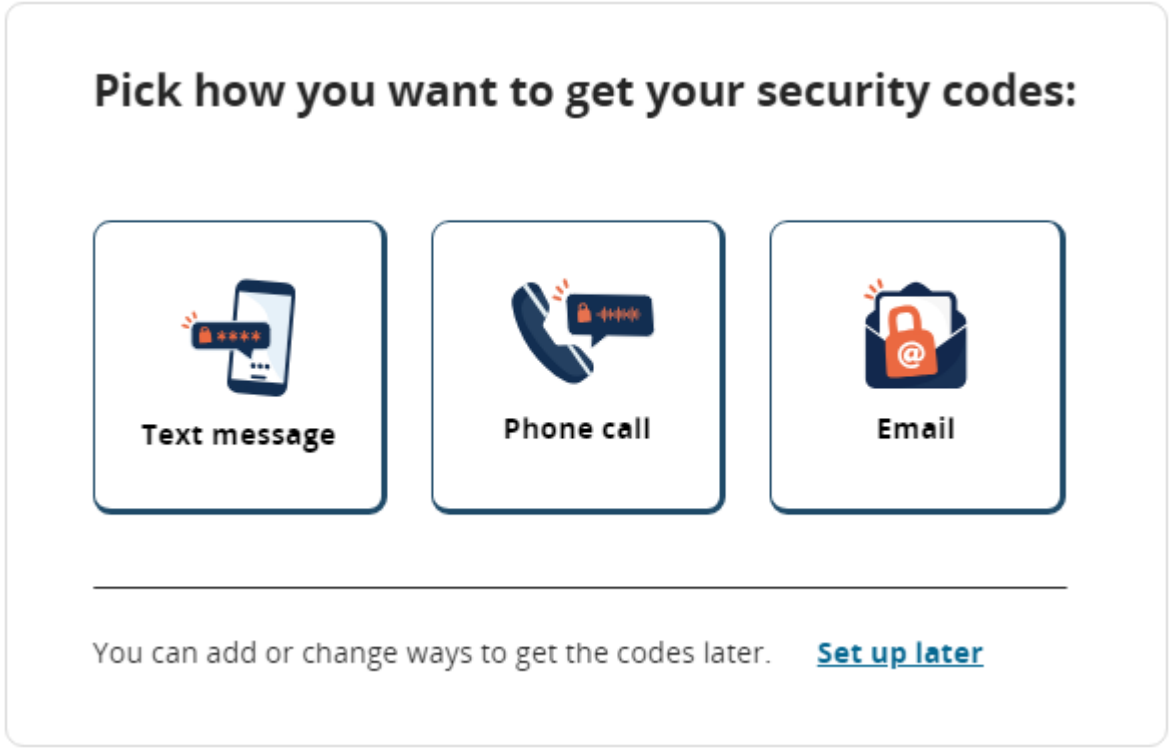
How to Apply?

Step 3: Login and Set Security Code Preference

You will then need to login, and be prompted to set up a security code via either phone or email. Set this up and then move forward. You can also skip and do this later.



How to Apply?

Step 4: Start Your Application

Gather everything you need for the application process. You can find a list here:

- https://www.healthcare.gov/downloads/apply-for-or-renew-coverage.pdf

You will need things like:

- Your personal information like name and date of birth
- Similar information for everyone in your household, like spouse, children, etc.
- Home and mailing addresses for everyone on the application
- Social Security Numbers for all people on the application
- Information on the person helping you apply if you have assistor on this
- Immigration Documentation (if applicable)
- Tax Information and estimate of total household income
- Employer income and information for everyone in the household
- Current health insurance information for each person in household
- If you have an HRA

Step 4: Start Your Application - Once logged in, you can then begin the application process. Scroll down slightly, select your state, and hit ‘start application’.

How to Apply?

Once Your Application is Complete

You will be presented with your health insurance plan options and the anticipated costs.

Health Care and Indigenous Peoples

What *is* Health Insurance?

Health insurance is a contract between you and a health insurance company.

- The health insurer can be a private plan, or something like Medicaid or Medicare.

This contract requires your health insurer to pay some or all of your health care costs, in exchange for a monthly fee, called a premium.

