

Federally-facilitated Marketplace Assister Curriculum: Marketplace Basics

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Center for Consumer Information & Insurance
Oversight

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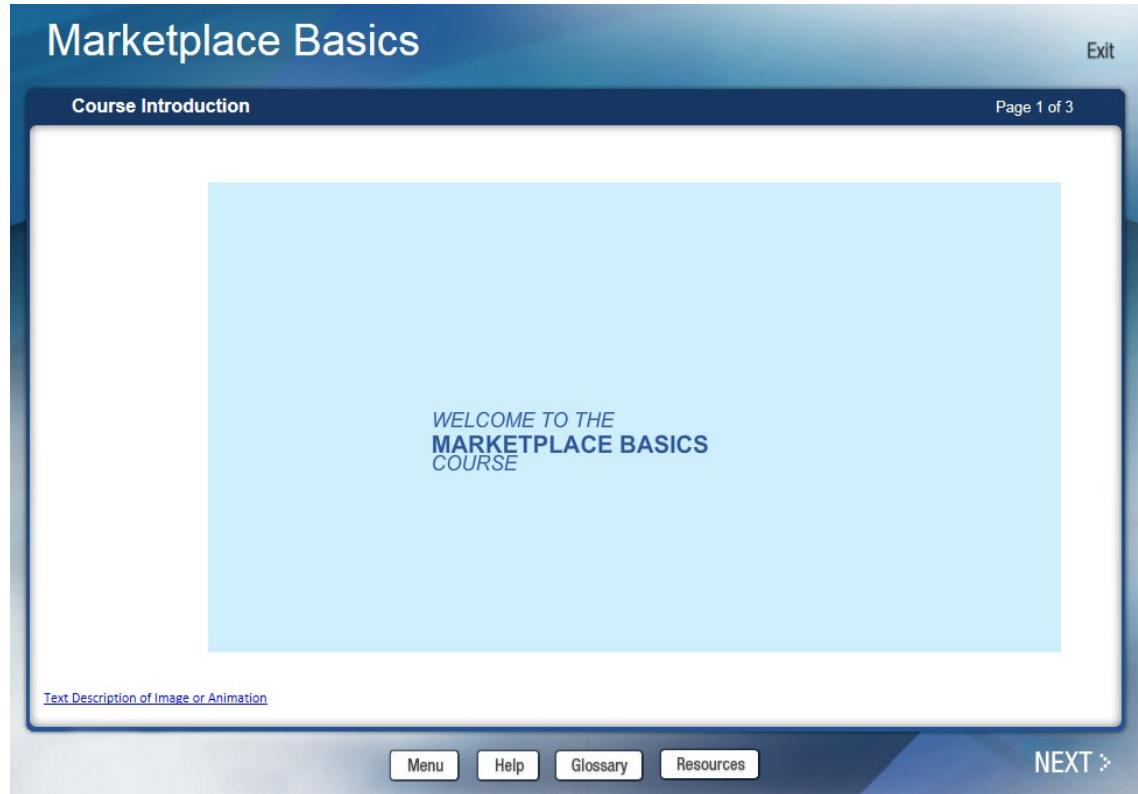
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Marketplace Basics Course

Course Introduction Module



Course Title

Welcome to the Marketplace Basics Course

The screenshot shows a web-based course interface titled "Marketplace Basics". At the top right are "Exit" and "Page 2 of 3" buttons. Below the title is a "Course Introduction" section with a "Course Overview" heading. The overview text welcomes the user to the course on Marketplace Basics, stating it provides an overview of the Federally-facilitated Marketplace, including definitions and key functions. It notes that the course includes information on the Individual Federally-facilitated Marketplace and the Small Business Health Options Program (SHOP) Marketplace, differences between them, risk pools and premium variation, and qualified health plans (QHPs), essential health benefits (EHB), and Marketplace health plan categories. It also defines "you" as Navigators, Non-Navigator assistance personnel, and State-based Marketplaces. A note at the bottom indicates the course is not required for certified application counselors but useful for them. Navigation buttons at the bottom include "Menu", "Help", "Glossary", "Resources", "BACK", and "NEXT".

Welcome to the course on Marketplace Basics! This course provides you with an overview of the Federally-facilitated Marketplace, including definitions and key functions.

The course includes information on:

- Definitions and key functions of the Individual Federally-facilitated Marketplace and the Small Business Health Options Program (SHOP) Marketplace
- Differences between the Individual Federally-facilitated Marketplaces and the SHOP Marketplace
- The concepts of risk pools and premium variation
- Qualified health plans (QHPs), essential health benefits (EHB), and Marketplace health plan categories

In this lesson, "you" refers to the following types of assisters:

- Navigators in the Federally-facilitated Marketplace, including State Partnership Marketplaces and FFMs where the state performs plan management functions
- Non-Navigator assistance personnel in the Federally-facilitated Marketplace, including State Partnership Marketplaces and FFMs where the state performs plan management functions
- Non-Navigator assistance personnel in State-based Marketplaces and State Partnership Marketplaces that are funded with Marketplace Establishment Grant funds.

Note: In some cases, "you" is also used to refer to a consumer, but it should be clear when this is the intended meaning.

This lesson is not a required lesson for certified application counselors in the Federally-facilitated Marketplace or State Partnership Marketplaces. However, the basic health insurance information included in this lesson will be useful for certified application counselors to know as they help consumers enroll in health coverage through the Marketplace. This course concludes with an exam.

Click **NEXT** to begin.

Menu Help Glossary Resources BACK NEXT

Course Overview

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Marketplace Definition and Key Functions Module

Marketplace Basics

Marketplace Definition and Key Functions

Page 1 of 13

Introduction

The Marketplaces are a way for consumers to access health coverage that fits their budgets and specific needs.

This training will provide you with the skills to:

- Define the Marketplaces
- Identify the three ways a Marketplace can be operated
- Distinguish between the Individual Marketplace and the Small Business Health Options Program (SHOP) Marketplaces

Click **NEXT** to continue.

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Introduction

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This training will provide you with the skills to:

- Define the Marketplaces
- Identify the three ways a Marketplace can be operated
- Distinguish between the Individual Marketplace and the Small Business Health Options Program (SHOP) Marketplaces

The screenshot shows a slide from a curriculum titled "Marketplace Basics". The main content area is titled "Marketplace Definition and Key Functions" and contains a section titled "Definition of the Marketplace". It describes how Marketplaces are resources for learning about health coverage options, comparing plans based on costs and benefits, and enrolling in coverage. It also explains that insurance plans offered in Marketplaces are called QHPs, which must provide a core comprehensive benefits package (EHB) and meet other Marketplace requirements. The slide also notes that plans sold outside of the Marketplaces don't need to be certified as QHPs. Below this, another section discusses programs that help consumers pay for coverage, including Medicaid and CHIP.

Definition of the Marketplace

The Marketplaces are a resource where qualified individuals, families, small employers, and their employees can learn about their health coverage options, compare health insurance plans based on costs and benefits, choose plans, and enroll in health coverage.

The insurance plans offered in the Marketplaces are called qualified health plans (QHPs). The Marketplaces certify each QHP sold in a state. Certification of a QHP means that each plan provides a core comprehensive benefits package (known as essential health benefits or EHB), follows limits on cost sharing for consumers, and meets other Marketplace requirements. While all QHPs sold in the Marketplaces are certified, it's important to note that health insurance plans sold outside of the Marketplaces don't need to be certified as QHPs.

The Marketplaces also provide information on programs that help consumers pay for coverage, including ways to save on monthly premiums and out-of-pocket costs, and programs such as Medicaid and the Children's Health Insurance Program (CHIP).

Small Businesses
1-800-706-7893

Individuals & Families
1-800-318-2596

HealthCare.gov

Click the [BLUE](#) link(s) to enable NEXT button

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Definition of the Marketplace

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Definition of Essential Health Benefits

The Affordable Care Act requires that most health plans sold both inside and outside of the Marketplaces cover EHBs, a core comprehensive set of benefits.

