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Key facts and definitions for applicants eligible for a Qualified Health Plan

Important dates for 2016 enrollment:

- **November 1, 2015:** Open Enrollment starts — first day you can enroll in a 2016 Marketplace plan
- **December 15, 2015:** Deadline to apply for coverage to start January 1, 2016
- **January 1, 2016:** First date 2016 coverage can start
- **January 31, 2016:** 2016 Open Enrollment ends

What are QHP, APTC, and CSR?

Qualified Health Plan (QHP)

Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

Source: https://www.healthcare.gov/glossary/qualified-health-plan/

Insurance plans can differ by the providers you see and how much you have to pay. Ask them for a Summary of Benefits and Coverage document that summarizes the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

Source: https://marketplace.cms.gov/outreach-and-education/downloads/c2c-roadmap.pdf

Advanced Premium Tax Credits (APTC)

A tax credit that can help you afford coverage bought through the Marketplace. Sometimes known as APTC, “advance payments of the premium tax credit,” or premium tax credit. Unlike tax credits you claim when you file your taxes, these tax credits can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance credit payments to apply to your premiums each month, up to a maximum amount. If the amount of advance credit payments you get for the year is less than the tax credit you're due, you'll get the difference as a refundable credit when you file your federal income tax return. **If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.**

TIP

You can apply part or all of this tax credit each month to your premium payments. The Marketplace will send your tax credit directly to your insurance company, so you pay less for your premiums each month. This is called “advance payment of the premium tax credit.

Source: https://www.healthcare.gov/glossary/advanced-premium-tax-credit/

Cost Sharing Reduction (CSR)

A discount that lowers the amount you have to pay out-of-pocket for deductibles, coinsurance, and copayments. You can get this reduction if you get health insurance through the Marketplace, your income is below a certain level, and you choose a health plan from the **Silver** plan category. If you're a member of a federally recognized tribe, you may qualify for additional cost-sharing benefits.

If you're a member of a federally recognized tribe or an Alaska Native Claims Settlement Act (ANCSA) Corporation shareholder, you may qualify for additional cost-sharing reductions.

Source: https://www.healthcare.gov/glossary/cost-sharing-reduction/

There are several important things to consider when you compare Marketplace plans.

Monthly Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you get the service. The amount can vary by the type of covered health care service.

Deductible

The amount you owe for covered health care services before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Out-of-pocket maximum/limit

The most you pay during a policy period (usually one year) before your health insurance or plan starts to pay 100% for covered essential health benefits. This limit must include deductibles, coinsurance, copayments, or similar charges and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This limit does not have to count premiums, balance billing amounts for non-network providers and other out-of-network cost-sharing, or spending for non-essential health benefits.

> The maximum out-of-pocket cost limit for any individual Marketplace plan for 2015 can be no more than $6,600 for an individual plan and $13,200 for a family plan.
>
> *The maximum out-of-pocket cost limit for any individual Marketplace plan for 2016 can be no more than $6,850 for an individual plan and $13,700 for a family plan.

Type of insurance plan and provider network

Some types of plans allow you to see almost any doctor or health care facility. Others limit your choices to a network of doctors and facilities, or require you to pay more if you use providers outside the network.

Benefits

All plans sold through the Marketplace provide the same essential health benefits and cover pre-existing conditions and offer free preventive services. But some plans offer additional benefits.

Plan Category

There are 5 categories of Marketplace insurance plans: Bronze, Silver, Gold, Platinum, and Catastrophic. Plans in these categories differ based on how you and the plan share the costs of your care. The categories have nothing to do with the amount or quality of care you get.

Platinum Plans cover 90% of expected costs.

Gold Plans cover 80% of expected costs.

Silver Plans cover 70% of expected costs.

Bronze Plans cover 60% of expected costs.

Source: https://www.healthcare.gov/choose-a-plan/comparing-plans/

The questions below can help you better understand your coverage and what you will pay when you get health care. If you don't know the answers to these questions, contact your insurance plan or state Medicaid agency.

- How much will I have to pay for a primary care visit? A specialty visit? A mental/behavioral health visit?
- Would I have to pay a different amount if I see an "in-network" or "out-of-network" provider?
- How much do I have to pay for prescription medicine?
- Are there limits on the number of visits to a provider, like a behavioral health provider or physical therapist?
- How much will it cost me to go to the Emergency Room if it's not an emergency?
- What is my deductible?
- Do I need a referral to see a specialist?
- What services are not covered by my plan?

Source: https://marketplace.cms.gov/outreach-and-education/downloads/c2c-roadmap.pdf

Find an Expert in Your Area

Find a local certified insurance agent or community partner who can help you with the enrollment process. Help is free and can be offered in person or by phone.

Insurance agents can give advice about which plans may be best for you and help you enroll. Community partners can help you enroll, but they **cannot** give advice about plans.

Source: http://www.oregonhealthcare.gov/get-help-2.html

*Source: www.cms.gov Chapter 11: Actuarial Value Calculator Page 11-14

https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Chapter11ActuarialValueCalculator-Ver1-3-5-2015.pdf