Frequently Asked Questions about the Health Marketplace

The health insurance Marketplaces (which are also called the Exchange) opened January 1, 2014. Most Americans are eligible to enroll in the Marketplace, and many are eligible for assistance in paying the premium.

States differ on whether they run the Marketplace themselves. As of July 2019, there are five state-run Marketplaces using the federal website, eleven state-run Marketplaces plus Washington D.C., six federally facilitated Marketplaces where the state conducts plan management, and 28 federally facilitated Marketplaces. See the KFF State Health Insurance Marketplace Types, 2019 for updates on state action on health marketplaces.

Enrolling in the Marketplace

Q1. When is open enrollment for the Marketplace?

A1. The first open enrollment period was October 1, 2013 through March 31, 2014.

Open enrollment for 2016 health coverage ended on January 31, 2016. Open enrollment for 2017 began on November 1, 2016, and ended on January 31, 2017.

Open enrollment for 2018 began on November 1, 2017, and ended on December 15, 2017. For benefit years beginning on January 1, 2019, and beyond, the annual open enrollment period begins on November 1 and extends through December 15 of the calendar year preceding the benefit year.

Q2. May a person who misses open enrollment enroll in a Marketplace plan mid-year?

A2. Mid-year enrollments will only be allowed if the person has a special enrollment event. The person must request coverage within 60 days[1] after the triggering event. Special enrollment events include:

- Marriage, divorce/separation (with loss of coverage), birth, adoption, placement for adoption, or placement in foster care, death
- Loss of eligibility for minimum essential coverage
- Becoming eligible or ineligible for the premium subsidy or cost-sharing subsidies
- Moving into a new Marketplace region

- Becoming eligible for Marketplace coverage as a result of becoming a citizen, national, or lawfully present individual
- Exhaustion of COBRA continuation coverage

Q3. May a person in a Marketplace plan voluntarily terminate Marketplace coverage during the year?

A3. Yes. A person may drop Marketplace coverage during the year with 14 days' notice.

Q4. Who may enroll in the Marketplace?

A4. All U.S. citizens, nationals and others who are lawfully present (for example, in the U.S. on a visa) may enroll in the Marketplace. People who are eligible for Medicaid or CHIP will be enrolled in those programs, rather the Marketplace coverage, however.

Q5. May a person who is eligible for Medicare enroll in the Marketplace?

A5. Yes, but a person may not have both Medicare and Marketplace coverage.

Q6. May a person enroll in both employer and Marketplace coverage?

A6. Yes. Coordination of benefits would be based on the terms of the plans. (Marketplace policies are considered individual policies unless provided through a Small Business Health Options Program (SHOP) Marketplace.)

Eligibility for Premium Subsidies

Q7. Who is eligible for a premium subsidy?

A7. A person is eligible for a premium subsidy if the person meets all of these requirements:

- Purchases coverage through the government Marketplace
- Has a household modified adjusted gross income between 100% or 133% (depending on their state) and 400% of Federal Poverty Level (FPL)
- Is not eligible for minimum essential medical coverage through a government program such as Medicare, Medicaid, or CHIP or through employer-provided coverage that both is minimum value[2] and affordable (less than 9.5% of household income, indexed each year)
- Has not purchased employer-provided coverage (regardless whether it is affordable and minimum value)
- Is a U.S. citizen, national or alien lawfully present in the U.S. (for example, on a visa)
- Is not eligible to be claimed as another person's tax dependent
- Files a tax return (if married, a joint return normally must be filed)

Q8. How does a person apply for a premium subsidy?

A8. A person who applies for Marketplace coverage will be screened for possible eligibility for the premium subsidy (or Medicaid). If the person may be eligible for a subsidy, the person will complete an application that includes information about income and access to affordable, minimum value coverage through an employer. The Marketplace will contact the employer to verify that the

employee's information is accurate. Employers are encouraged, but not required, to respond to these verification requests.

Determining the Premium Subsidy Amount

Q9. How large is the premium subsidy?

A9. The amount of the premium subsidy depends on the person's household income. The percentage of income a person will be expected to pay for coverage ranges from about 2% for someone whose income is 100% of FPL (133% of FPL if the person's state has expanded Medicaid eligibility) to about 9.5% for someone whose income is 300% to 400% of FPL. Basically, the Marketplace will look at how much a specific silver (70% value) plan costs in the Marketplace and determine how much of that cost the person should pay based on their income.

Q10. What is Federal Poverty Level?

A10. For 2019, the Federal Poverty Level (FPL) in the 48 contiguous states and Washington D.C., is $12,490 for a single household and $25,750 for a household of four. It is $15,600 and $32,190 in Alaska, and $14,380 and $29,6200 in Hawaii.

Q11. How is household income determined?

A11. Household income essentially is the modified adjusted gross income, plus Social Security and investment income, of everyone listed as a spouse or dependent on the person's tax return.

Q12. How are adult children handled?

A12. Tax filing status controls. This means, for example, that if a 24-year old child is covered by the employee's health plan, but the child is employed and files his own tax return, then the child's income will be disregarded for purposes of determining the employee's household income. In contrast, if the 24-year old is a student claimed as a tax dependent by the employee, then the child's income would be added to the household income.

Q13. How is the premium subsidy calculated?

A13. The premium subsidy amount is based on the cost of coverage in the Marketplace, not the cost of employer-provided coverage. The subsidy decreases as the person's income increases, using the following table. (A sliding scale, rounded to the nearest one-hundredth of one percent, applies between the minimum and maximum percentage.)