EHBs must include items and services from at least the following 10 categories:

Marketplace Basics Course

Marketplace Definitions
and Key Functions

1. Ambulatory patient services (e.g., doctor and clinic visits)
2. Emergency services (e.g., ambulance, first aid, and rescue squad)
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices (e.g., therapy sessions, wheelchairs, oxygen)
8. Laboratory services
9. Preventive and wellness services and chronic disease management (e.g., blood pressure screening, immunizations)
10. Pediatric services, including dental* and vision care

Health plans must offer benefits in these categories to be certified and sold in the Marketplaces. In states expanding the Medicaid program, all Medicaid plans provided to people newly eligible for Medicaid must cover EHBS.

** Note that the consumers who want pediatric dental coverage will need to confirm whether pediatric dental coverage is included in a QHP or will require purchasing a separate dental plan if stand-alone dental policies are offered through their state's Marketplace.*

Marketplace Basics

Marketplace Definition and Key Functions

Your Role in the Marketplace

You're responsible for helping consumers make informed decisions during the application and coverage selection process. You should provide consumers with fair, accurate, and impartial information about the full range of health coverage options for which they're eligible and help them through the eligibility and enrollment process.

Your duty to provide fair, accurate, and impartial information includes:

- Providing information that helps consumers with submitting the eligibility application
- Clarifying the distinctions among health coverage options, including QHPs
- Helping consumers make informed decisions during the health coverage selection process.

You may NOT recommend specific health plans to consumers, make eligibility determinations for them, or enroll on their behalf (unless otherwise authorized to do so). You'll learn more about [health plan categories](#) later in the training.

You should remind consumers to consider [plan provider networks](#) when comparing and selecting plans. If consumers' preferred doctors or hospitals aren't part of a plan's network, are part of a tiered network, or their medication isn't on the plan's formulary (or drug list), you should remind consumers that the cost of treatment may not be covered (or may only be covered in part).

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Definition of Health Plan Category

There are five categories of qualified health plans:

1. Bronze
2. Silver
3. Gold
4. Platinum
5. Catastrophic

Each plan type divides the cost of care between itself and consumers in a different way. Silver category plans are the only category that allow for savings on out-of-pocket costs, known as "cost-sharing reductions."

Definition of Plan Provider Networks

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

Marketplace Basics

Marketplace Definition and Key Functions

Operation of the Marketplaces

A Marketplace can be operated by a [state](#), the federal government, or a combination of both.

- Some states manage all Marketplace functions. This is called a State-based Marketplace (SBM).
- Some states hold primary responsibility for managing Marketplace functions, but rely on the federal information technology platform to manage their eligibility and enrollment functions. This is called a State-based Marketplace on the Federal Platform (SBM-FP).
- Some states have opted to operate only the SHOP Marketplace, while the federal government operates the Individual Marketplace in that state.
- Some states chose to have the federal government operate a Marketplace through what's called the Federally-facilitated Marketplace. In Federally-facilitated Marketplaces, the federal government manages all Marketplace functions.
- Some states have partnered with the federal government to operate what's called a State Partnership Marketplace.
 - State Partnership Marketplaces are a type of Federally-facilitated Marketplace in which the state engages actively with the federal government in the operation of certain aspects of the Federally-facilitated Marketplace.
 - A state with a State Partnership Marketplace can be responsible for plan management or consumer assistance activities.

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Operation of the Marketplaces

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- Some states hold primary responsibility for managing Marketplace functions, but rely on the federal information technology platform to manage their eligibility and enrollment functions. This is called a State-based Marketplace on the Federal Platform (SBM-FP).
- Some states have opted to operate only the SHOP Marketplace, while the federal government operates the Individual Marketplace in that state.
- Some states chose to have the federal government operate a Marketplace through what's called the Federally-facilitated Marketplace. In Federally-facilitated Marketplaces, the federal government manages all Marketplace functions.
- Some states have partnered with the federal government to operate what's called a State Partnership Marketplace.
 - State Partnership Marketplaces are a type of Federally-facilitated Marketplace in which the state engages actively with the federal

government in the operation of certain aspects of the Federally-facilitated Marketplace.

- A state with a State Partnership Marketplace can be responsible for plan management or consumer assistance activities.

More Information about State

Assisters should know their state's policies and Marketplace type.

The screenshot shows a slide titled "Marketplace Basics" with a sub-section titled "Marketplace Definition and Key Functions". The main content area is labeled "Knowledge Check" and contains the following text:
Which of the following statements are TRUE about the Marketplace?
Select all that apply and then click Check Your Answer.

Below this, there is a list of four statements, each preceded by a checkbox:

- A. The Marketplace is a collection of government owned insurance programs.
- B. The Marketplace is a resource where individuals, families, small employers, and their employees can learn about their health coverage options.
- C. The Marketplace certifies insurance plans called qualified health plans (QHPs).
- D. The Marketplace can be run by a state or the federal government.

A blue button labeled "Check Your Answer" is visible. At the bottom of the slide, a message says "Complete the Knowledge Check to enable NEXT button". Navigation buttons at the bottom include "Menu", "Help", "Glossary", "Resources", "BACK", and "NEXT".

Knowledge Check

Which of the following statements are TRUE about the Marketplace?

Select all that apply.

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- C. The Marketplace certifies insurance plans called qualified health plans (QHPs).
- D. The Marketplace can be run by a state or the federal government.

Feedback: The correct answers are B, C, and D. The Marketplace is a resource where individuals, families, small employers, and their employees can learn about their health coverage options. The Marketplace certifies insurance plans called QHPs. The Marketplace can be run by a state or the federal government.

Marketplace Basics

Exit

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Marketplace Definition and Key Functions

Functions of the Marketplace

The Marketplace performs major functions, including:

- Determining (or assessing if applicable) if consumers are eligible:
 - to enroll in QHPs through a Marketplace
 - for programs to help lower their costs
 - for enrollment in Medicaid or CHIP
- Assisting with the process to enroll eligible:
 - consumers in a QHP
 - employers and their employees in QHPs through the SHOP Marketplace
- Monitoring health insurance companies that sell QHPs (e.g., determining if health plans meet certification requirements)



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- Determining (or assessing if applicable) if consumers are eligible:
 - to enroll in QHPs through a Marketplace
 - for programs to help lower their costs
 - for enrollment in Medicaid or CHIP
- Enrolling eligible:
 - consumers in a QHP
 - employers and their employees in QHPs through the SHOP Marketplace
- Monitoring health insurance companies that sell QHPs (e.g., determining if health plans meet certification requirements).

Marketplace Basics

Marketplace Definition and Key Functions

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Introduction to Verification and the Federal Data Services Hub

A Marketplace determines a consumer's eligibility for enrollment in a QHP, as well as for programs to help lower costs using information from the consumer's application.

The Centers for Medicare & Medicaid Services (CMS) uses a system called the Federal Data Services Hub (the Hub) to verify that the information entered in an application is correct. The Hub provides a single secure connection between state systems, federal systems, and trusted data sources to verify specific information in consumers' applications.

The Hub isn't a database. It doesn't retain or store data. It's a routing tool to send information securely from various trusted government databases through protected networks.

You'll learn more about this subject later in the training.



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Introduction to Verification and the Federal Data Services Hub

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The screenshot shows a web-based knowledge check interface. At the top, a blue header bar reads "Marketplace Basics". On the right side of the header are "Exit" and "Page 8 of 13" buttons. Below the header, a dark blue navigation bar contains "Marketplace Definition and Key Functions" on the left and "Knowledge Check" on the right. The main content area has a white background. A question is displayed: "Which one of the following statements is NOT a function of the Marketplaces? Select the correct answer and then click Check Your Answer." Below the question is a list of four options, each preceded by a radio button:

- A. Determining consumers' eligibility for enrollment in a qualified health plan (QHP)
- B. Determining or assessing consumers' eligibility for enrollment in Medicaid or the Children's Health Insurance Program (CHIP)
- C. Enrolling consumers in TRICARE
- D. Enrolling eligible employers and their employees in coverage through the Small Business Health Options Program (SHOP) Marketplaces

A blue rectangular button labeled "Check Your Answer" is positioned below the list. At the bottom of the page, a message says "Complete the Knowledge Check to enable NEXT button". Below this message are four small buttons: "Menu", "Help", "Glossary", and "Resources". To the right of these buttons are "BACK" and "NEXT" buttons.