- Health insurance protects you from having to pay ***high bills for health care*.**

Examples of Health Insurance				
Aetna	Anthem	Cigna	Blue Cross Blue Shield	Care1st Health Plan
Arizona Health Care Cost Containment System or AHCCCS (Medicaid in Arizona)	American Indian Health Plan (AIHP) (Medicaid Fee-for-Service health plan in Arizona)	Arizona Long Term Care System (ALTCS) and Tribal ALTCS	Centene (e.g. multiple plans, but one is Arizona Complete Health)	Banner-University Family Care
Blue Cross Blue Shield Health Choice	Highmark	Kaiser Permanent	Medical Mutual	Medicare (various types and Advantage plans)
Mercy Care	Molina Healthcare	United Healthcare Community Plan	WellCare Health	

Do I *Need* Health Insurance as an American Indian/Alaska Native (AI/AN)?

There is a difference between federal government funding of health care facilities that provide healthcare to American Indians and Alaska Natives (AI/ANs) and health insurance.

- As an American Indian or Alaska Native, you can always receive services at an I/T/U (IHS, Tribally-owned and operated 638 facility, or Urban Indian Health Program), typically free of charge.

However, health insurance is still very important for several reasons.

- If you are not near an I/T/U, health insurance is ***extremely important***, because if you become sick or have an accident and need to use the healthcare system outside of I/T/U's, if you **do not have health insurance**, then you are responsible for paying for the costs of care, out-of-pocket. These costs can quickly add up, and be very pricey.

Health insurance covers many things that Indian health care programs do not provide. Some examples include:

- Certain Specialists,
- Getting covered services without IHS Purchase Referred Care Authorization, and
- Getting health care when you are away from home.

Health Insurance is a safety net.

Do I *Need* Health Insurance as an American Indian/Alaska Native (AI/AN)?

While it is true, that if you receive services through an I/T/U, you do not pay for your health care treatment, many Tribal lands are located in extremely rural areas. This means that many healthcare facilities may refer patients out to larger facilities, due to a lack of resources and specialty staffing. The service that you may require, may not be available.

So, while there are no deductibles, coinsurance, or copayments for covered services provided directly at an I/T/U or when referred to non-Indian health providers under the IHS Purchased/Referred Care (PRC) program, there are instances when this will not be an option.

This is why it is extremely important for AI/AN individuals to understand, if they are eligible for Medicaid they should enroll.

AI/AN individuals should also understand what options they have when being enrolled.

High Level Overview of Medicaid and Medicare

Medicaid and Medicare

When shopping on the Health Insurance Marketplace, it's important to know whether or not you have other options. Understanding what Medicaid and Medicare are, and having a general idea of whether or not you and your family may qualify, can help you as you search for health insurance.

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Medicaid and Medicare

What is the Difference Between Medicaid and Medicare?

Although similar in name, the Medicare and Medicaid programs vary in the health services they provide, and the populations to which they are provided.

Medicare

- At a glance, Medicare primarily serves older adults over 65 and individuals with disabilities.
- As with private insurance, beneficiaries pay deductibles, coinsurance, and monthly premiums.
- There are several Medicare plans to choose from, including Original Medicare and Medicare Advantage Plans.

Medicaid

- Medicaid is a State medical assistance program for low-income individuals and families. The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid agency, and Medicaid within the State is often referred to as "AHCCCS."
- AHCCCS provides medical insurance coverage to more than 2 million Arizonans each year and partners with the Department of Economic Services (DES) who manages the Medicaid application process through HEA-Plus

Qualifying for Medicare

How Do You Qualify for Medicare?

You need to be either:

- 65 years of age and older, *or*
- If younger than 65, have:
  - A qualifying disability; *or*
  - End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant); *or*
  - ALS (also called Lou Gehrig's disease or amyotrophic lateral sclerosis).

Qualifying for Medicaid

How Do You Qualify for Medicaid?

To participate in Medicaid, federal law requires states to cover certain groups of individuals.

- Low-income families, qualified pregnant women and children, and individuals receiving Supplemental Security Income (SSI) are examples of mandatory eligibility groups.

States have additional options for coverage and may choose to cover other groups, such as individuals receiving home and community-based services and children in foster care who are not otherwise eligible.

Source:
https://www.azahcccs.gov/Members/GetCovered/Categories/adults.html

Qualifying for Medicaid

How Do You Qualify for Medicaid?

Some States are considered Medicaid-expansion States. Arizona is one of them.

- This means that you can qualify for Medicaid services, if your income is at or below:
  - 1 person (individual): $20,040
  - 2 people (couple): $27,192
  - 3 people (family): $34,344
  - 4 people (family): $41,496
  - 5 people (family): $55,824

Household Size	Gross Monthly Income Limit Effective 02/01/2024
1	$1,670
2	$2,266
3	$2,862
4	$3,458
5	$4,055
Each additional person $597*	

Arizona Advisory Council on Indian Health Care

Source:
https://www.azahcccs.gov/Members/GetCovered/Categories/adults.html

Medicare: What is it?

