Riskier Business

A Guide for Dramatists and Performing Arts Workers on Finding Affordable Health Coverage and Care

(UPDATED EDITION)

United Hospital Fund
Improving Health Care for Every New Yorker

November 2025

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Peter Newell
Director of United Hospital Fund's Health Insurance Project

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Ben Pesner, Program Director of Venturous Theater Fund, provided valuable insights that strengthened this report.

About United Hospital Fund

UHF works to build an effective and equitable health care system for every New Yorker. An independent, nonprofit organization, we are a force for improvement, analyzing public policy to inform decision-makers, finding common ground among diverse stakeholders, and developing and supporting innovative programs that improve health and health care. We work to dismantle barriers in health policy and health care delivery that prevent equitable opportunities for health. For more on our initiatives and programs, please visit our website at www.uhfnyc.org and follow us on X at https://x.com/unitedhospfund and on LinkedIn at www.linkedin.com/company/united-hospital-fund.

About Venturous Theater Fund

Venturous Theater Fund (VTF) supports ambitious new work for the stage and the writers who create it. VTF makes grants to fund the production of plays that are "venturous"—ambitious in scale, epic in scope, challenging in form, controversial in subject matter, experimental in concept, and/or unabashed in their theatricality. Production support includes Venturous Capital Grants that help writers achieve the freedom to write the plays they fear would otherwise go unproduced by enabling producing organizations to say "yes" instead of "no" to worthy but challenging author-driven projects. VTF also funds artist-driven initiatives that embrace agency, champion creative growth, and bolster financial security for playwrights at all stages of their careers through grantmaking that provides dramatists and other theater workers with increased access to health insurance and health care resources, as well as opportunities for relationship-building and artist-to-artist collaboration across national boundaries. Key initiatives include the Venturous Playwright Fellowships at the Playwrights' Center, the Legacy Playwrights Initiative at the Dramatists Guild Foundation, support for playwright service organizations, playwright collectives, writers who self-produce, and more. VenturousTheaterFund.org.

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Foreword

Every performing arts professional deserves access to quality health care and affordable insurance. Yet recent legislative changes have made it more challenging than ever for dramatists and other freelancers—those who work project to project, whose income fluctuates month to month, who lack employer-provided insurance or a union plan—to find reasonably priced coverage and care.

Our colleagues at United Hospital Fund are here to help. They created this guidebook in 2024 to address the health care needs of dramatists, based in part on in-depth conversations with playwrights. This newly updated resource is equally useful for anyone who works in the performing arts or anyone who needs assistance navigating the complex, often bewildering landscape of health coverage options. It's designed to give you the knowledge to make confident choices at every stage of your career, whether you're seeking coverage as a freelancer, navigating the Affordable Care Act (ACA) marketplace, planning for retirement, or searching for medical care and prescriptions when uninsured. It will walk you through your options, including how to secure coverage, what questions to ask, where to find free counseling, and how to avoid "junk" insurance. It will help you become your own best advocate as you navigate the devastating cuts and problematic rule changes made to the ACA, Medicaid, and other programs in 2025 and 2026.

Your health is your most valuable asset. We hope this guidebook will serve as a valuable companion to aid you in securing the health care you deserve—so that you can continue to do what you do best: tell vital stories on stage.

Ben Pesner
Program Director
Venturous Theater Fund

Introduction

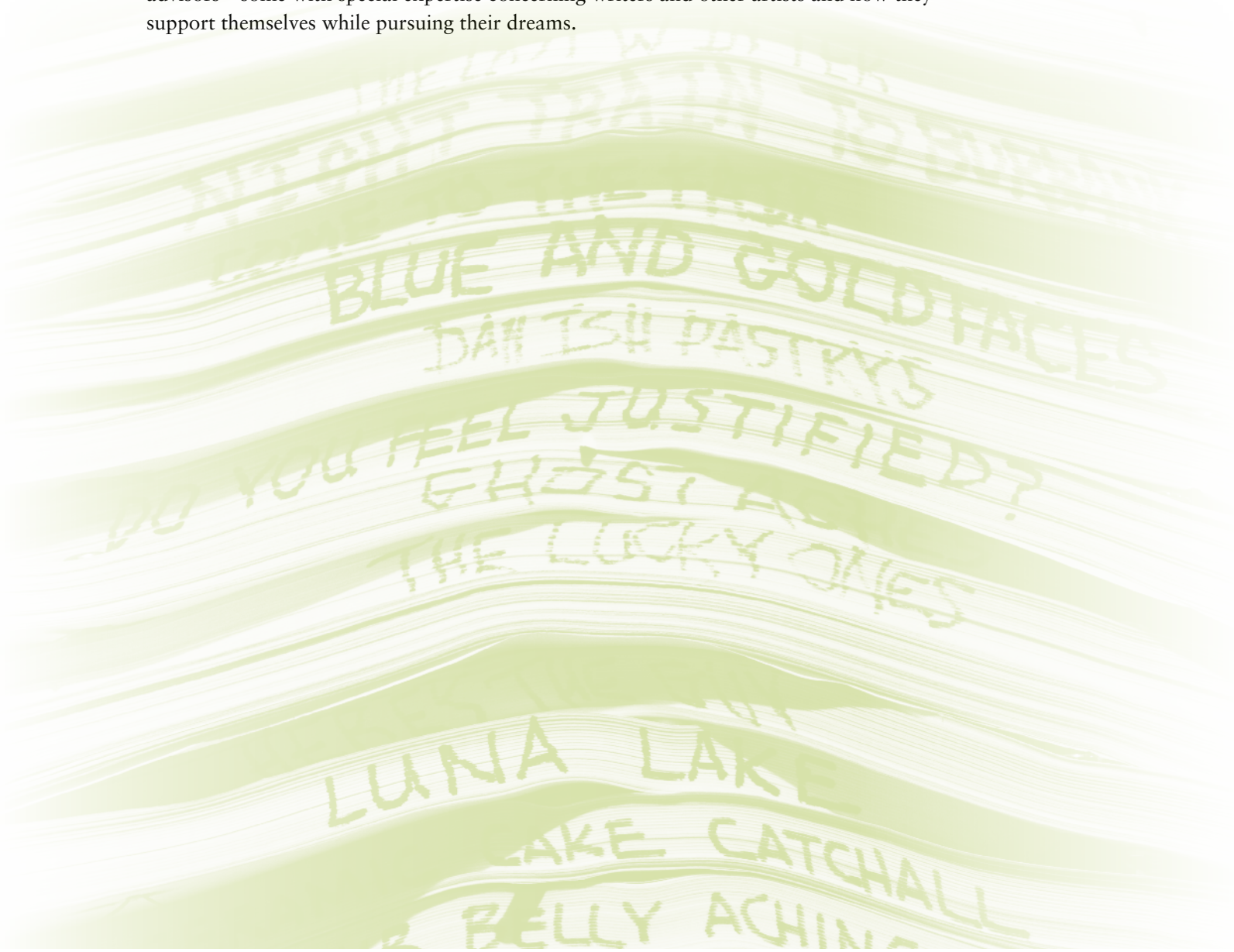
Theater work is a risky business. Whether it's writing plays (or musicals or operas), acting, or contributing to productions in manifold other ways, there's the risk of pouring your heart and soul into a work only to face rejection, a bad review, or a short run. But there's also the risk of being on your own in finding and maintaining health coverage in a system that's not set up for people like you, and of facing the health and financial risks that come with periods of uninsurance. Unfortunately, a new Congress and Presidential administration with different spending priorities—and different views on health care access and consumer protections—have made the profession even riskier for 2026, when it comes to finding and affording health coverage. Recent changes and uncertainties are described in "The Plot Thickens" (Act II, page 6), and some provisions are still hung up in the courts. In general, new laws and regulations adopted in 2025 make coverage more expensive, harder to sign up for, and harder to keep in 2026. In the event of further Congressional action or additional regulations or court decisions, we will post new updates here.

