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Your Maine Connection to the Health Insurance Marketplace

Marketplace

FAQs

Marketplace FAQs

Below are some Frequently Asked Questions about the Health Insurance Marketplace. Don't see your question here or have others? Contact the Consumers for Affordable Health Care HelpLine at 1-800-965-7476.

Who can buy coverage in the Marketplace?
Most people can shop for coverage in the Marketplace. To be eligible, you must live in Maine, be a citizen of the U.S. or be lawfully present in the U.S., and not currently incarcerated.

Not everyone who is eligible to purchase coverage in the Marketplace will be eligible for subsidies, however. To qualify for subsidies (also called premium tax credits) people must:

- Have income between 138% - 400% FPL
- Not be eligible for Medicare or full MaineCare
- Not have access to insurance through their employer (except when the employee share of the premium is more than 9.78% of employee's household income or the insurance doesn't cover 60% of health care costs).

Can I get help with my Marketplace application?
Yes. Please call Consumers for Affordable Health Care at 1-800-965-7476 to locate help in your area.

What is a Premium?
A premium is your monthly payment for health insurance. You must pay your premium even when you do not use your insurance. When you have Marketplace insurance, you'll pay your premiums directly to the insurance company, not to the Marketplace. Your plan won't start if you do not pay your first premium before the start date. Most people with Marketplace plans are eligible for help with premium costs, called "Advance Premium Tax Credits" (APTC).

I picked a plan. Do I send my premium to the Marketplace?
No, make your premium payments directly to the health insurance company. Once you've selected your plan, the Marketplace will direct you to your insurance company's website to make the initial premium payment. The insurance company must receive and process your payment at least one day before coverage begins. Make sure you understand and follow your insurance company's payment requirements and deadlines, so your coverage begins on time. Your enrollment in the health plan is not complete until the insurance company receives your first premium payment.

When do you have to make your first premium payment?
Before the date that your plan will begin. If you enroll during Open Enrollment, you must pay your first premium before January 1st. Sometimes you can make your first payment when you enroll online but you will still need to contact your insurance company to arrange for ongoing payments or pay the bill each month by check in the mail. You should call your insurance company a few days after you enroll to make sure you know when and how you can pay your premiums.

Remember, you can only apply for Marketplace insurance during Open Enrollment unless you have certain life events that give you a Special Enrollment Period.

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What if you do not pay your premium on time?

It depends on whether it is your first payment for that plan:

- **First Premium Payment: If you do not pay on time, your plan will not start.**
- **All Other Premium Payments**: If you do not pay on time, you get a grace period to catch up on your premium payments that will last 30 or 90 days- depending if you get a tax credit to help pay your premiums.
- **If you do not get a tax credit to help pay premiums**: You will have 30 days to make your late payment and any new payments that are due. During these 30 days, your plan will still pay your claims if you see a health care provider. If you aren't caught up on your premium payments by 30 days, your plan will cancel. You will have to pay for any care you got during those 30 days.
- **If you do get a tax credit to help pay premiums**: You will have 90 days total to make your late payment and any new payments that are due. During the first 30 days your plan will still pay your claims if you see the doctor. After 30 days, your plan will stop paying for benefits. You will still have another 60 days to get caught up on your premiums. If you pay all the premiums you owe during this 60-day period, or within 90 days from when you first missed a payment, you will be reimbursed for any coverable benefits that you paid yourself during this time which could have been paid by your plan.

If all late payments are not made within 90 days of when you first missed a payment, your plan will be cancelled.

What happens if my plan is cancelled?

If your plan is cancelled for not paying your premiums on time, it cannot be reopened. If you do not qualify for a Special Enrollment Period, you may have to wait until the next Open Enrollment period to enroll in coverage.

Was your plan cancelled for nonpayment when you were receiving tax credits to lower the cost of your premiums?

The insurance company may bill you for the premium you missed on your cancelled plan. This happens if you enroll in another plan **with the same insurance company** within 12 months of when your previous plan was cancelled. Insurance companies can't collect outstanding premiums from previous plans if:

- you don't enroll in another plan with the same insurance company you owe the premium to;
- the premium you owe is from a plan that ended more than 12 months ago; or
- you weren't receiving APTC during the time your plan was cancelled.

What if I need services outside of Maine?

All Marketplace plans must cover:

- emergency services if you get hurt while you're visiting another state, and
- services not available in-network that you have to get out-of-state that have prior approval by the insurance company.

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What if I use a provider outside my network?
You may have to pay more. Providers in your plan's network have agreements with your insurance company for how much they will be paid for a service. This is sometimes called the "negotiated rate" or "allowed amount." Any amount you pay in a copay, coinsurance, or towards your deductible, along with any amount paid by your plan, makes up this negotiated rate. The negotiated rate is a discounted rate you get for being a member of your plan. If an in-network provider charges more for a service than the allowed amount, you can't be billed for the difference. However, if you go out of network, the provider can bill you for the difference between the plan's negotiated rate and how much they charge for the service. This is called balance billing. So, even if your PPO plan includes out-of-network benefits, you may have to pay much more for out-of-network services than the out-of-network deductible and cost-sharing amounts listed in your plan.