Knowledge Check

Which one of the following statements is NOT a function of the Marketplaces?

Select the correct answer.

- A. Determining consumers' eligibility for enrollment in a qualified health plan (QHP)
- B. Determining or assessing consumers' eligibility for enrollment in Medicaid or the Children's Health Insurance Program (CHIP)
- C. Enrolling consumers in TRICARE
- D. Enrolling eligible employers and their employees in coverage through the Small Business Health Options Program (SHOP) Marketplaces

Feedback: The correct answer is C. The Marketplaces are responsible for determining consumers' eligibility for enrollment in a QHP, determining or assessing consumers' eligibility for Medicaid or CHIP, as well as enrolling eligible employers and their employees through the SHOP Marketplaces.

Marketplace Basics

Marketplace Definition and Key Functions

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How Consumers Use the Marketplaces

Each state has a Marketplace where qualified individuals, families, small employers, and their employees can access and enroll in health coverage. The Marketplaces are a way to find health coverage that fits the budgets and specific needs for:

- Individuals and families who can find coverage through the Individual Marketplaces
- Eligible small employers and their employees, former employees, and dependents of employees and former employees, who can find coverage through the SHOP Marketplaces

Consumers can compare options and enroll in health coverage through the Marketplaces online, by phone, or by mail for the Individual Marketplaces. The FF-SHOP does not accept enrollments via mail.

Open enrollment for health coverage through the Marketplaces will begin on November 1, 2016, and end on January 31, 2017. Coverage will begin on January 1, 2017, for consumers who enroll on or before December 15, 2016.



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Marketplace Basics

Marketplace Definition and Key Functions

Introduction to the Individual Marketplaces

Eligible individuals and families can enroll in health coverage through the Individual Marketplaces and choose plans that best fit their budgets and needs.

Self-employed consumers whose businesses have no employees generally may not purchase group coverage through a SHOP Marketplace, but may be eligible to purchase coverage for themselves and their families through the Individual Marketplaces.

If a consumer's job-based coverage doesn't cover dependents, the consumer's dependents may be eligible for help paying for coverage through the Individual Marketplaces.

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Introduction to the Individual Marketplaces

Eligible individuals and families can enroll in health coverage through the Individual Marketplaces and choose plans that best fit their budgets and needs.

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If a consumer's job-based coverage doesn't cover dependents, the consumer's dependents may be eligible for help paying for coverage through the Individual Marketplaces.

Marketplace Basics

Marketplace Definition and Key Functions

Introduction to the SHOP Marketplaces

The SHOP Marketplace helps eligible small employers provide health insurance to their employees, former employees, and to dependents of their employees and former employees.

The SHOP Marketplace is open to small employers with from 1 to 50 (100 in some states) full time and full-time equivalent (FTE) employees, on average, on business days during the preceding calendar year. If an employer was not in existence throughout the preceding calendar year, the count of full-time and FTE employees is based on the average number of employees that the employer is reasonably expected to employ on business days in the current calendar year. Participating employers determine the share of premium costs they will cover for their employees.

Unlike many consumers who obtain coverage through the Individual Marketplaces, consumers with access to coverage through the SHOP Marketplaces generally can't qualify for Marketplace programs to lower their costs (e.g., premium tax credits and cost-sharing reductions). Some employers who offer coverage through the SHOP Marketplaces, however, might be eligible to get small business health care tax credits through the SHOP Marketplaces to help make offering coverage to their employees more affordable.

PANADERIA • PASTELERIA
LA ESPIGA
FIAMBRES TORTAS



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Introduction to the SHOP Marketplaces

The SHOP Marketplace helps eligible small employers provide health insurance to their employees, former employees, and to dependents of their employees and former employees.

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The screenshot shows a web-based knowledge check interface. At the top, a blue header bar reads "Marketplace Basics". On the right side of the header are "Exit" and "Page 12 of 13" buttons. Below the header, a dark blue navigation bar contains "Marketplace Definition and Key Functions" on the left and "Knowledge Check" on the right. The main content area has a white background. It starts with a question: "Which one of the following statements is a major difference between the Individual Marketplaces and the Small Business Health Options Program (SHOP) Marketplaces?". Below the question, instructions say "Select **the correct answer** and then click **Check Your Answer**". A list of four options follows:

- A. The Individual Marketplaces are for individuals; the SHOP Marketplaces are for large employers.
- B. The Individual Marketplaces provide health coverage options for eligible individuals and families, while the SHOP Marketplaces provide health coverage options for eligible small employers and their employees.
- C. The Individual Marketplaces are run by states, while the SHOP Marketplaces are run by the federal government.
- D. The Individual Marketplaces provide health coverage options for eligible small employers and their employees, while the SHOP Marketplaces provide health coverage options for eligible individuals and families.

At the bottom of the content area is a blue button labeled "Check Your Answer". Below the content area, a message says "Complete the Knowledge Check to enable NEXT button". At the very bottom, there are several small buttons: "Menu", "Help", "Glossary", "Resources", "<< BACK", and "NEXT >".

Knowledge Check

Which one of the following statements is a major difference between the Individual Marketplaces and the Small Business Health Options Program (SHOP) Marketplaces?

Select **the correct answer**.

- A. The Individual Marketplaces are for individuals; the SHOP Marketplaces are for large employers.
- B. The Individual Marketplaces provide health coverage options for eligible individuals and families, while the SHOP Marketplaces provide health coverage options for eligible small employers and their employees.
- C. The Individual Marketplaces are run by states, while the SHOP Marketplaces are run by the federal government.
- D. The Individual Marketplaces provide health coverage options for eligible small employers and their employees, while the SHOP Marketplaces provide health coverage options for eligible individuals and families.

Feedback: The correct answer is B. Each state has an Individual Marketplace to provide health coverage options for individuals and families and a SHOP Marketplace to provide health coverage options for eligible small employers and their employees.

Marketplace Basics

Marketplace Definition and Key Functions

Exit

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Key Points

- The Affordable Care Act created the Marketplaces to help individuals, families, small employers, and their employees shop for health coverage in a way that allows easy comparison of available plan options.
- Marketplaces are operated as a State-based Marketplace, a Federally-facilitated Marketplace, or a State Partnership Marketplace.
- There are Individual Marketplaces and SHOP Marketplaces. Each serves a specific population of consumers.

Click **NEXT** to continue.

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Key Points

- The Affordable Care Act created the Marketplaces to help individuals, families, small employers, and their employees shop for health coverage in a way that allows easy comparison of available plan options.
- Marketplaces are operated as a State-based Marketplace, a Federally-facilitated Marketplace, or a State Partnership Marketplace.
- There are Individual Marketplaces and SHOP Marketplaces. Each serves a specific population of consumers.

Individual Marketplaces and SHOP Marketplaces Module

The screenshot shows a web-based training module titled "Marketplace Basics". At the top, there's a header bar with the title "Marketplace Basics" on the left and an "Exit" link on the right. Below the header, the page title "Individual Marketplaces and SHOP Marketplaces" is displayed, along with a "Page 1 of 16" indicator. The main content area is titled "Introduction" and contains text about the purpose of the module and the skills it aims to provide. It also lists several learning objectives. At the bottom of the content area, there's a note to click "NEXT" to continue. A navigation bar at the very bottom includes links for "Menu", "Help", "Glossary", and "Resources", as well as "BACK" and "NEXT" buttons.

Introduction

This module provides an overview of the Individual Marketplaces and the Small Business Health Options Program (SHOP) Marketplaces.

It's important for you to understand the difference between the Individual Marketplaces and the SHOP Marketplaces so you can provide accurate and impartial information to help consumers, families, small employers, and their employees get health coverage.

This training will provide you with the skills to:

- Describe the Marketplaces and "risk pools"
- Describe premium variations in the Marketplaces
- Define the eligibility requirements for the Individual Marketplaces
- Define the eligibility requirements for the SHOP Marketplaces
- Recognize key differences between the Individual Marketplaces and the SHOP Marketplaces

Click **NEXT** to continue.