Most U.S. adults under the age of 65 (about 60% in 2023) get their coverage on the job, through arrangements in which employers, unions, or insurers assume the risk for workers' health care by purchasing or organizing coverage; most employees chip in to pay a portion of the premium for the plan through a payroll deduction, and employees and employers receive generous tax breaks. And while many theater workers find coverage through other employment, a partner's job-based plan, or an entertainment industry union, the union coverage door remains closed for many. A quirk in federal law limits union benefit plans for dramatists, and many others in the theater world don't meet available union plan eligibility standards. But even entertainment union coverage can be iffy: A California couple recently took the extraordinary step of creating a short film to maintain eligibility for their union plan.

The landmark Affordable Care Act (Obamacare or ACA) expanded eligibility for Medicaid and created new health care options for theater workers. New York and other states have taken advantage of opportunities to enhance the affordability of those options. With the support of Venturous Theater Fund, we've assembled this updated guide to help dramatists and other theater workers navigate the often-Byzantine world of health insurance, find affordable coverage and care, and become their own best advocates.

This guide is organized in five main parts. Act I contains a glossary of useful terms; Act II highlights regulatory and legal changes new for 2026; Act III features an FAQ-style script for finding coverage in New York State; Act IV details extra help available to find care if you don't have insurance, or to get the most out of the coverage you have; and Act V lists resources for coverage for those living in other states. Before the curtain rises, here are three important "notes" to keep in mind in these uncertain times:

- Despite recent changes and federal funding cuts, New York has worked to preserve affordable coverage options. Situations in other states vary; see Act V.
- If you are enrolled in coverage through a state or the federal marketplace, make sure to visit your account and update contact information and other matters, and keep an eye out for mail, texts, or other notifications.
- Looking for a health plan can be daunting, but free help is available from experienced advisors—some with special expertise concerning writers and other artists and how they support themselves while pursuing their dreams.



Act I. Speaking Insurance

Health insurance has its own complicated language. But knowing the following terms is a must for finding and using coverage and will help make this guide a more useful resource:

ACA—the Affordable Care Act (aka "Obamacare"), the 2010 federal law that made accessible, higher-quality, lower-cost health coverage available to consumers without job-based coverage and ineligible for public programs like Medicaid; expanded Medicaid eligibility at the option of states; and authorized the creation of federal and state "marketplaces" (also known as an "exchange") for people to shop for coverage.

Premium—the amount of money you pay every month to be enrolled in a health insurance plan. Usually, a higher premium up front means lower out-of-pocket expenses when you access covered services, and a lower premium means higher out-of-pocket costs.

Cost sharing—the expenses that covered persons usually incur for health services in addition to the premium. These "out-of-pocket" expenses can include a deductible, copayments, and coinsurance. Preventive care is exempt from cost sharing under the ACA, and New York is also seeking to maintain reduced cost sharing for diabetes services and maternity care for some plans. New York programs like Medicaid, Child Health Plus, and the Essential Plan have no, or very low, cost sharing.

Deductible—the amount you might have to pay for covered health services before your insurance plan begins to pay. For example, if you have a $500 deductible, it means that you will pay for the first $500 worth of covered services yourself. After you've met this deductible, other cost sharing may kick in, such as copayments or coinsurance, but the insurance company will pay the rest. Depending on the type of health plan, certain services, such as preventive care or prescription drugs, may not be subject to the deductible.

Copayment (or copay)—a fixed dollar amount ($20 for a primary care visit, for example) you pay for a health care service directly to the provider after you've paid your deductible.

Coinsurance—a fixed percentage you pay for a health care service after you've paid your deductible. For example, if your insurance plan has set the coinsurance rate for outpatient lab tests as 20%, then a $50 charge will cost you $10 and the insurance plan will pay the remaining $40.

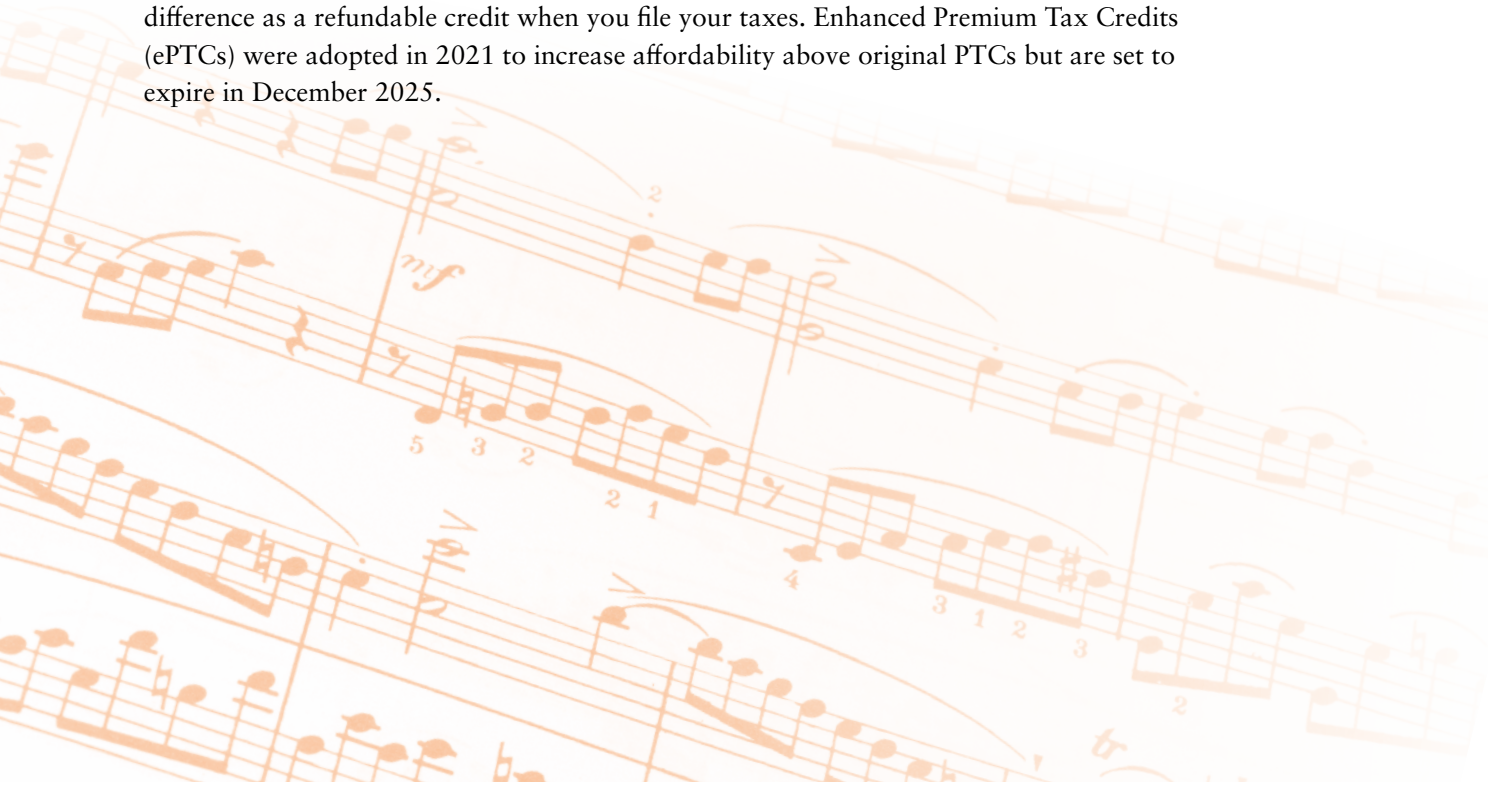
Out-of-pocket (OOP) Maximum/Limit—a cap on the total amount in deductibles, copayments, and coinsurance you must pay for health services in a one-year period. Once this limit is reached, your health plan is obligated to cover 100% of the costs of your covered health services.

