WHAT YOU NEED TO KNOW

Moving from Medicaid to Marketplace Coverage

Now that the COVID-19 emergency is over, the government is restarting the yearly process of making sure people on Medicaid or CHIP are still qualified for these programs. The process is called Medicaid Redetermination. It helps make sure Medicaid stays strong and can serve those who need it most.

Since COVID began in 2020, things may have changed for you, including where you live, or work, and how much you earn. As a result, some people may lose their Medicaid or CHIP coverage, but you still have other options. You may be able to get health insurance from your employer. Or you may be able to buy a plan — with financial help if you qualify — from the state insurance marketplaces.

What Is Marketplace Coverage?

Things may have changed for you since the start of the COVID-19 pandemic – including where you live, where you work, and how much you earn. As a result, it's possible you are no longer eligible for Medicaid. But you may be able to get health insurance through the Health Insurance Marketplace (also known as the "Marketplace" or "exchange"). The Marketplace provides health care coverage options for people who do not have access to coverage through their job and are ineligible for Medicaid and Medicare.

In most states, the federal government runs the Marketplace through HealthCare.gov, although some states run their own Marketplaces at different websites. On average, people shopping for coverage through the Marketplaces can choose coverage from 6 to 7 health insurance providers.

Most people with Marketplace coverage qualify for savings, or a subsidy, to help lower their health care costs. These savings, or subsidies, are based on household income and size.

TAKE ACTION NOW!

If you lose Medicaid coverage, you may be eligible for free or low-cost coverage through the Health Insurance Marketplace. **Visit HealthCare.gov to find and enroll in a health plan or call the Marketplace Call Center at 1-800-318-2596.**

1. **UPDATE** Your information with your state's Medicaid program
2. **WATCH** In your email, mail, and texts for more information about how to renew your coverage
3. **REPLY** As soon as you get information so there's no drop in your health coverage

More about Medicaid in your state: Renew Your Medicaid or CHIP Coverage | Medicaid

If you are eligible for health insurance through your job, ***you have 60 days to enroll*** *after the date you lose Medicaid coverage.*

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Key Differences Between Medicaid and Marketplace Coverage

	Medicaid	Marketplace Coverage
Costs	Paid for by the government and taxpayers. Most people enrolled in Medicaid do not pay a monthly premium or for services when they get health care or medications.	People enrolled in Marketplace coverage pay a monthly premium directly to their health insurance provider. **Most people qualify for financial help to lower monthly costs.** Most enrollees can find a plan for less than $10 per month. People enrolled in Marketplace coverage may have out-of-pocket costs—including deductibles, copays, or coinsurance—when they seek health care or medications. Some people may be eligible for additional financial help that provides extra savings on these out-of-pocket costs. Costs are different from plan to plan. Be sure to know what each plan offers and what important terms mean so you can choose the plan that best fits your needs.
Benefits	Covers most health care, like hospital and doctor visits, lab tests and X-rays, mental health care, home health services, and prescription drugs. Medicaid covers annual check-ups, immunizations, preventive care, and other wellness services. In some states, Medicaid covers other services like dental care, vision services, eyeglasses, and routine medical transportation.	Covers most health care, like hospital and doctor visits, prescription drugs, emergency care, mental health, and hospitalizations. Benefits vary from state to state and plan to plan, so be sure you know what benefits and services are included in your coverage, and which are not. For more information on a plan's benefits, reach out to the health insurance provider who offers that plan.
Types of Coverage	Most people with Medicaid get their care through Managed Care Organizations (MCO). People can choose their MCO, but there are very few differences in benefits and out-of-pocket costs. The main differences are the specific providers available through each MCO. Ten states do not use MCOs – in those states, people with Medicaid all choose from the same providers chosen by the state.	The Marketplace offers four different health plan categories: Bronze, Silver, Gold, and Platinum. Choosing between these categories doesn't have to be complicated. The main differences between the categories are the amount you pay in monthly premiums versus the amount you pay out of pocket for health care services. • Bronze plans have the lowest premiums but you will have higher out-of-pocket costs when you need care. A bronze plan may be a good choice if you want a low-cost way to protect yourself from worst case medical scenarios. • Silver plans offer more moderate monthly premiums and moderate costs when you need care. **If you qualify for financial help to lower your out-of-pocket costs, you must pick a Silver plan to get extra savings.** Silver plans are a good choice if you qualify for extra savings. • Gold and Platinum plans have higher premiums, but you will have lower out-of-pocket costs when you need care. If you use care a lot, a Gold or Platinum plan could be a good value. Once you pick a plan category, you may be able to choose from a variety of different plan types, such as Health Maintenance Organizations (HMO) or a Preferred Provider Organization (PPO). The main difference between the two is whether you have coverage for out-of-network providers. Typically, an HMO will have a lower monthly premium but you may not have coverage for out-of-network providers and may have to pay out-of-pocket.