Applicable Percentage Table for 2019

Household income as a percent of FPL	Applicable Percentage	
	Minimum	Maximum
Up to 133 percent	2.08	2.08
133 to 150 percent	3.11	4.15
150 to 200 percent	4.15	6.54
200 to 250 percent	6.54	8.36
250 to 300 percent	8.36	9.86
300 to 400 percent	9.86	9.86

Applicable Percentage Table for 2020

Household income as a percent of FPL	Applicable Percentage	
	Minimum	Maximum
Up to 133 percent	2.06	2.06
133 to 150 percent	3.09	4.12
150 to 200 percent	4.12	6.49
200 to 250 percent	6.49	8.29
250 to 300 percent	8.29	9.78
300 to 400 percent	9.78	9.78

The applicable percentage is multiplied by the person's household income to determine his required share of premiums for the second least expensive silver plan in the Marketplace.

Q14. Does employer-provided coverage affect eligibility for the premium subsidy?

A14. Yes. An employee (or dependent) is not eligible for a premium subsidy if either:

- The person is eligible for minimum value[2] coverage through an employer and the cost of single coverage is affordable (not more than 9.5% of household income, indexed each year), even if the employee has dependents.
- The person purchases employer-provided coverage even if that coverage is not affordable and minimum value.

Receiving the Premium Subsidy

Q15. How is the premium subsidy paid?

A15. The premium subsidy actually is a tax credit that is available in advance. Each month, the government will pay the premium subsidy directly to the insurer. The person will pay his or her share directly to the insurer.

Everyone who receives a premium subsidy must file a federal income tax return. The tax return will be used to true-up the amount of subsidy the person received and the amount that the person was entitled to. If the subsidy was too large the person will have to pay extra tax (to a maximum). If it was too small, the person will get a refund.

Q16. What is the most a person would have to repay if they received a premium subsidy that is too great?

A16. The maximum amount an individual who received too great a subsidy would repay is:

- $300 if filing single and $600 if filing other than single if household income is less than 200% of FPL
- $775 if filing single and $1,550 if filing other than single if income is 200% up to 300% of FPL
- $1,300 if filing single and $2,600 if filing other than single if income is 300% to 400% of FPL

Q17. Can a person get the premium subsidy amount adjusted during the year?

A17. Yes. Recipients will be encouraged to notify the Marketplace of mid-year changes in income and number of dependents that might impact the amount of subsidy the person is eligible for.

Q18. Is a new employee eligible to receive a premium subsidy during the plan's eligibility waiting period?

A18. Yes.

Special Issues for Non-Calendar Year Plans

Q19. Is eligibility for the Marketplace a Section 125 change in status event?

A19. Yes. The Marketplace enrollment event permits plans to allow participants who are eligible to enroll in Marketplace coverage during a special enrollment period to drop employer-sponsored health coverage mid-year, so long as the employee intends to enroll in Marketplace coverage. The employer only has to obtain a reasonable representation from the employee that he or she intended to enroll on the Marketplace. The following conditions must be met for this change:

1. The employee is eligible for a special enrollment period to enroll in a qualified health plan through the Marketplace pursuant to guidance issued by the Department of Health and Human Services (HHS) and any other applicable guidance, or the employee seeks to enroll in a qualified health plan through a Marketplace during the Marketplace's annual open enrollment period; and

2. The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the employee and any related individuals who cease coverage due to the revocation in a qualified health plan through the Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

Q20. Should an employer amend its Section 125 plan to allow employees to terminate plan coverage to enroll in the Marketplace?

A20. Each employer will need to decide whether it wants to encourage employees to enroll in the Marketplace. Employers that wish to encourage Marketplace enrollment will likely want to amend their Section 125 plan to allow for this. Employers that prefer that their employees remain in their plan likely will not want to amend their Section 125 plan to allow employees to move to Marketplace coverage.

Q21. Is the individual responsibility requirement a change in status event?

A21. The requirement that people have health coverage or pay penalties is not a Section 125 change in status event.

Q22. If a plan is on a non-calendar year plan, is the plan renewal date a special enrollment event for Marketplace coverage?

A22. No, a plan renewal that occurs other than on January 1 is not a special enrollment event since the employee remains eligible for employer-provided coverage.

Note: Because a person may drop Marketplace coverage during the year with 14 days' notice, it will be simple for an employee to move from Marketplace coverage to employer-provided coverage at plan open enrollment if the employee wishes to do that. An employee who wishes to move to Marketplace coverage likely will need to pay premiums for plan coverage on an after-tax basis so that he can drop plan coverage mid-year and move to the Marketplace plan as of January 1.

Q23. If an employer wants to amend its Section 125 plan to treat Marketplace eligibility as a change in status event, when is the amendment due?

A23. A cafeteria plan must be amended to allow the permitted election change. The amendment must be adopted on or before the last day of the plan year in which the election is allowed, and may be effective retroactively to the first day of that plan year, provided that the cafeteria plan operates in accordance with the guidance under IRS Notice 2014-55 and the employer informs participants of the amendment. An election to revoke coverage on a retroactive basis is prohibited.

[1] 30 days in the SHOP Marketplace
[2] Minimum value means the plan has an actuarial value of at least 60% (is expected to cover at least 60% of claims)

7/21/2016
7/23/2019