Network—the group of providers and health care facilities with whom your health plan has contracted to provide health services to enrollees at an agreed-upon rate of payment. In New York, coverage for out-of-network (OON) care is very rare for individuals, so if you go to a non-network provider then you will likely have to pay the full price, which can be expensive.

Federal Poverty Level (FPL)—a measure of income issued every year by the federal government that is used to determine eligibility for certain programs and benefits, including savings on Affordable Care Act coverage, enrollment in Medicaid, Medicare assistance, the Child Health Insurance Program (CHIP), the Essential Plan (EP), and discounted hospital and health center services. For these purposes, a household's income is divided by the guideline that equals 100% of the Federal Poverty Level, and the resulting percentage is used to determine eligibility. For example, a household comprised of a single individual with an income of $45,000 in 2025 represents an income ratio of about 2.87 or about 300% FPL ($45,000 divided by $15,650). Charts showing multiples of the FPL for different years are available here. You can also plug your income and family size into this calculator to determine your household's percentage of FPL. The marketplace uses the 2025 guidelines to determine affordability assistance during Coverage Year (CY) 2026 for Qualified Health Plans. The 2025 guidelines, expected to be updated in January 2026, are used for Medicaid, the Essential Plan, and Child Health Plus eligibility determinations, and discounted hospital and health center services, until the 2026 guidelines are issued.

Cost-sharing Reduction (CSR)—for eligible purchasers of Silver-level Qualified Health Plans (QHPs) through the New York State of Health (NYSOH) marketplace, a discount that lowers the amount you have to pay out of pocket for deductibles, copays, and coinsurance.

Premium Tax Credit (PTC)—for eligible purchasers of QHPs through the NYSOH marketplace, a tax credit that can lower your monthly premium. Eligible consumers can use the credit in advance ("advance premium tax credits or APTCs") to lower monthly premiums. If you use more advance payments of the tax credit than you qualify for, based on your final yearly income, you must repay the difference when you file your federal income tax return in 2027. If you use fewer premium tax credit payments than you qualify for, you'll get the difference as a refundable credit when you file your taxes. Enhanced Premium Tax Credits (ePTCs) were adopted in 2021 to increase affordability above original PTCs but are set to expire in December 2025.



Act II. The Plot Thickens: Changes for 2026 (Mostly Bad Ones)

New federal regulations issued by the Centers for Medicare & Medicaid Services (CMS) and legislation passed by Congress known as HR1 make numerous changes to Medicaid, Medicare, and Affordable Care Act health coverage. In general, federal funding for states has been cut, in some cases dramatically. Other changes limit eligibility for some consumers, add new red tape, and increase premiums, although some consumers might benefit from some new provisions. Complicating matters further, some new provisions have been stayed in federal court proceedings, and the changes do not apply uniformly across all states and the federal marketplace, HealthCare.gov. Finally, Congress could still act before the end of 2025 to address potentially huge premium increases for consumers.

For the latest ACA updates, go here.

Following is a summary of some of the more important changes that will affect consumers' coverage for 2026, depending on their home state. The New York State of Health marketplace will provide updates for New York consumers at this site, as more information becomes available, and many state marketplaces will offer similar ways to stay abreast of changes. We'll provide updates for this guide on this page when court decisions, regulatory actions, or Congressional activity change the health care landscape for consumers.

Enhanced Premium Tax Credits (ePTCs). A 2021 law that enhanced original Affordable Care Act (ACA) premium tax credits for consumers purchasing Qualified Health Plans (QHPs) from the marketplace expires on December 31, 2025. The law was designed to improve affordability at all income levels, and failure to extend it will increase premiums for consumers on average by about 75%, according to some experts. Enrollees in ACA plans earning over 400% of the Federal Poverty Level (FPL, about $62,500 per year for an individual) will lose all financial assistance. Consumers in all states can use this calculator to estimate their premium if the enhanced subsidies are not extended.

Immigrants with Deferred Action for Childhood Arrival (DACA). DACA recipients are no longer eligible for tax credits toward the purchase of QHPs. Income-eligible DACA recipients in NYS can still enroll in Medicaid and Essential Plan coverage.

Other Immigrants. Lower-income immigrants who are "lawfully present" under the ACA, but who do not meet new HR 1 standards, are no longer eligible for premium tax credits. In New York, a landmark court case preserves low-income immigrants' ability to maintain coverage, though the budgetary impact is extreme. This provision will be especially problematic in states that have chosen not to expand Medicaid.

Gender-Affirming Care. The federal marketplace rule eliminated gender-affirming care as an "Essential Health Benefit" for Qualified Health Plans purchased in the marketplace; some states have challenged this provision in court. And some states, such as New York, have laws requiring the coverage, and the federal rule change does not prevent health plans from covering the benefit or states from "defraying" the cost of these services, which is believed to be nominal. This article summarizes the complex current status of the benefit. Affected consumers should contact their marketplace or health plan for more information.

Data Matching Issues. Consumers whose estimated income differs substantially from available data on previous years' income (known as Data Matching Issues, and a common problem for theater workers) may have to provide additional documentation and will have a shorter grace period to address the issues and receive tax credits instead of paying the full cost of coverage.

Tax Credit Repayments (Reconciliation). Consumers receiving PTCs are required to "reconcile" the amount of tax credits they received based on their estimated income with the amount of credits they should have received based on their actual income when they file their taxes. For 2026 (taxes filed in 2027), consumers who received "excess" tax credits during 2026 will have to repay the entire amount when they file their taxes in 2027. For now, income-based caps protect consumers who underestimated their income when they applied for the credits.

Special Enrollment Periods. More paperwork may be required when coverage is sought during a Special Enrollment Period (triggered by events such as loss of employer coverage, marriage, the birth of a child, or other life changes) in some marketplaces.

Health Savings Accounts. Consumers with Health Savings Accounts (HSAs) can use funds for "direct primary care services" up to $150 per month for individuals and $300 per families, and all marketplaces will have HSA-eligible product offerings.

Catastrophic Plans. Consumers who are ineligible for tax credits and over the age of 30 but who demonstrate "hardship" can enroll in "catastrophic" plans with low premiums but sky-high deductibles (about $10,000 for individuals) at HealthCare.gov. They may also be able to enroll at other marketplaces, depending on state policy.

In the midst of this uncertainty, consumers up for renewal are strongly encouraged to log into their marketplace accounts and update their information and to also be on the lookout for any communications regarding coverage for 2026.

Act III. Q&A for New York Coverage

Coverage on the Marketplace

While employer-sponsored coverage is the most common type of arrangement, those without a job that offers coverage must buy it on their own or enroll in a state-sponsored plan, and there are many different available programs.

Is Obamacare still in effect?

Yes. While the pending expiration of enhanced premium tax credits (ePTCs) in December 2025 has received a lot of deserved attention, the Affordable Care Act (ACA) core programs are still in effect. Other state-sponsored coverage also remains available.

Where do I go to find health coverage?