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- Describe premium variations in the Marketplaces
- Define the eligibility requirements for the Individual Marketplaces
- Define the eligibility requirements for the SHOP Marketplaces
- Recognize key differences between the Individual Marketplaces and the SHOP Marketplaces

Marketplace Basics

Individual Marketplaces and SHOP Marketplaces

Page 2 of 16

Marketplace and Risk Pools

A "risk pool" is a group of consumers whose estimated medical costs are combined to calculate health insurance premiums. A well-balanced risk pool includes a mix of consumers who rarely use medical services with those who use them frequently.

The Marketplaces are open to qualified consumers regardless of their medical history. But if only consumers with pre-existing conditions enrolled in coverage, participating insurance companies might have to raise premiums to unaffordable levels in order to have enough funds to cover the cost of services for chronically or seriously ill consumers. By requiring everyone to maintain health coverage or pay a fee, the market becomes large enough to have a risk pool with a mix of high-risk and low-risk consumers.

Within the Individual Marketplaces and the SHOP Marketplaces, health insurance companies decide how much to charge consumers for premiums based on the makeup of the risk pool.



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Within the Individual Marketplaces and the SHOP Marketplaces, health insurance companies decide how much to charge consumers for premiums based on the makeup of the risk pool.

Marketplace Basics

Individual Marketplaces and SHOP Marketplaces

Premium Variations in the Marketplaces

Private health insurance plans available in the Individual Marketplaces and SHOP Marketplaces are called qualified health plans (QHPs). Consumers enrolled in QHPs pay fixed monthly amounts, called premiums, to the health insurance companies that offer the QHPs.

Consumers may be charged different [premium rates](#) for the same QHP, depending on a limited number of factors including age, family composition (e.g., single versus family coverage), geographic area, and tobacco use. The difference in premium rates is limited to a ratio of 3 to 1 for age for adults and 1.5 to 1 for tobacco use.

For example, a plan's premium rates for 64 year old consumers may be no more than three times higher than those for 21 year old consumers based on their ages.

These restrictions help ensure that consumers - including consumers in the small group market - can't be charged more because of the covered consumers' health status, medical history, gender, or the type of industry in which they work.

Age
Family Composition
Geographic Area
Tobacco Use

Click the [BLUE](#) link(s) to enable NEXT button

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These restrictions help ensure that consumers - including consumers in the small group market - can't be charged more because of the covered consumers' health status, medical history, gender, or the type of industry in which they work.

More Information on Premium Rates

Consumers should be advised that premiums may increase each year due to the rising cost of health care, and as they age, within the established limits. How much a plan's premium increases at re-enrollment will vary by plan and state.

Marketplace Basics

Individual Marketplaces and SHOP Marketplaces

Exit

Page 4 of 16

Eligibility Requirements for the Individual Marketplaces

To get health coverage through the Individual Marketplaces, a consumer:

- Must live in the United States (U.S.)
- Must be a U.S. citizen or national (or be lawfully present)
- Can't be currently incarcerated (unless pending the [disposition of charges](#))

Your role is to provide fair, accurate, and impartial information and services to consumers, which includes: providing information that helps consumers with submitting eligibility applications; clarifying the distinctions among available health coverage options, including QHPs; and helping consumers make informed decisions during the health coverage selection process. You can't recommend specific health insurance plans to consumers and you can't make [eligibility](#) determinations.



Click the [BLUE](#) link(s) to enable NEXT button

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Eligibility Requirements for the Individual Marketplaces

To get health coverage through the Individual Marketplaces, a consumer:

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- Can't be currently incarcerated (unless pending the disposition of charges)

Your role is to provide fair, accurate, and impartial information and services to consumers, which includes: providing information that helps consumers with submitting eligibility applications; clarifying the distinctions among available health coverage options, including QHPs; and helping consumers make informed decisions during the health coverage selection process. You can't recommend specific health insurance plans to consumers and you can't make eligibility determinations.

Definition of Disposition of Charges

Disposition of charges means being held without having been formally convicted of a crime.

More Information on Eligibility

Eligibility for the SHOP Marketplaces is determined differently than eligibility for the Individual Marketplaces and will be discussed later in this training.

The screenshot shows a web-based knowledge check titled "Marketplace Basics". At the top, it says "Individual Marketplaces and SHOP Marketplaces" and "Page 5 of 16". Below that is a section titled "Knowledge Check". A story about Elizabeth is provided, followed by a question asking which questions to ask her. A note says to "Select all that apply" and "Check Your Answer". A list of four options is shown, each with a checkbox. At the bottom, there's a "Check Your Answer" button, a note to complete the check before enabling the next button, and navigation links for "Menu", "Help", "Glossary", "Resources", "BACK", and "NEXT".

Knowledge Check

Elizabeth moved to the United States (U.S.) two years ago and started her own business, working as a florist on her own without other employees. She comes to you to see if she might be eligible for health coverage through an Individual Marketplace.

Which of the following questions should you ask Elizabeth to assess whether she might be eligible to get coverage through an Individual Marketplace or a Small Business Health Options Program (SHOP) Marketplace?

Select all that apply and then Check Your Answer.

A. Are you a U.S. citizen or lawfully present?
 B. Are you a smoker?
 C. How much income does your business generate each year?
 D. Do you have any employees?

Check Your Answer

Complete the Knowledge Check to enable NEXT button

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Which of the following questions should you ask Elizabeth to assess whether she might be eligible to get coverage through an Individual Marketplace or a Small Business Health Options Program (SHOP) Marketplace?

Select all that apply.

- A. Are you a U.S. citizen or lawfully present?
- B. Are you a smoker?
- C. How much income does your business generate each year?
- D. Do you have any employees?

Feedback: The correct answers are A and D. By asking Elizabeth about her immigration status, you can help her assess whether she meets the requirements to get coverage through an Individual Marketplace. Her ability to participate in an Individual Marketplace isn't determined by whether she smokes or the amount of income her business generates, although if she's found eligible for coverage, her income and whether she's eligible for affordable, minimum essential coverage through an employer may affect her eligibility for

programs to lower her costs (e.g., premium tax credits and cost-sharing reductions). By asking Elizabeth whether she has employees, you can help her assess whether she might be eligible to participate in a SHOP Marketplace.

The screenshot shows a web-based curriculum page titled "Marketplace Basics". At the top, there are links for "Individual Marketplaces and SHOP Marketplaces" and "Exit". The page header indicates "Page 6 of 16". Below the header, a section titled "Eligibility Requirements for the SHOP Marketplaces" is displayed. It contains a bulleted list of requirements for small employers to participate in the SHOP Marketplaces. At the bottom of the page, there is a message: "Click the BLUE link(s) to enable NEXT button". Navigation buttons include "Menu", "Help", "Glossary", "Resources", "BACK", and "NEXT".

Eligibility Requirements for the SHOP Marketplaces

The SHOP Marketplaces help eligible small employers offer health coverage to their employees, former employees, and dependents of employees and former employees. To participate in the SHOP Marketplaces, a small employer must:

- Be a small employer. Generally, this means an employer that had from 1 to 50 (100 in some states) full time and full-time equivalent (FTE) employees, on average, on business days during the preceding calendar year. If an employer was not in existence throughout the preceding calendar year, the count is based on the average number of employees that the employer is reasonably expected to employ on business days in the current calendar year. The rules around determining employer size are complex and Assisters should refer to official HHS and IRS rules and guidance before advising employers regarding their size.
- Have a primary business address in the state where they're applying for and offering coverage in the SHOP Marketplaces where eligible employees' primary worksites are located.
- Offer SHOP coverage to all full-time employees.
- Have at least one employee who isn't the owner or business partner, or the spouse of the owner or business partner.

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- Have a primary business address in the state where they're applying for and offering SHOP coverage OR applying for and offering coverage in the SHOP Marketplaces where eligible employees' primary worksites are located.
- Offer SHOP coverage to all full-time employees.
- Have at least one employee who isn't the owner or business partner, or the spouse of the owner or business partner.