How Do I Enroll in Marketplace Coverage?

If you are no longer eligible for Medicaid, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596 to submit an application. You are eligible for a special enrollment period (SEP) to enroll in Marketplace coverage outside of the annual open enrollment period. Visit the Marketplace as soon as possible to see if you are eligible for coverage and financial assistance to lower your monthly premium. Enroll as soon as possible to avoid a gap in coverage.

How Do I Choose Coverage that's Right for Me?

Ask yourself a few questions about what kind of health care you want to be covered, and what costs you are most comfortable paying. Typically, plans cover similar services, but will have different costs and cost structures. For example, if you are willing to pay more toward your premium, you are likely to pay less out of pocket for health care services, and vice versa.

You can get help picking a plan and filling out an application by calling the Marketplace Call Center at 1-800-318-2596. If you want in-person help submitting an application or choosing a health plan, visit localhelp.healthcare.gov.

Here are a few important questions to think about:

Do I qualify for financial help to lower my premium and out-of-pocket costs?

Submit a Marketplace application to see if you (or other members of your household) qualify for coverage and financial help through the Marketplace. If you are eligible for extra savings, you must choose a Silver plan in order to lower your deductible, copay, or coinsurance.

Are my doctors and hospitals in network?

Health insurance providers negotiate lower prices for you with hospitals, health systems, doctors, and other providers. These providers are considered "in network." Going to in-network providers helps you save money with your health plan. If a doctor or facility does not contract with your health plan, they're considered out-of-network and can charge you full price. If you see an out-of-network provider, you will likely pay significantly more than you would pay in-network. In cases of emergency services, you will owe only the in-network cost-sharing amount, regardless of who you see.

Are my prescription drugs covered?

Each health plan has its own "formulary," which is a list of prescription drugs that it covers. Some drugs may be 100% covered, while others may require some payment from you. Before enrolling, check the plan's formulary to see if your medications are covered and what your costs would be.

Coverage through the Marketplace can vary from plan to plan and may be different from your Medicaid coverage. For example, some services or prescription drugs covered by your Marketplace coverage may be subject to prior authorization (pre-approval) or step therapy. Reach out to your broker, assister, or health plan to understand how those services are covered.

Do I have a chronic health condition that I need help managing?

If you have a chronic condition – such as a heart condition, or diabetes – make sure services, treatments, or benefits you expect to use are covered by the health plan.

What are the out-of-pocket costs for my doctors (including copays and coinsurance)?

A **premium** is the amount you pay monthly to keep your coverage. You may be eligible for financial assistance to lower your monthly premium amount. 4 out of 5 people can find a plan for less than $10 a month.

A **copay (or copayment)** is a flat fee that you pay at the point of service each time you go to your doctor or fill a prescription. Copays cover your portion of the cost of a doctor's visit or medication.

Coinsurance is a portion of the medical cost you pay after your deductible has been met. Coinsurance is a way of saying that you and your insurance carrier each pay a share of eligible costs that add up to 100%.

A **deductible** is the amount you pay for most eligible medical services or medications before your health plan begins to share in the cost of covered services.

Do I want a lower monthly premium but higher out-of-pocket costs when I get care – or a higher premium and lower out-of-pocket costs when I get care?

Think about how you are most comfortable paying for your health care. Choosing a Bronze plan may mean paying higher out-of-pocket costs when you receive care but saving money if you don't expect to use your health coverage often. A Gold or Platinum plan may mean paying higher monthly premiums, but also allows for more predictability in your costs, even when you experience an emergency or health issue you didn't expect.

How Do I Use Marketplace Coverage?

Once you have enrolled in coverage, be sure you understand your benefits and the costs for various procedures and services. Here are a few important things to remember when using your new health plan:

- Contact your providers and pharmacy to make sure they have your updated insurance information.
- If you don't already have a primary care provider, find a doctor that is in your network. If you do have a primary care provider, be sure to make sure your doctor is in-network before seeking care.
- Be sure to get regular check-ups and ask your doctor about preventive screenings to help you stay healthy.
- Keep track of your health care spending so you can use that information during the next open enrollment period to ensure you have a plan that best fits your needs.

Visit AHIP.org/health-insurance-terms for a full glossary and definitions of frequently used terms. Always reach out to your health insurance provider if you have specific questions about your coverage.

Everyone deserves affordable access to comprehensive coverage that protects their health and financial stability. Health insurance providers are committed to working to help you enroll in coverage that best fits your needs.