New York State of Health (NYSOH), also known as the "marketplace" or the "exchange," is the official one-stop shop for free or low-cost public and private coverage; "full premium" unsubsidized plans are also available through NYSOH. Authorized by the ACA, the marketplace maintains a website and a hotline (1-855-355-577, TTY 1-800-662-1220) where consumers can shop for plans that meet state and federal standards for quality, consumer protections, and benefits. It's the only place to go to get financial help with coverage. The main programs offered through the marketplace are Medicaid, Child Health Plus, the Essential Plan, and Qualified Health Plans. Dental plans are offered too. Free expert advice is available to help consumers navigate the system, and help is readily available in dozens of languages besides English.

Will I be able to afford the coverage available in the NYSOH marketplace?

A wide range of affordable health plans is available on the marketplace, including free or very low-cost options. Federal budget cuts have forced New York to pull back on certain programs, and consumers may face reduced help with premiums and cost-sharing if the ePTCs expire, but many options remain.

What's the difference between the types of coverage?

NYSOH offers access to several different kinds of coverage. All of the programs rely on participating managed care plans to deliver services. Benefits vary slightly among plans but are comprehensive, with doctors, hospitals, labs, mental health, and prescription drugs all covered. There is no cost-sharing (such as a copay) in any of the programs for preventive care services (like vaccines, screening tests, and PrEP medication). Eligibility is based on age and household income. Here is a summary:

Medicaid is the federal/state health insurance program for low-income children and adults who are enrolled through NYSOH, and the "aged, blind and disabled," who are usually eligible for Medicare too and are enrolled through counties at present. Enrolling in Medicaid means joining nearly 7 million fellow New Yorkers who are also covered under the program.

The income limit is 138% of the Federal Poverty Level (FPL) for adults; the limit is higher for children (154% of FPL) and pregnant women (223% of FPL). Of the options available through NYSOH, Medicaid has the most comprehensive benefits, including services like home care and nursing homes, vision and dental care, and transportation to medical appointments. There are no premiums, and cost sharing is minimal and capped at $200 per year.

Essential Plan (EP) coverage is intended for New Yorkers ages 19 to 64, who are ineligible for Medicaid and earn up to 250% of the FPL. About 1.3 million New Yorkers were enrolled in 2025. There are $0 premiums and deductibles for enrollees, and copayments are low. The EP offers comprehensive benefits to all its members, with those at the lower end of the income scale receiving Medicaid-like benefits. The maximum enrollee out-of-pocket (OOP) expense is capped at $2,000 annually. All EP enrollees are eligible for free dental and vision services. Due to severe federal budget cuts, NYS has applied for permission to reduce EP eligibility to enrollees earning up to 200% of the FPL, beginning July 1, 2026. If the application is approved, current enrollees earning between 200 and 250% of the FPL will be notified of the change and be offered the chance to enroll in a different plan. Affected consumers will be notified of any changes at least 90 days before the July 1, 2026, deadline.

Qualified Health Plans (QHPs) are available to enrollees in households above the EP eligibility level of 250% FPL (tentatively decreasing to 200% FPL in July 2026) and come in four "metal levels": Platinum, Gold, Silver, and Bronze. Degrees of cost sharing vary by level, as shown in this table. Over 220,000 New Yorkers picked QHPs in 2025. As you'd expect, Platinum plans have the highest premiums and lowest cost sharing, and Bronze plans have the highest cost sharing and the lowest premiums. A fifth plan, catastrophic, is available for policyholders under the age of 30 willing to pay over $10,000 in out-of-pocket costs before the policy kicks in. NYSOH has the option of allowing consumers over the age of 30 to apply if they meet certain other requirements.

Enrollees in the QHPs (except catastrophic plans) may be eligible for two kinds of affordability subsidies to reduce costs, based on the size of the household and income. First, enrollees in the four "metal" plans can apply for sliding scale Premium Tax Credits (PTCs). Eligibility for the credits starts at 250% FPL and ends at 400% of FPL, unless Congress extends the current law, which provides the credits until a consumer's premium payments no longer exceed 8.5% of their household income. The credits can be taken in advance (APTCs) to reduce monthly premiums, or as a refund at tax time. At the end of the tax year, those receiving credits must reconcile the amount received with their actual income and then repay the amount of credits that exceeded the correct amount that should have been allocated based on income. If the reverse is true, enrollees may be entitled to a refund. Second, enrollees in Silver plans earning up to 400% FPL (about $62,600 for an individual in CY 2025) are eligible for Cost Sharing Reductions (CSRs) to significantly reduce OOP costs. Beginning in 2025, a QHP enrollee earning up to 350% of the FPL (about $55,000 in 2025) became eligible for a "Silver Supreme" plan with a deductible of only $350. Enrollees in new "Silver Enhanced" plans earning less than 400% FPL are also eligible for reduced cost sharing. These cost sharing reductions adopted for QHPs in 2025 are summarized here. The availability of these additional CSRs for 2026 may be affected by ongoing discussions between NYSOH and federal officials regarding a state plan to mitigate federal funding cuts. QHPs without affordability help, also known as "full premium" plans, are also available on the NYSOH marketplace.

Consumers who are currently enrolled in QHPs will be notified beginning on November 1, 2025, about premiums and any APTCs that are available. For coverage effective January 1, 2026, decisions must be made by December 15, 2025. With ePCTs set to expire on December 31 at this point, consumers will need to make some hard decisions on what they can afford. Those who don't respond will be re-enrolled in their current plans, which will be more expensive.

Child Health Plus (CHP) complements Medicaid to provide very affordable coverage for kids under the age of 19 who are residents of New York State, not eligible for Medicaid, don't already have insurance, and are not eligible for public employee plans. Almost 570,000 children were enrolled in CHP through about 10 health plans in August 2025. Benefits are comprehensive, and deductibles and co-payments are not permitted. CHP has no premiums for families earning less than 220% (or 2.2 times) of the FPL. After that, premiums range from $15 per month per child to $60 per month per child depending on income and family size. For larger families, the monthly fee is capped at three children. Income eligibility is detailed on this chart. Many families piece together coverage with CHP for kids and other coverage for adults. Families with incomes more than four times the FPL can buy "full premium" CHP, still without any cost sharing, with premiums in the $300 per month range. Children can also be covered through QHPs as dependents on family and parent/child policies. In addition, about 4,000 children were covered under QHP "child-only" plans in 2023, with premiums adjusted to reflect a child's lower medical costs compared to an adult's.

Which insurance companies participate in NYSOH?

It's a mix of plans specializing in the Medicaid program, homegrown New York regional nonprofit managed care plans, Blue Cross carriers, and some national for-profit plans. Some insurers focused on the employer market like CIGNA don't participate at all; others, like Anthem (Empire) BCBS and UnitedHealthcare, participate through subsidiaries originally organized to serve New York's Medicaid program. All counties have at least two competing health plans, and NYC counties have the most.

What are the provider networks like on the marketplace plans?

State agencies and NYSOH review all the health plan provider networks and must find that they are adequate to meet the health care needs of enrollees before products can be marketed and sold. The marketplace networks are likely not as broad as the networks that serve employees of large businesses or institutions like universities. And marketplace plans certainly face the same problems affecting the entire health care system, such as the shortage of primary care providers and mental health and substance use disorder providers.

Can I be rejected by NYSOH or charged more money if I have a pre-existing condition?

No, that is not permitted under New York State and ACA consumer protections. That said, beware of "junk insurance" that might be available through unscrupulous operators that are trying to trick consumers into buying coverage that looks like NYSOH coverage, but is substandard. With the potential reduction of ACA premium subsidies, many are concerned that Congress is creating an opening for scam artists to target more victims with "junk" plans.

What's junk insurance?