The screenshot shows a web-based curriculum page titled "Marketplace Basics". The main content area is titled "Individual Marketplaces and SHOP Marketplaces" and "Eligibility Requirements for the SHOP Marketplaces (cont.)". It contains several paragraphs of text about employer requirements, including a note about minimum participation rates and enrollment windows. At the bottom, there are navigation links for "Menu", "Help", "Glossary", "Resources", "BACK", and "NEXT". A status bar at the bottom indicates "Click the BLUE link(s) to enable NEXT button".

Eligibility Requirements for the SHOP Marketplaces (cont.)

Renewing employers that were small employers when they began participating in a SHOP but have increased their number of employees may remain eligible for SHOP as long as they have not stopped participating in the SHOP since first determined eligible. These employers must also continue to meet all other eligibility requirements.

Eligible employers in all states with an FF-SHOP also have to meet a minimum participation rate requirement to purchase coverage through the FF-SHOP. State-based SHOPS might also have minimum participation rate requirements.

For plan years beginning on or after January 1, 2016, in most states with an FF-SHOP, at least 70% of full-time employees of a participating employer must enroll in the health coverage offered by the employer through the FF-SHOP, or be enrolled in coverage through another group health plan, governmental coverage (such as Medicare, Medicaid, or TRICARE), coverage sold through the individual market, or in other minimum essential coverage, in order for the employer to be able to purchase coverage through the FF-SHOP, unless the enrollment happens between November 15 and December 15.

This is called the Minimum Participation Rate requirement.

More Information on Minimum Participation Rate Requirements

Employers who apply for SHOP Marketplace coverage between November 15 and December 15 of each year can enroll without meeting the applicable participation rate requirements, which are set at 70% for most states with a Federally-facilitated SHOP (but could vary by state).

Marketplace Basics

Individual Marketplaces and SHOP Marketplaces

Page 9 of 16

Small Business Health Care Tax Credit

Some small employers participating in the SHOP Marketplaces may be eligible for tax credits that for tax years beginning in 2014, can be worth up to 50% of their contribution toward their employees' premium costs (and up to 35% for tax-exempt employers).

To qualify for the small business health care tax credit, an employer must:

- Have fewer than 25 FTE employees (based on a 40-hour work week), excluding certain business owner(s), certain working family members of business owners, and (generally) seasonal employees
- Pay average annual wages of less than \$50,000 per FTE (as adjusted for inflation)
- Contribute at least 50% of the cost of employee health insurance premiums under a qualifying arrangement

Generally, only premiums paid by the employer for persons enrolled in qualified health plans (QHPs) offered through a Small Business Health Options Program (SHOP) Marketplace are counted when calculating the credit. Eligible employers can get the tax credit for only two consecutive tax years beginning in tax year 2014 (or any later year).

The tax credit is highest for companies with fewer than 10 FTE employees who earn an average of \$25,000 or less. Generally speaking, the smaller the business, the bigger the tax credit will be.

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Marketplace Basics

Individual Marketplaces and SHOP Marketplaces

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SHOP Marketplaces: Risk Pools

Traditionally, small employers have had a difficult time offering affordable coverage to their employees because their risk pools were small. The SHOP Marketplaces offer plans with premiums based on a large, diverse, and more predictable risk pool.

This means health insurance companies can offer lower premiums for many small business employers and their employees, making health plans offered through the SHOP Marketplaces more affordable.



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Marketplace Basics

Individual Marketplaces and SHOP Marketplaces Page 11 of 16

FF-SHOP Marketplaces: Minimum Participation Rate Requirements



In states with an FF-SHOP, a certain percentage of an eligible employer's full-time employees who are offered coverage through the FF-SHOP must enroll either in the coverage offered through the FF-SHOP, or in certain other kinds of coverage, in order for the employer to be able to buy coverage through the FF-SHOP. This is called the minimum participation rate requirement. In most states with an FF-SHOP, the minimum participation rate is 70%. Employer groups can enroll in FF-SHOP Marketplace coverage between November 15th and December 15th each year without meeting this requirement.

It's important to understand who is and isn't factored into this calculation.

- For plan years beginning on or after January 1, 2016, the minimum participation rate is calculated as the number of full-time employees accepting the FF-SHOP coverage offer, plus the number of full-time employees who, at the time the employer submits the FF-SHOP group enrollment, are enrolled in coverage through another group health plan, governmental coverage (such as Medicare, Medicaid, or TRICARE), coverage sold through the individual market, or in other minimum essential coverage, divided by the number of full-time employees offered coverage. Full time employees with individual coverage who are offered coverage through the FF-SHOP are included in the numerator and denominator of this calculation.

Here's a [key tip](#) to remember about the minimum participation rate requirements.

Click the [BLUE](#) link(s) to enable NEXT button

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SHOP Marketplace: Minimum Participation Rate Requirements

In states with an FF-SHOP, a certain percentage of an eligible employer's full-time employees who are offered coverage through the FF-SHOP must enroll either in the coverage offered through the FF-SHOP, or in certain other kinds of coverage, in order for the employer to be able to buy coverage through the FF-SHOP. This is called the minimum participation rate requirement. In most states with an FF-SHOP, the minimum participation rate is 70%. Employer groups can enroll in FF-SHOP Marketplace coverage between November 15th and December 15th each year without meeting this requirement.

It's important to understand who is and isn't factored into this calculation.

- For plan years beginning on or after January 1, 2016, the minimum participation rate is calculated as the number of full-time employees accepting the FF-SHOP coverage offer, plus the number of full-time employees who, at the time the employer submits the FF-SHOP group enrollment, are enrolled in coverage through another group health plan, governmental coverage (such as Medicare, Medicaid, or TRICARE), coverage sold through the individual market, or in other minimum essential coverage, divided by the number of full-time employees offered coverage. Full time employees with individual coverage who are offered coverage through the FF-SHOP are included in the numerator and denominator of this calculation.

Here's a key tip to remember about the minimum participation rate requirements.

Key Tip

Assisters should check to see what the minimum participation rate requirement is in their state.

Marketplace Basics

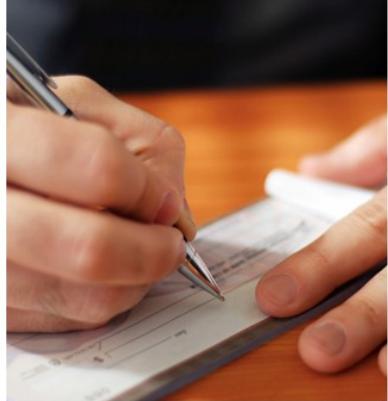
Individual Marketplaces and SHOP Marketplaces

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SHOP Marketplaces: Employee Choice and Premium Contributions

Employers participating in all SHOP Marketplaces have the option of offering employees all available QHPs within a single health plan category (e.g., all Silver plans). Participating employers in all states with an FF-SHOP have the option of offering their employees either a single QHP, or all available QHPs within a single health plan category (e.g., all Silver plans). In some states with an FF-SHOP, for plan years beginning on or after January 1, 2017, participating employers will also have the option of offering employees all QHPs offered through the FF-SHOP by a single issuer across all available health plan categories in addition to offering employees either a single QHP or all available QHPs within a single health plan category.

Small employers participating in a SHOP decide what percentage of the QHP cost they'll contribute toward employee premiums.



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SHOP Marketplaces: Employer Choice and Premium Contributions

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Small employers participating in a SHOP decide what percentage of the QHP cost they'll contribute toward employee premiums.

The screenshot shows a knowledge check interface titled "Marketplace Basics". The main content area is titled "Individual Marketplaces and SHOP Marketplaces" and "Knowledge Check". A question asks about Duane's interest in offering coverage to his employees through the SHOP Marketplace. Below the question, it says to "Select all that apply" and click "Check Your Answer". To the right is a list of four options (A, B, C, D) with checkboxes. At the bottom left is a "Check Your Answer" button, and at the bottom right are "Menu", "Help", "Glossary", "Resources", "BACK", and "NEXT" buttons. A note at the bottom center says "Complete the Knowledge Check to enable NEXT button".

Duane owns his own auto body shop and is interested in offering coverage to his employees through the Small Business Health Options Program (SHOP) Marketplace.

What would you describe as the main features of the SHOP Marketplaces?