Medicare Explained

Medicare is a federal health insurance program that provides health insurance for people 65 years of age and older, and some younger people who have specific disabilities, and people with End-State Renal Disease.

- You may hear Medicare referred to as Part A, Part B, Part C, or Part D.

This can be confusing, because it is.

First, what are the different PARTS?

- **Part A:** Covers Inpatient hospitalization, skilled nursing, hospice and home health care services.
- **Part B:** This is called your "Medical Insurance" (sometimes referred to as "Physician Services"). Part B covers things like doctor office visits, lab tests, MRI's, outpatient surgery, and so on
- **Part C (Medicare Advantage):** This is a way to receive your Part A (hospital), Part B (medical), and in many cases Part D (pharmacy drug coverage) all in one convenient plan
- **Part D:** Covers prescription drugs (medications) that you pick up at a pharmacy. There are only two ways to get Part D coverage.

People who qualify for Medicare have TWO enrollment options.

Medicare Enrollment Options

Option 1 (Parts A & B + Part D + Medicare Supplement Plan)

What is it?:

- Think of Option 1 as an *a la carte* menu. You get typical Medicare (Parts A and B), but you also need to choose a Medicare Supplement Plan to supplement the health care costs not covered by Medicare. You will also need to choose Part D for your prescription coverage.
- Some people mistakenly think that Medicare Supplement Plans offer benefits beyond what Medicare covers. This is not true. If Medicare covers a procedure or service, then a Medicare supplement plan will cover the same procedure or service - paying the portion that you are responsible for up to plan limits. Medicare supplement plans are standardized, meaning they offer the same benefits and provider choices regardless of the insurance company.

Plan Names:

- Parts A & B, plus Part D, plus a Medicare Supplement Plan

Network Restrictions?:

- ***NO!*** These plans typically ***DO NOT*** have network restrictions. You can use the insurance anywhere in the U.S. that you travel.

Referrals Required?: Typically no.

Premium Cost Comparison:

- Medicare Supplement Plan premiums are typically higher than Medicare Advantage plans. The premiums also typically increase as you get older.

Any Extra Benefits?: *NO.* By putting your own “plan options” you sacrifice perks for a wider network of providers.

Medicare Enrollment Options

Option 2 (Medicare Advantage Plan/Part C)

What is it?:

- You can choose a private insurance company who will manage your Medicare benefits for you.

Plan Names:

- This is called a ***Medicare Advantage Plan***. It is also called ***Part C.***

Network Restrictions?:

- ***YES!*** These plans typically ***DO*** have network restrictions. You have to stay within the Provider Network set up by your Medicare Advantage Plan.

Referrals Required?: It depends on the insurance provider you choose.

Premium Cost Comparison:

- Cheaper than a Medicare Supplement Plan. Premiums tend to remain the same even as you age.

Any Extra Benefits?:

- ***YES!*** Some Medicare Advantage Plans include extra perks, such as dental, vision, chiropractic and acupuncture coverage. Things like free gym memberships (to keep subscribers active and help in the prevention of chronic diseases that are preventable by a good lifestyle) and free transportation to and from the doctors may also be included.

Wrap Up

Takeaways

The Affordable Care Act has opened up the health insurance options that we have, by creating the Health Insurance Marketplace, allowing us to have 10 Essential Benefits for all health plans, and preventing previously excluded groups from being either excluded, or charged premiums for health insurance.

Understanding how to navigate the Health Insurance Marketplace, and understanding the health insurance options for you and your family, can help ensure that you have the best and most affordable health insurance possible.

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Resources

Resources

AHCCCS:

- https://www.azahcccs.gov/Members/GetCovered/Categories/adults.html

Health Insurance Glossary:

- https://www.healthinsurance.org/glossary/essential-health-benefits/
- https://www.healthinsurance.org/glossary/affordable-care-act/

Health and Human Services (HHS) Resources:

- https://www.hhs.gov/answers/health-insurance-reform/what-is-the-health-insurance-marketplace/index.html

Resources

Healthcare.Gov Resources:

- www.Healthcare.gov
- https://www.healthcare.gov/see-plans/#/
- https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit
- https://www.healthcare.gov/quick-guide
- https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/
- https://www.healthcare.gov/job-based-help/ichra/
- https://www.healthcare.gov/job-based-help/qsehra/

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Thank You!