NYSOH certifies QHPs to make sure they meet federal and state quality and consumer protections standards on preexisting conditions and other matters and provide value and financial protection to enrollees. New York's Department of Financial Services and Health Department makes sure that "look-alike" coverage available from licensed state insurers also meets these standards. About 12 New York insurers offered these "off exchange" plans in 2023, and about 40,000 were sold. But scammers posing as government websites are aggressively marketing "cheaper" plans lacking important consumer protections on pre-existing conditions, or without benefits like maternity care and mental health. Some of the plans, such as short-term limited duration insurance, are illegal in New York, and another type of coverage, known as a health care sharing ministry, isn't insurance at all. One New York couple fell for a telemarking scam that made them fictitious employees of a fake company and stranded them with thousands of uncovered medical bills. These plans—known as "junk insurance"—leave consumers on the hook for catastrophic medical expenses. One sure tip-off of a scam: being asked medical questions as part of the application. Also consumers should steer clear of company websites for plans that do not have ".gov" in their url.

Will I get dinged with a tax penalty if I don't have coverage in New York?

No, not in New York. Since Congress "zeroed out" the penalty in 2019, a handful of states (including New Jersey) have adopted shared responsibility payments, but not New York.

Can anyone apply to NYSOH?

All New York residents who are not incarcerated can apply to NYSOH, but eligibility for Medicaid, EP, and QHPs is limited to U.S. citizens, U.S. nationals, and lawfully present immigrants. "Lawfully present" is the ACA term that describes the many categories of non-U.S. citizens who have permission to live and work in the U.S. because of their immigration status. This guide outlines NYS rules for program eligibility. CHP is open to children up to age 19 regardless of immigration status. Young adults with Deferred Action for Childhood Arrivals (DACA) status are eligible for Medicaid or the EP, depending on their incomes, but are no longer eligible for APTCs for QHPs because of a recent federal rule. Undocumented immigrants who are income eligible can enroll in Emergency Medicaid at NYSOH (or get a referral to where they can enroll). Undocumented residents over age 65 who are ineligible for Medicare can now apply for Expanded Medicaid if they meet income and resource tests, in a program administered by New York City and local social services districts.

Can I apply for coverage any time of year?

Enrollment for Medicaid, Child Health Plus, and the Essential Plan is open year-round. QHPs can only be purchased during the regular NYSOH Open Enrollment Period (November 1 through January 31), unless a consumer qualifies for one of the many types of special enrollment periods triggered by "qualifying life events" under NYSOH rules. These events include marriage, moving to New York permanently (or to a different part of the state that makes other plans available), divorce, pregnancy, and births. Other qualifying events are not so intuitive, such as becoming eligible or ineligible for financial help through NYSOH for your QHP, becoming a citizen, or losing other health insurance coverage (for reasons other than you did not pay).

How does the Marketplace application process work?

The process starts with the applicant obtaining a special NYS ID (which in our online world can involve some confusion about multiple user names and forgotten passwords). After the login and opening an account, a guided questionnaire (linked to federal and state databases) takes a consumer through a process focused on verifying identity, residency in New York, citizenship, immigration status, and household members. Along the way, the system tries to match a consumer's entries with the external database sources.

Consumers seeking financial help must answer another series of questions based on their expected or projected income for the period when coverage is sought. At various stages, consumers must attest that the information is true and consent to sharing private information. Experienced hands call the process "building an applicant's profile." Some applications are simple, but others might require additional information and documents; dramatists are likely to spend more time on the income section. Here is a list of some of the documents that may be required.

Once the process is complete, the system steers the applicant toward the program that matches their eligibility and a set of choices involved with choosing a plan and signing up. For QHPs, the selection is activated by paying the first month's premium.

Can I check out the Marketplace first without signing up to get an idea about what's available and what it would cost?

Yes, and it's a really good idea to do that. NYSOH's "anonymous shopper" feature lets you test drive available health plans and see whether you might be eligible for financial assistance, and how much. From the NYSOH webpage, click on "Get an Estimate" and then the "compare plans & estimate costs" button and answer basic questions on your county, the number of persons in your household and those seeking coverage, and income. The next screen will show the amount of tax credits that may be available. After selecting the type of plan you're looking for (.i.e., individual or parent/child), the next screen shows available QHPs organized by "metal" category and the amount you would pay after the tax credit is applied to the premium. The metal categories start with the lowest premium Bronze plan, with an option to load more plans up to the Platinum level. For those eligible for tax credits, a Silver plan is the best bet.

Consumers potentially eligible for free or low-cost Medicaid, EP, or CHP will get a message directing them to the NYSOH hotline. Scrolling down through the plan options shows how far the credit goes when applied to different metal plans with different insurers. Filters can help shoppers narrow the choices. A Brooklyn playwright earning $40,000 would be eligible for about $580 in tax credits in 2026, for example (about $125 less per month than in 2025 because of the looming ePTC expiration), and would see options ranging from a $66 monthly premium Bronze plan (with a $5,500 deductible and $8,500 out-of-pocket maximum), to a $789 monthly premium Platinum plan (with a $0 deductible and a $2,000 out-of-pocket limit). Without the ePTC extension, $0 monthly premium plans will be harder to find in 2026. Spending about $200 more on monthly premiums for a Silver plan might be the best bet since it leverages the Cost Sharing Reductions that can really slash deductibles and other cost-sharing amounts.

Simulating a plan selection is a useful illustration of the different types of risks consumers might face when they actually sign up for a plan. For example, consumers who earn more than they

projected when they opted for advanced premium tax credits might be required to pay back all or a portion of that subsidy at tax time. Consumers who choose the lowest-price Bronze plan (often out of necessity) expose themselves to a different kind of risk: high out-of-pocket costs when hit with an unexpected and expensive treatment.

If I'm offered coverage at work, but it's too expensive, can I get tax credits for a QHP instead?

Usually, eligibility for a job-based plan disqualifies an individual for a QHP tax credit, but not if the job coverage fails either of two tests. First, the coverage at work (through you or a spouse) must meet the "minimum value standard." Most but not all employer-sponsored plans meet this standard, except for plans that were in place prior to the enactment of the ACA, known as "grandfathered" plans. Typically plans that meet the standard cover both hospital and doctor services and don't have annual or lifetime maximums on the benefits the policy pays, and they are designed to cover at least 60% of the expenses a typical covered employee would incur. Second, the coverage must be "affordable." If the employee's premium contribution for the employer plan for single coverage does not exceed 9.96% of the employee's **household** income, the plan is considered affordable. However, the rest of the family may still be eligible for QHP tax credits depending on whether family plans are offered and how expensive they are. NYSOH makes this useful tool available to check your own employer plans for affordability. This article explains how these two tests work in detail, and this Internal Revenue Service guidance provides information.

Can I sign up for a Marketplace plan by myself, or is there someplace I can go for help?

About 25% of marketplace enrollees do it themselves, but getting free help is highly recommended, and there are lots of options available for assistance. NYSOH uses the term "assistor" as a catch-all for different kinds of advisors available, including the customer service reps on the NYSOH hotline at (855) 355-5777 or through live chat; licensed insurance brokers reimbursed by a health plan; marketplace-facilitated enrollers who work for health plans; and certified application counselors who may work for providers or community-based organizations (CBOs). But consumer groups tout the benefits of the independent navigators affiliated with CBOs that are trained by NYSOH. A NYSOH search tool for assistors by zip code is available, and a special statewide list of navigators is another good place to find help. Navigators at the Entertainment Community Fund focus exclusively on the entertainment industry and are experienced dealing with dramatists' and other theater workers' special issues, such as fluctuating or sporadic income; it's free and only a simple registration is required. Once you have registered and completed your health insurance counseling request form, a navigator will reach out to you within two-to-three business days.