Select **all that apply** and then click **Check Your Answer**.

- A. The SHOP Marketplaces offer eligible employers access to tax credits that for tax years beginning in 2014 and thereafter can be worth up to 50% of their contribution toward their employees' premium costs.
- B. The SHOP Marketplaces offer small employers flexibility in setting the amount they contribute to premiums.
- C. SHOP Marketplace premiums may not be different based on an employee's medical history.
- D. Consumers can get individual market health coverage through the SHOP Marketplaces.

Check Your Answer

Complete the Knowledge Check to enable NEXT button

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Knowledge Check

Duane owns his own auto body shop and is interested in offering coverage to his employees through the Small Business Health Options Program (SHOP) Marketplace.

What would you describe as the main features of the SHOP Marketplaces?

Select **all that apply**.

- A. The SHOP Marketplaces offer eligible employers tax credits that for tax years beginning in 2014 can be worth up to 50% of their contribution toward their employees' premium costs.
- B. The SHOP Marketplaces offer small employers flexibility in setting the amount they contribute to premiums.
- C. SHOP Marketplace premiums may not be different based on an employee's medical history.
- D. Consumers can get individual market health coverage through the SHOP Marketplaces.

Feedback: The correct answers are A, B, and C. The SHOP Marketplaces offer eligible employers access to tax credits that can be worth up to 50% of their contribution toward their employees' premium costs and offer small employers flexibility regarding the amount they contribute to premiums. SHOP Marketplace premiums may not be different

based on an employee's medical history. Consumers can't get individual market health coverage through the SHOP Marketplaces.

Key Differences Between the Individual Marketplaces and the SHOP Marketplaces

The Individual Marketplaces and the SHOP Marketplaces perform some of the same core functions, such as making QHPs available. However, there are some key differences.

Individual Marketplaces	SHOP Marketplaces
The Individual Marketplaces collect and verify eligibility information from consumers and their families; determine their eligibility for enrollment in a QHP through the Individual Marketplace; and help with enrollment.	The SHOP Marketplaces collect eligibility information from small employers and their employees and former employees to whom they offer coverage; determine employers' eligibility to offer coverage through the SHOP Marketplace; determine employees' and former employees' eligibility for enrollment in a QHP through the SHOP Marketplace; and help with group enrollment.
Consumers and their families may qualify for programs to lower their costs (e.g., premium tax credits or cost-sharing reductions) to help them afford the cost of coverage.	Premium tax credits and cost-sharing reductions aren't available to persons enrolled through the SHOP Marketplaces. Instead, some small employers offering coverage through the SHOP Marketplaces might be eligible for small business health care tax credits worth up to 50% of their premium contributions.
Immigration status is one eligibility criterion for health coverage through the Individual Marketplace. An individual must be a U.S. citizen or national or be lawfully present to enroll in health coverage through the Individual Marketplace.	Enrolling in health coverage through the SHOP Marketplaces doesn't include a review of citizenship or immigration status information, since employers are required to determine that their employees are able to work legally. However, employer and enrollee tax identification numbers (e.g., Social Security numbers) are collected through the SHOP applications.

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Key Differences Between the Individual Marketplaces and the SHOP Marketplaces

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The Individual Marketplaces collect and verify eligibility information from consumers and their families; determine their eligibility for enrollment in a QHP through the Individual Marketplace; and help with enrollment.	The SHOP Marketplaces collect eligibility information from small employers and their employees and former employees to whom they offer coverage; determine employers' eligibility to offer coverage through the SHOP Marketplace; determine employees' and former employees' eligibility for enrollment in a QHP through the SHOP Marketplace; and help with group enrollment.

Individual Marketplaces	SHOP Marketplaces
<p>Consumers and their families may qualify for programs to lower their costs (e.g., premium tax credits or cost-sharing reductions) to help them afford the cost of coverage.</p>	<p>Premium tax credits and cost-sharing reductions aren't available to persons enrolled through the SHOP Marketplaces. Instead, some small employers offering coverage through the SHOP Marketplaces might be eligible for small business health care tax credits worth up to 50% of their premium contributions.</p>
<p>Immigration status is one eligibility criterion for health coverage through the Individual Marketplace. An individual must be a U.S. citizen or national or be lawfully present to enroll in health coverage through the Individual Marketplace.</p>	<p>Enrolling in health coverage through the SHOP Marketplaces doesn't include a review of citizenship or immigration status information, since employers are required to determine that their employees are able to work legally. However, employer and enrollee tax identification numbers (e.g., Social Security numbers) are collected through the SHOP applications.</p>

The screenshot shows a knowledge check section titled "Knowledge Check". The question asks: "Which of the following are accurate statements about the Individual Marketplaces and Small Business Health Options (SHOP) Marketplaces?". Below the question, it says: "Select all that apply and then click Check Your Answer." There are four options labeled A, B, C, and D, each preceded by a checkbox. Option A: Both the Individual Marketplaces and SHOP Marketplaces offer access to qualified health plans (QHPs), collect eligibility information, determine eligibility for enrollment in a QHP, and process enrollment. Option B: Only the SHOP Marketplaces offer access to QHPs, collect eligibility information, determine eligibility for enrollment in a QHP, and process enrollment. Option C: Only the Individual Marketplaces offer access to premium tax credits and cost-sharing reductions to help individuals and families afford coverage. Option D: Only the SHOP Marketplaces offer some employers, who offer their employees health insurance coverage through the SHOP Marketplaces, access to a small business health care tax credit that can be worth up to 50% of employer premium costs for tax years beginning in 2014 and thereafter. At the bottom left is a "Check Your Answer" button. A note above the button says: "Complete the Knowledge Check to enable NEXT button". At the bottom right are "BACK" and "NEXT" buttons. Navigation links at the bottom include "Menu", "Help", "Glossary", and "Resources".

Knowledge Check

Which of the following are accurate statements about the Individual Marketplaces and Small Business Health Options (SHOP) Marketplaces?

Select all that apply.

- A. Both the Individual Marketplaces and SHOP Marketplaces offer access to qualified health plans (QHPs), collect eligibility information, determine eligibility for enrollment in a QHP, and process enrollment.
- B. Only the SHOP Marketplaces offer access to QHPs, collect eligibility information, determine eligibility for enrollment in a QHP, and process enrollment.
- C. Only the Individual Marketplaces offer access to premium tax credits and cost-sharing reductions to help individuals and families afford coverage.
- D. Only the SHOP Marketplaces offer some employers, who offer their employees health insurance coverage through the SHOP Marketplaces, access to a small business health care tax credit that can be worth up to 50% of employer premium costs for tax years beginning in 2014 and thereafter.

Feedback: The correct answers are A, C and D. Both the Individual Marketplaces and SHOP Marketplaces perform similar core eligibility and enrollment functions. In the Individual Marketplaces, eligible individuals and families may qualify for premium tax credits and cost-sharing reductions. Some employers offering employees health insurance coverage through the SHOP Marketplaces may qualify for a small business health care tax credit that can be worth up to 50% of their premium costs for tax years beginning in 2014.

Marketplace Basics

Exit

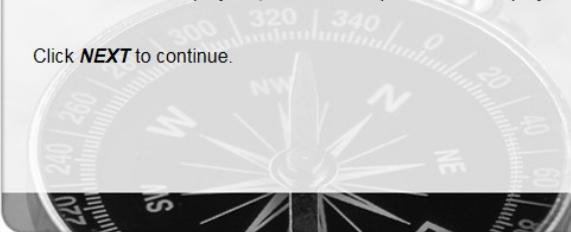
Individual Marketplaces and SHOP Marketplaces

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Key Points

- Consumers may be charged different premium rates for the same QHP, based on a limited number of factors including age, family composition (e.g., single versus family coverage), geographic area, and tobacco use.
- The Individual Marketplace is where qualified individuals and families, including self-employed individuals, can enroll in health coverage that fits their budget and needs.
- The SHOP Marketplace is where eligible small employers can offer health coverage to their employees and former employees, and to the dependents of employees and former employees.

Click **NEXT** to continue.