What happens if I want to quit my Marketplace health plan during the year?
It is important that you contact both the Marketplace and the insurance company to let them know you no longer want this coverage. To tell the Marketplace:

- log into your Marketplace account, select the "terminate coverage" option, and enter the required information. If you have a family policy and want to remove one person from the policy but keep coverage in effect for others, log in to your Marketplace account, select the "report a life change" option, and enter the required information. Making these changes through your Marketplace account will create a written record that you tried to end coverage.
- You can get help canceling from a Navigator or CAC in your area. Call Consumers for Affordable Health Care at 1-800-965-7476 to find help in your area.
- You can call the Marketplace directly at 1-800-318-2596 to cancel your plan or to remove just one person from a plan.

Do not simply stop paying the premium for your Marketplace health plan to terminate coverage. Nonpayment will eventually cause your coverage to end, but in the future, if you try to enroll in coverage again with that insurer, you might be prevented from doing so until you repay the missed premium.

I heard the individual mandate ended. Does it still make sense to sign up?
Yes. Congress did eliminate the tax penalty for not having health insurance, starting January 1, 2019. While there is no longer a tax penalty for being uninsured, it is still important to have insurance coverage in case you get sick or in an accident.

Open Enrollment for 2020 health insurance and subsidies is still happening in every state. Uninsured individuals who need coverage can apply starting November 1st for health plans and financial help for the 2020 year. People already enrolled in Marketplace plans should return to the Marketplace to

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review 2020 plan choices and renew or change coverage, and to update their application for financial assistance.

I enrolled in a Marketplace plan and now realize that my doctor isn't in my plan's network.
If you enroll in a Marketplace plan, you can only switch to another plan until the date your coverage starts. After your coverage effective date, you won't be able to change your plan until the next Open Enrollment, unless you have certain life events that give you a Special Enrollment Period.

Examples of qualifying life events are:

- moving to a new state,
- certain changes in your income,
- changes in your family size (for example, if you marry, divorce, or have a baby), or
- getting or losing an offer of job-based coverage.

If you decide to switch plans, ask your doctor which insurance companies' provider networks they're in. You'll see a link to a list of providers in each plans' network where you can search to see if your doctor is in-network or out-of-network. Call the Marketplace Call Center at 1-800-318-2596 if you need help applying for coverage and enrolling in the Marketplace plan you want. Find out when your new coverage starts before you cancel your current plan, so you don't have a gap in coverage.

Do I have to prove eligibility for a Special Enrollment Period (SEP)?
Yes. The Marketplace requires people to provide documentation of eligibility for special enrollment before you can enroll in coverage. Pre-enrollment verification is required for the following qualifying events:

- Loss of minimum essential coverage
- Permanent move
- Marriage
- Adoption, placement for adoption, placement for foster care, or child support or other court order

If you experience one of these qualifying events and apply for coverage on the Marketplace, it will let you select a health plan, but will delay the coverage start date while it verifies your eligibility for the SEP. Once you apply for the SEP and select a health plan, you will have 30 days to provide documentation to the Marketplace. Once the Marketplace verifies your eligibility, you will be able to complete enrollment in the plan you selected.

It is very important to act quickly to complete this verification process. If you do not submit the required documentation within 30 days, your plan selection will be cancelled, and you will no longer be eligible for the SEP.

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I'm leaving my job and will be eligible for COBRA. Can I shop for coverage and subsidies on the Marketplace instead?

Yes, losing eligibility for job-based health coverage caused by leaving a job will trigger a special enrollment period that lasts for 60 days before or 60 days after the loss. You can apply for Marketplace health plans and (depending on your income) for premium tax credits and cost sharing reductions during that period. However, if you enroll in COBRA coverage through your former employer you will need to wait until the next Marketplace Open Enrollment period if you want to switch to a Marketplace plan. No premium tax credits are available for COBRA plans.

What do the "Bronze," "Silver," and "Gold" levels of Marketplace plans mean?

Plans in Maine's Marketplace are separated into three categories: Bronze, Silver, or Gold. These terms refer to the amount of cost sharing they require. Cost sharing refers to health plan deductibles, co-pays and co-insurance, your out of pocket costs. For most covered services, you will have to pay (or share) some of the cost, at least until you reach the annual out of pocket limit on cost sharing. The exception is for preventive health services, which health plans must cover entirely.

In the Marketplace, Bronze plans have the highest deductibles and other cost sharing. Silver plans require somewhat lower cost sharing. Gold plans have even lower cost sharing. In general, plans with lower cost sharing will have higher premiums, and vice versa.

What are "Catastrophic Plans? And can I get one?

Catastrophic plans are only for adults up to age 30 and for older people who cannot find any other Marketplace plan that costs less than 8.24% of their income. Catastrophic plans have the highest cost sharing. In 2020, Catastrophic plans will have an annual deductible of $8,150 ($16,300 in family plans). You must pay the entire cost of covered services (other than preventive care) until you've spent $8,150 out of pocket; after that your plan will pay 100 percent of covered in-network services for the rest of the year.

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