What should I have handy when I sit down with a navigator/assistor or start myself?

You should have your legal name, social security number (or equivalent if you have one), date of birth, and tax filing status. If you are seeking financial help, you will need the name and address of all your employers, all income information, and your most recent tax return. You'll also need all your immigration documents (if applicable), such as Green Cards or visas. Finally, you should make a list of the names of the doctors, hospitals, and other providers you would like to see in your new plan. The typical process for a successful applicant, assuming no additional documentation is required, can usually be completed from start to finish in about an hour.

My income fluctuates from month to month, and from year to year. How do I go about estimating it?

You're not alone. That's an occupational hazard for dramatists, other kinds of artists and entertainment professionals, and a wide range of gig workers and self-employed individuals.

So where do I start?

For those whose incomes are more consistent from year to year, using the Adjusted Gross Income figure (line 11 on form 1040 in your most recent tax return) might pass muster. This method works best if you think your income will be within 10%-15% of that amount for the coming year. For others, it means building an estimate using varying income sources. The two most common building blocks for this estimate are W2 payroll income (where taxes have already been deducted) and 1099 income (no taxes taken out) from multiple companies, from which expenses can be deducted. One experienced counselor recommends using the "Irregular/day to day" category for these income sources, along with appropriate dates, or taking advantage of opportunities to consolidate the income. And though many people believe they are self-employed, they usually aren't if they're working for multiple employers. For those who are truly self-employed, entering income after checking the "self-employed" box and using a three-month spreadsheet to show income and expenses can be a good approach. More sophisticated self-employment arrangements, such as an LLC, C-Corp, or S-Corp, may provide an opportunity to sync the salary selected to the amount of the premium tax credit available.

Do I have to report other kinds of income too?

Yes, and these other sources include interest, unemployment benefits, dividends, rental income, royalties, advances, commissions, and residuals. Grants, fellowships, and scholarships might count too (check with your accountant if you have one).

Do I have to show proof of anything?

You should be able to document all income, but when the system identifies significant differences between your estimates and other available data sources, "data matching issues" (DMIs) are flagged. Applicants are then asked to submit those documents necessary to get over the finish line. The type of documents required are related to the sources of income and might include tax returns and schedules, letters from employers, unemployment benefit records, pay stubs (use with care, since they can be misleading if not for a full-time job), business ledgers, bank statements, Zelle or Venmo records, profit and loss statements, simple written explanations, or other items from the list here. Conditional enrollment with premium assistance is allowed while document requests are pending. For income-based DMIs, consumers were entitled to a grace period of 90 days and an automatic 60-day extension to submit the needed documents in 2025; that additional 60-day extension has been eliminated for 2026.

Trying to predict my income makes me nervous. What if I get it wrong?

You are only expected to do your best with the information you have now. There are also prudent ways to limit your risk for those so inclined. Some consumers entitled to advance premium tax credits—who can afford it—defer all or a portion of the credits and instead collect it as part of their tax return to avoid having to repay any excess tax credit amounts owed during the reconciliation. If you were approved for tax credits, you will have the opportunity to use the slider tool on the website to increase or decrease the amount you are receiving in advance at any time. It is also a good idea to log on to your account to report any life changes when they occur, such as a new job, higher- or lower-than-expected income, or the like. Staying current can both result in changes that improve affordability and protect you from unexpected expenses at reconciliation time. Another important factor to consider: Up until 2026, income-based caps limited the amount of tax credits that consumers might have to repay, but Congress eliminated these caps for those filing taxes for 2027. Consumers who received advance credits exceeding the amount for which they were eligible, based on their income estimate, will be liable for the entire amount.

My income is lower than usual, so I ended up qualifying for Medicaid. If my income goes up again—and I think it will—can I get in trouble?

No. As long as you've responded to all requests for additional documentation, your enrollment in Medicaid (and EP) is good for 12 consecutive months from the date of your enrollment. At that time, your application will be reevaluated. It is a good idea to periodically update your account as well to capture any life changes that occurred during the year.

Experienced navigators can help with the income estimate and the whole application process—finding a deduction while building an income profile that leads to a more affordable plan, shaking loose an application stuck in the system, suggesting documents that get an application past verification hurdles—as well as picking a plan. It's possible to schedule appointments in advance or in person.

If I disagree with a Marketplace decision in my case, is there anything I can do about it?

Yes, you can appeal the decision with NYSOH by phone, in writing, online, or through the informal hearing process within 60 days of the order you wish to appeal. Here is what the appeal form looks like.

Picking a Plan

I'd like to get a PPO (Participating Provider Organization) plan so I can see providers that aren't in the network. Are there any available?

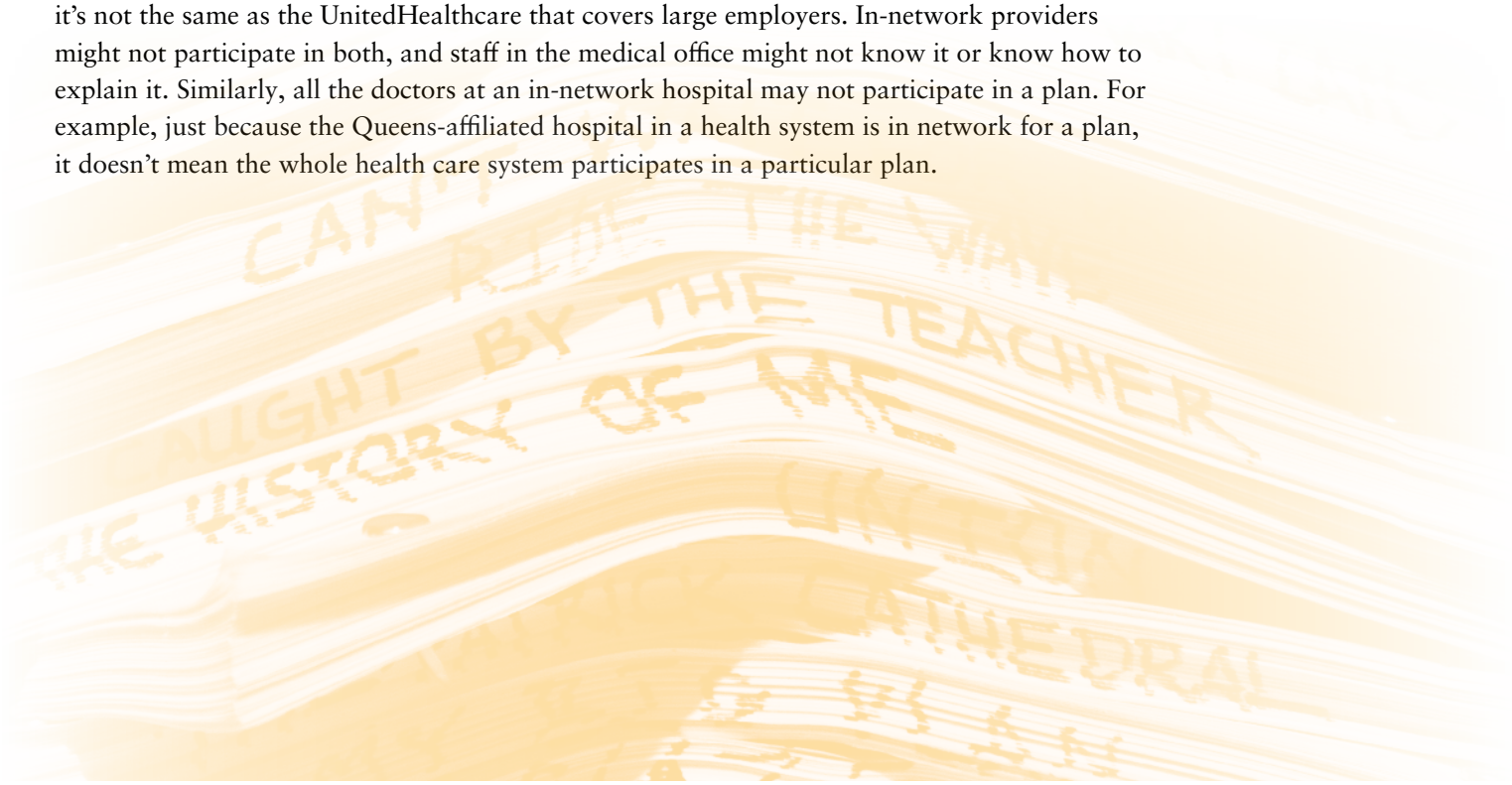
No, only in-network plans are available on the NYSOH marketplace.