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Key Points

- Consumers may be charged different premium rates for the same QHP, based on a limited number of factors including age, family composition (e.g., single versus family coverage), geographic area, and tobacco use.
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- The SHOP Marketplace is where eligible small employers can offer health coverage to their employees and former employees, and to the dependents of employees and former employees.

Qualified Health Plans Module

Marketplace Basics

Qualified Health Plans

Page 1 of 12

Introduction

This training provides basic information about qualified health plans (QHPs). It will help you answer questions consumers may have about health coverage options available through the Marketplaces.

This training will provide you with the skills to:

- Define QHPs
- Identify the essential health benefits (EHB) required for QHPs
- Identify the different health plan categories

Click **NEXT** to continue.

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Introduction

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- Define QHPs
- Identify the essential health benefits (EHB) required for QHPs
- Identify the different health plan categories

Marketplace Basics

Qualified Health Plans

Overview of Qualified Health Plans

A QHP is a [health plan](#) that is certified by the Marketplace, provides EHBs, and follows established limits on cost sharing, such as deductibles, copayments, and out-of-pocket maximum amounts. QHPs may also have to meet other state-specific requirements.

Health insurance companies that sell QHPs through the Marketplaces must:

- Be licensed and in good standing in the state where the plan is sold
- Offer at least one Silver and one Gold plan through the Marketplace

QHPs must:

- Include EHBs, a minimum set of benefits
- Meet nondiscrimination and network adequacy requirements
- Offer the same premium whether they're sold inside or outside of the Marketplaces



Click the [BLUE](#) link(s) to enable NEXT button

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Overview of Qualified Health Plans

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- Offer at least one Silver and one Gold plan through the Marketplace

QHPs must:

- Include EHBs, a minimum set of benefits
- Meet nondiscrimination and network adequacy requirements
- Offer the same premium whether they're sold inside or outside of the Marketplaces

Definition of Health Plans

There are five categories of Marketplace health plans: Bronze, Silver, Gold, Platinum, and catastrophic.

Plans in these categories differ based on how consumers and the plan share the costs of care. The categories have nothing to do with the amount or quality of care consumers get.

The screenshot shows a knowledge check interface titled "Marketplace Basics" under the "Qualified Health Plans" section. The page is labeled "Page 3 of 12". A "Knowledge Check" section asks: "To be certified, a qualified health plan (QHP) must meet which of the following criteria?". It instructs the user to "Select all that apply" and click "Check Your Answer". Below the question is a list of four options (A-D) each preceded by an empty checkbox. At the bottom left is a "Check Your Answer" button, and at the bottom right is a note: "Complete the Knowledge Check to enable NEXT button". Navigation buttons for "Menu", "Help", "Glossary", and "Resources" are at the bottom center, and "BACK" and "NEXT" buttons are on the right.

To be certified, a qualified health plan (QHP) must meet which of the following criteria?

Select all that apply and then click **Check Your Answer**.

A. Be sold by a health insurance company that offers at least one Silver and one Gold plan through the Marketplace.
B. Include coverage of essential health benefits (EHBs).
C. Offer the same premium whether the plan is sold inside or outside of the Marketplaces.
D. Offer higher premiums for plans sold inside the Marketplaces than plans sold outside of the Marketplaces.

Check Your Answer

Complete the Knowledge Check to enable NEXT button

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Knowledge Check

To be certified, a qualified health plan (QHP) must meet which of the following criteria?

Select all that apply.

- A. Be sold by a health insurance company that offers at least one Silver and one Gold plan through the Marketplace.
- B. Include coverage of essential health benefits (EHBs).
- C. Offer the same premium whether the plan is sold inside or outside of the Marketplaces.
- D. Offer higher premiums for plans sold inside the Marketplaces than plans sold outside of the Marketplaces.

Feedback: The correct answers are A, B, and C. A QHP must be sold by a health insurance company that offers at least one Silver and one Gold plan through the Marketplace. A QHP must include coverage of EHBs and offer the same premium whether the plan is sold inside or outside of the Marketplaces.

Marketplace Basics

Qualified Health Plans Exit Page 4 of 12

Essential Health Benefits

The Affordable Care Act requires that most health plans sold both inside and outside of the Marketplaces cover EHBs, a core comprehensive set of benefits.

EHBs must include items and services from at least the following 10 categories:

1. Ambulatory patient services (e.g., doctor and clinic visits)
2. Emergency services (e.g., ambulance, first aid, and rescue squad)
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices (e.g., therapy sessions, wheelchairs, oxygen)
8. Laboratory services
9. Preventive and wellness services and chronic disease management (e.g., blood pressure screening, immunizations)
10. Pediatric services, including dental* and vision care

Health plans must offer benefits in these categories to be certified and sold in the Marketplaces. In states expanding the Medicaid program, all Medicaid plans provided to people newly eligible for Medicaid must cover EHBs.

* Note that the consumers who want pediatric dental coverage will need to confirm whether pediatric dental coverage is included in a QHP or will require purchasing a separate dental plan if stand-alone dental policies are offered through their state's Marketplace.

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The screenshot shows a knowledge check interface titled "Marketplace Basics". At the top, it says "Qualified Health Plans" and "Page 5 of 12". The main content area is titled "Knowledge Check" and contains the following text: "Pranav is currently uninsured and asks you what types of benefits are covered by health plans offered through the Marketplace. You tell him that qualified health plans (QHPs) offered through the Marketplaces must all cover the same categories of essential health benefits (EHBs).". Below this is a question: "Which one of the following benefits is NOT included in EHBs?". It asks the user to select the correct answer from four options: A. Routine adult dental care, B. Emergency services, C. Hospitalization, and D. Outpatient services. There is a "Check Your Answer" button at the bottom left. At the bottom right, it says "Complete the Knowledge Check to enable NEXT button". Navigation buttons include "Menu", "Help", "Glossary", "Resources", "BACK", and "NEXT".

Knowledge Check

Pranav is currently uninsured and asks you what types of benefits are covered by health plans offered through the Marketplace. You tell him that qualified health plans (QHPs) offered through the Marketplaces must all cover the same categories of essential health benefits (EHB).

Which one of the following benefits is NOT included in EHBs?

Select the correct answer.

- A. Routine adult dental care
- B. Emergency services
- C. Hospitalization
- D. Outpatient services

Feedback: The correct answers are B, C, and D. A QHP must offer a core comprehensive package of items and services in at least 10 categories of EHBs, including outpatient services, emergency services, and hospitalization but not routine adult dental care.

Marketplace Basics

Qualified Health Plans

Exit

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Health Plan Categories

Health plans in the Marketplace are separated into five health plan categories, four of which are also referred to as metal tiers or metal levels: Bronze, Silver, Gold, and Platinum. These health plan categories are based on the plan's actuarial value (AV). AV is the percentage of total average costs for covered benefits that a plan will cover. Health plan categories do not reflect the quality or amount of care the plans provide.

Select each image below for the AV percentage of each plan level. You must click on each image before advancing to the next screen.

BRONZE SILVER GOLD PLATINUM

[Text Description of Image or Animation](#)

Click through the activity to enable the NEXT button

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- Bronze - 60% AV (the QHP issuer pays, on average, 60% of the cost of EHB coverage)
- Silver - 70% AV (the QHP issuer pays, on average, 70% of the cost of EHB coverage)
- Gold - 80% AV (the QHP issuer pays, on average, 80% of the cost of EHB coverage)
- Platinum - 90% AV (the QHP issuer pays, on average, 90% of the cost of EHB coverage)

Marketplace Basics

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Catastrophic Health Plans

Catastrophic health plans are a fifth QHP category. These plans are only available in the individual market, and protect consumers from very high medical costs by providing coverage only when a consumer needs a lot of care. They generally have lower premiums than other plan categories, but higher out-of-pocket costs for deductibles, copayments, and coinsurance. Consumers cannot use a premium tax credit to reduce the monthly cost of a catastrophic plan.

This type of plan meets all the requirements that apply to other QHPs but doesn't cover any benefits other than three primary care visits per year and certain preventive services until the plan's deductible is met.

Under certain circumstances, a consumer may enroll in a catastrophic health plan. Consumers under 30 or who qualify for a hardship or affordability exemption (for example, because the Marketplace has determined that they're unable to afford coverage) may buy a catastrophic health plan.



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Marketplace Basics

Qualified Health Plans Exit

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Description of Actuarial Values

The QHP health plan category a consumer chooses affects the total amount they're likely to spend on EHB services rendered during the year. Consumers who choose plans in higher health plan categories (Gold or Platinum) will pay higher monthly premiums on average, but will generally pay less for cost-sharing expenses (deductibles, coinsurance, and copayments).

If a plan has an AV of 70%, for example, consumers would, on average, be responsible for 30% of the cost of covered benefits for the year. Consumers could be responsible for a higher or lower percentage of the total costs of covered services, however, depending on their actual health care needs.

Assisters can learn more about the benefits included in a health plan category by using the [AV calculator](#) to view a breakdown of costs and services.



Click the [BLUE](#) link(s) to enable NEXT button

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The screenshot shows a knowledge check interface titled "Marketplace Basics". At the top right is an "Exit" link and the page number "Page 9 of 12". The main content area is titled "Qualified Health Plans" and "Knowledge Check". A scenario states: "Maxine selects a Bronze plan. She asks you to describe what her selection means for her monthly health care costs and the coverage she'll receive." Below this is a question: "Which of the following statements are true about a Bronze plan?". It instructs the user to "Select all that apply and then click Check Your Answer.". To the right is a list of four options, each with a checkbox:

- A. The health insurance company pays, on average, 60% of the cost of essential health benefits (EHBs) for the consumer.
- B. A Bronze plan generally has higher monthly premiums but lower out-of-pocket costs than Silver, Gold, or Platinum plans.
- C. A Bronze plan generally has lower monthly premiums but higher out-of-pocket costs than Silver, Gold, or Platinum plans.
- D. The health insurance company pays, on average, 90% of the cost of EHBs for the consumer.

A "Check Your Answer" button is located at the bottom left of the content area. At the bottom center, a note says "Complete the Knowledge Check to enable NEXT button". Navigation buttons "Menu", "Help", "Glossary", and "Resources" are at the bottom left, and "BACK" and "NEXT" buttons are at the bottom right.

Knowledge Check

Maxine selects a Bronze plan. She asks you to describe what her selection means for her monthly health care costs and the coverage she'll receive.

Which of the following statements are true about a Bronze plan?

Select all that apply.

- A. The health insurance company pays, on average, 60% of the cost of essential health benefits (EHBs) for the consumer.
- B. A Bronze plan generally has higher monthly premiums but lower out-of-pocket costs than Silver, Gold, or Platinum plans.
- C. A Bronze plan generally has lower monthly premiums but higher out-of-pocket costs than Silver, Gold, or Platinum plans.
- D. The health insurance company pays, on average, 90% of the cost of EHBs for the consumer.

Feedback: The correct answers are A and C. The health plan category indicates a qualified health plan's (QHP's) actuarial value (AV). A Bronze plan will generally have lower monthly premiums, but higher out-of-pocket costs, than health plans with a higher AV. A health insurance company pays, on average, 60% of the total cost of EHBs in a Bronze plan.

Marketplace Basics

Qualified Health Plans Exit

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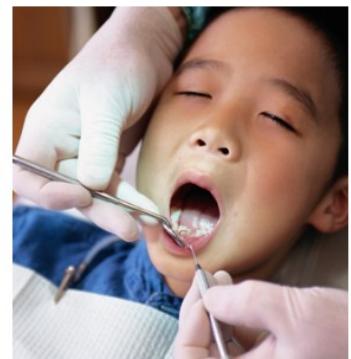
Stand-Alone Dental Plans

Routine adult dental coverage isn't included as an EHB, and most QHPs don't offer it. Consumers may, however, purchase stand-alone dental plans through the Marketplaces.

Pediatric dental care is an EHB and must be offered through the Marketplaces as part of QHPs or as coverage offered by stand-alone dental plans. Pediatric dental services must be included in EHBs for consumers under age 19, but states may require dental coverage for older consumers. When stand-alone dental policies are offered through a Marketplace, other health plans offered through the Marketplace don't have to include pediatric dental benefits.

Each state selected a benchmark plan that is the basis for determining which services a QHP offered through the Marketplace must cover as an EHB. If the benchmark plan chosen by the state lacks pediatric dental or vision coverage, it must be supplemented with benefits from the applicable Federal Employee Dental and Vision Insurance Program with the largest national enrollment, or the benefits available under the state's separate Children's Health Insurance Program (CHIP) plan benefit (if one exists) to the eligibility group with the highest enrollment.

*Note: A consumer can be enrolled in a plan that includes both medical and dental coverage. In that case, the consumer pays a single premium that covers both the medical and dental benefits and the plan can be canceled if the consumer doesn't pay the premium. Alternatively, the consumer can be enrolled in separate medical and dental plans and pay a separate premium for each. In that case, if a consumer does not pay the premium, the health insurance company generally can only terminate the plan for which the consumer doesn't pay the premium.



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Marketplace Basics

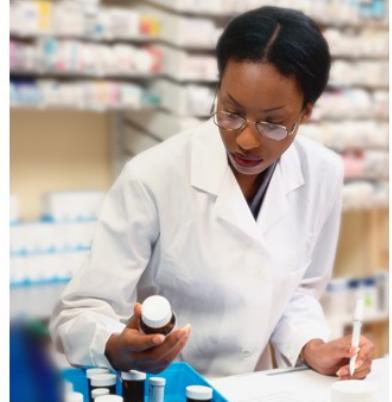
Qualified Health Plans Exit

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Prescription Drug Coverage

Prescription drug coverage is an EHB. Be sure to talk with consumers about their prescription medications. Consumers are likely to be interested in selecting a plan that offers reasonable copays for their medications, especially if they rely on medications to manage chronic conditions and need to purchase them on a recurring, long-term basis.

You may need to review a specific QHP's formulary, drug tiers, copay, and coinsurance requirements for prescription drugs with consumers to ensure that the QHP they choose covers the prescription drugs they need.



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Key Points

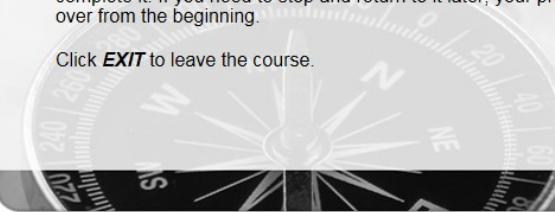
- Consumers who are eligible to purchase coverage offered through the Marketplaces have a choice of QHPs that meet certain requirements and are certified by the Marketplaces.
- All QHPs must cover EHBs, a core comprehensive package of items and services, known as essential health benefits.
- There are five health plan categories: Bronze, Silver, Gold, Platinum, and catastrophic health plans.

You've successfully completed this course.

Click Exit to leave the course and take the Marketplace Basics exam. Once you've started an exam, you must complete it. If you need to stop and return to it later, your progress won't be saved. You'll need to start the exam over from the beginning.

Click **EXIT** to leave the course.

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Key Points

- Consumers who are eligible to purchase coverage offered through the Marketplaces have a choice of QHPs that meet certain requirements and are certified by the Marketplaces.
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- There are five health plan categories: Bronze, Silver, Gold, Platinum, and catastrophic health plans.

You've successfully completed this course.

Marketplace Basics Resources

Actuarial Value Calculator

Resource that provides a detailed break-down of the health care services and benefits associated with the actuarial value of a health plan.

<http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-av-calculator-final.xlsxm>

HealthCare.gov

A resource where consumers can create a Marketplace account and access information about health coverage and the Health Insurance Marketplaces.

<https://healthcare.gov>

Health Insurance MarketplaceSM Training Resources

A variety of training resources from the Center for Consumer Information and Insurance Oversight (CCIIO) on the Marketplaces.

http://www.cms.gov/cciio/Resources/Training-Resources/index.html#Affordable_Insurance_Exchanges

Marketplace Call Center

Contact information for the Marketplace Call Center, a 24 hour, 7 day a week resource for consumers seeking health coverage through the Marketplaces.

<https://www.healthcare.gov/contact-us/>