So how can I find the plans with the doctors and hospitals I want?

Right after the NYSOH "get started" page, NYSOH provides a link to the "Search by Health Plan, Provider or Facility" tool. Using the correct filters on the Provider Network Data System (PNDS), you can generate information on all participating providers for one health plan, for example, or even better, list all the plans in which a trusted or desired provider is in-network. The facility tool can check hospital systems and works the same way, by a single plan or all the plans in which the hospital participates. Here is another version of the PNDS search in a different format with a special tool that focuses on hospitals.

Is the network information in the tool accurate?

Provider directories are infamously out of date. One experienced navigator recommends "triangulating." First, compare the NYSOH PNDS information to the health plan's individual online directories, available from each plan when searching with the compare plans and estimate costs tool. For individual plans, you can search by clicking on "plan documents and useful links" at the bottom of the page, then selecting "provider network." But then always call the provider's office and ask if they participate in the specific plan you are looking for on the marketplace—Medicaid, EP, or QHPs. Most insurers do business under many names and different licenses; UnitedHealthcare Community plan offers a QHP in the marketplace, but it's not the same as the UnitedHealthcare that covers large employers. In-network providers might not participate in both, and staff in the medical office might not know it or know how to explain it. Similarly, all the doctors at an in-network hospital may not participate in a plan. For example, just because the Queens-affiliated hospital in a health system is in network for a plan, it doesn't mean the whole health care system participates in a particular plan.



What if I can't find the kind of provider I need?

New York has important consumer protections—such as a process that allows a patient to seek care out of network if your plan does not have the kind of provider needed—and the ability to appeal a health plan's denial of such out-of-network care to an independent panel supervised by the Department of Financial Services. Dedicated consumer groups like Community Health Advocates, with services available in many languages and over 25 local partners throughout New York, are available to help you file appeals, dispute claims and coverage denials, and use your coverage. You can contact them through their hotline or find an office near you. For behavioral health and substance use disorder care, specialties that are experiencing a shortage of providers, NYS recently adopted new regulations that set time limits for plans in providing in-network care and a process for consumers to see providers out of network if in-network care is unavailable, at no additional cost. The regulation is summarized here.

Besides the network, what else should I look at when comparing plans?

Some experts recommend estimating how much medical care and what kind of services you will need in the year ahead (as hard as that can be) before you pick a plan. Those who expect to be high users of services might be better off with a plan with lower out-of-pocket costs and a higher premium. NYSOH has a tool on its homepage that can help you estimate your costs in different metal plans. Trying to predict needed services can also help you select plans with benefits and cost-sharing features that may be better for you. Some non-standard plans might have lower cost sharing for specialty visits or through preferred providers, or offer acupuncture coverage for a bad back. Some plans allow direct access to specialists without a referral. Consumers can save with lower-premium Bronze plans, but those with regular prescription costs will pay the full cost of the drugs until a deductible is met, rather than co-pays required under a Silver, Gold, or Platinum plan. Choosing a plan with a formulary that groups your prescriptions on a more favorable tier (co-pay schedule) can also generate savings. It may take some effort, and formularies can change, but plan formularies are usually found by clicking through the plan documents and useful links page for plan formularies.

Can I get dental and vision coverage on the Marketplace?

Yes. All plans cover pediatric dental, and Medicaid and the EP also cover dental for adults, without costs. Adult/family dental through QHPs can be added in two ways. First, there are "stand-alone" dental plans offered by five different dental insurers with varying levels of benefits; and second, dental coverage can also be added to medical coverage in a QHP, the most popular nonstandard plan. Dental coverage varies widely, often has an annual benefit cap, and might include a waiting period for orthodontic services if covered. Waiting periods were eliminated in 2025 for non-orthodontic services. This marketplace tool can help sort through the options. Vision care is also offered by some health plans though not required, except for kids, and it is often paired with dental benefits. The vision plans typically cover annual check-ups and at least partial reimbursement of the cost of lenses and frames or contacts.

Coverage on the Job

Some dramatists and theater workers are able to enroll in a health plan through employment, membership in a union (such as the Writers Guild of America or Actors' Equity), or a family member's plan. This section describes what happens when that coverage ends.

I think I'm going to lose eligibility for my union plan soon. Is there any way to stay on it until I figure something out?

Yes, the federal COBRA or continuation law provides rights for most workers to continue coverage under their employer or union health plans for at least 18 months; New York's continuation law supplements the federal law, extending coverage to small business workers and others. These rights are triggered when an individual or family experiences a "qualifying event," such as a layoff, reduction in hours worked or eligibility, death, or other major life changes. Employees have 60 days from the date of termination to elect to continue coverage, which extends for 18 months or as long as 36 months depending on the event and whether dependents are also on the plan. New York's continuation law also extends the normal federal COBRA period from 18 to 36 months, but only if the underlying coverage is a "fully insured" plan overseen by New York regulators.

But I heard COBRA was really expensive.

It is. COBRA allows employers to charge workers continuing coverage up to 102% of the total premium for an individual or family plan for employees; in New York, that amounted to about $9,589 annually for individual plans and $27,188 for family policies in 2024. For those with the means, COBRA can help enrollees maintain relationships with providers or hospitals that might not be available under a new plan, particularly during an ongoing course of treatment, or to tread water if coverage might be reinstated.

Is there any place to get help to afford that COBRA premium?

Yes. New York's Department of Financial Services (DFS) administers the COBRA Premium Assistance for Entertainment Industry Employees program, working in tandem with all the major entertainment unions. The Fiscal Year 2026 New York State budget allocates $3 million for the program, which provides subsidies that can reduce the COBRA premium by 75% for eligible individuals. New York residents losing coverage from an entertainment industry union health plan who meet the income standards (for an individual, less than $5,217 per month in income) can access the subsidy for up to 12 months in any five-year period. The Entertainment Community Fund also provides applications.

How long can I stay on my parents' insurance plan?

Under the ACA, young adults can remain covered under their parents' employer-sponsored coverage until the age of 26, after which COBRA may apply. New York State provides two options that allow young adults to stay on their parents' employer-sponsored plans until age 29 through a "young adult option" and a "make available" option, but these extensions only apply to "fully insured" plans in New York. A fully insured plan is an insurance policy purchased by an employer from a state-regulated health insurer to cover benefits. The health insurers bear the risk or the gain if benefit costs are higher or lower than expected.

In "self-funded" or "self-insured" plans, an employer doesn't purchase a policy but instead sets aside funds to cover benefits and hires an administrator to run the plan. Self-funded plans are exempt from most state insurance regulation. Your employer's HR department can tell you what type of plan is in place.

Coverage Options for "Seasoned" Dramatists

Now that I'm getting up there, when do I have to start thinking about Medicare?

Unless you're disabled (in which case, social security disability would trigger earlier benefits), Medicare enrollment begins in a seven-month window that starts three months before you turn 65 and ends three months after the month of your 65th birthday.

What are my options?

There are two main options for coverage. The first, known as "Original Medicare," is a throwback to early kinds of health insurance and has three main components. Part A covers hospital care and is usually free, based on an enrollee's paid Federal Insurance Contributions Act or "FICA" taxes through payroll deductions. But the coverage includes significant cost sharing, such as a $1,632 deductible for the first hospital inpatient stay. Part B (with premiums projected to be about $206 per month in 2026 for those earning less than $100,000 annually) covers doctors and outpatient services; surcharges may apply to higher-income enrollees. Importantly, consumers can use any provider or facility that accepts Medicare reimbursement without a referral. Part D, not added until 2006, covers prescriptions, and is purchased from private insurers, each with their own formulary and participating pharmacies (average cost $46 per month, but surcharges can apply to higher-income beneficiaries). Although Part D is optional, signing up for a drug plan during your initial enrollment period is important because it can help you avoid coverage gaps and "late enrollment penalties." These penalties are permanently added to your monthly Part D premium. Many enrollees also buy one of 10 federally standardized Medicare Supplement policies from private insurers to cover the substantial deductibles in Original Medicare. The state Department of Financial Services maintains a helpful guide to the available plans and rates as well as general consumer advice on the rules that govern the market.

The second option is Medicare Advantage or Part C, with a drug benefit included. Private insurance companies administer Medicare Advantage plans, which usually come with managed care features like a network of providers, prior authorization of services, co-pays, deductibles, and out-of-pocket maximums. Enrollment in Part A and Part B is required to enroll in Medicare Advantage.

Do I have to join Medicare?

Sooner or later. Most people should enroll in that seven-month window, known as the initial enrollment period. Active workers with benefits on the job covering themselves and especially dependents can defer and instead enroll in a special enrollment period, usually within eight months from when the job ends or the health benefits end, whichever comes first. Missing the appropriate enrollment period can result in a stiff late penalty that is permanently added to your monthly premium. Those with retiree benefits also have some important decisions to make and should consult with the company benefit manager or a consumer advisor.

What's better, Original Medicare or Medicare Advantage?

It's a personal choice. More people are enrolled in Original Medicare, but Medicare Advantage is growing in popularity as many people are attracted by the added benefits, such as dental and vision care or gym memberships. Many consumers pick Original Medicare to preserve their ability to live elsewhere part of the year, since the network is national, and to see their provider of choice at any time without referrals and prior authorization requirements that are typically part of a Medicare Advantage plan and can be difficult for consumers. Although enrollees can switch Part C and Part D plans during an annual open enrollment period (and may want to because of changes in formularies and pharmacy networks), it can be difficult to change your mind and switch back from a Medicare Advantage plan to Original Medicare in states other than New York.

I'm going to need long-term care services, and Medicare doesn't provide them, right?

Correct, this is one of Medicare's major shortcomings. However, low-income seniors and those with disabling conditions or chronic illnesses may be eligible for what's called non-MAGI Medicaid (also known as Medicaid for the Aged, Blind, and Disabled). It's administered through counties and New York City, which can arrange for long-term care services, usually through a managed care plan. New York State will transition the non-MAGI population to its NYSOH automated system (a vast improvement) in 2026; consumers will be notified of any change. For consumers ineligible for Medicaid, some services may also be available through the NYS Office for the Aging Expanded In-Home Services Program, although some counties may have waiting lists for services. Information is available through NY Connects (800-342-9871) or your local county's Area Agency on Aging.

But what about the costs? I can't afford a Medicare Supplement plan, and I don't even know whether I can afford my Part A deductibles and Part B premiums and deductibles.

Non-MAGI Medicaid also addresses Medicare's other major shortcoming: out-of-pocket costs. Medicaid programs known as Medicare Savings Programs (MSP) can help with deductibles, premiums and drug costs as well, although a recent law adopted by Congress "paused" provisions that streamlined eligibility ramps for these services and cut down on red tape. This page explains NYS rules for the MSP. Non-MAGI Medicaid does place limits on your assets and resources in order to be eligible for certain programs (unlike Medicaid for those under 65), and its income limits may differ too. Some applicants with incomes just above the limit can gain access to benefits through the Excess Income program, however, which allows applicants to apply medical expenses to "spend down" their income to the eligibility level.

Are there any good resources to help figure this out?

Yes. Medicare itself has a wealth of information about what it covers and doesn't, a hotline for help over the phone, apps, and interactive guides to help decision-making, with tools to compare and choose Medicare Advantage and Part D plans that are best based on your personal needs. New York's Health Insurance Information Counseling and Assistance Program (HIICAP) connects seniors to a statewide network of trained counselors in counties to answer Medicare and Medicaid questions. One-on-one counseling is available for entertainment professionals through the Entertainment Community Fund, and the Medicare Rights Center operates a toll-free hotline for Medicare questions. For Medicaid/Medicare questions concerning those who may be "dually eligible" for both programs due to age, income, or disability, assistance is also available through a special New York statewide counseling program. The NY Legal Assistance Group (NYC) and Law Help New York can also assist with eligibility questions and a variety of other legal and public benefit matters.

Act IV. Extra Help to Meet Health Care and Other Needs

Despite recent federal rule changes and actions (and inaction) by Congress, New York State's range of affordable health plan options is still among the nation's best. But many dramatists and theater workers may be unable to afford or maintain comprehensive coverage, leaving them at risk for the costs of treating unexpected injuries, chronic medical conditions that flare up, or other problems that can lead to punishing medical debt. This section outlines health care options for individuals without coverage, resources for nonmedical needs, and guidance for those enrolled in a health plan on where to turn for help in getting the most out of your plan.

Accessing Care When You Can't Afford Coverage

There are a variety of consumer protections and assistance programs, lower-cost providers, income-based subsidies, and state and private programs to help consumers access care. Of course, many of these programs depend on individuals having the courage and energy to become their own best advocates—and a willingness to ask for help when it's needed. Some of the financial assistance and discount programs discussed are based on the income of the people living in a household, and how it compares to a federal measure of income issued annually and known as the federal poverty level (FPL) guidelines. The FPL is explained here with a link to the most recent ratios/percentages illustrated for households of different sizes and incomes. This calculator will help you determine how your income compares to eligibility levels for various programs, such as financial assistance from hospitals or care at a community health center, for example.

Hospital Programs

New York's Hospital Financial Assistance Law (HFAL), also known as the Patients' Financial Aid Law, requires hospitals to adopt policies that provide minimum levels of financial assistance to uninsured or underinsured patients based on income and family size. All New York State residents are eligible for financial assistance for *emergency care* at any hospital in the state, while patients receiving care in their local hospital's "primary service area" may be eligible for assistance for a broader array of "medically necessary" services provided by the hospital. Here are the types of patients who can benefit, according to NYS Department of Health guidance:

- Low-income individuals without health insurance;
- Underinsured individuals (with out-of-pocket costs accumulated in the past 12 months that exceed more than 10% of such individual's gross annual income); or
- Patients who have exhausted their health insurance benefits and who can illustrate an inability to pay full charges, based on their household income, medical expenses, and health coverage. Information about hospital service areas and services can be found here.

Hospitals are required to provide ample notice to patients about how to apply for financial assistance. There are limits on the timing of hospital collection actions and activities, and patients can apply for assistance at any time during a collection process. Once an application is submitted, the hospital billing or financial assistance unit must approve or reject the application

within 30 days. Language assistance is typically provided for those who need it, and denials of assistance can be appealed.

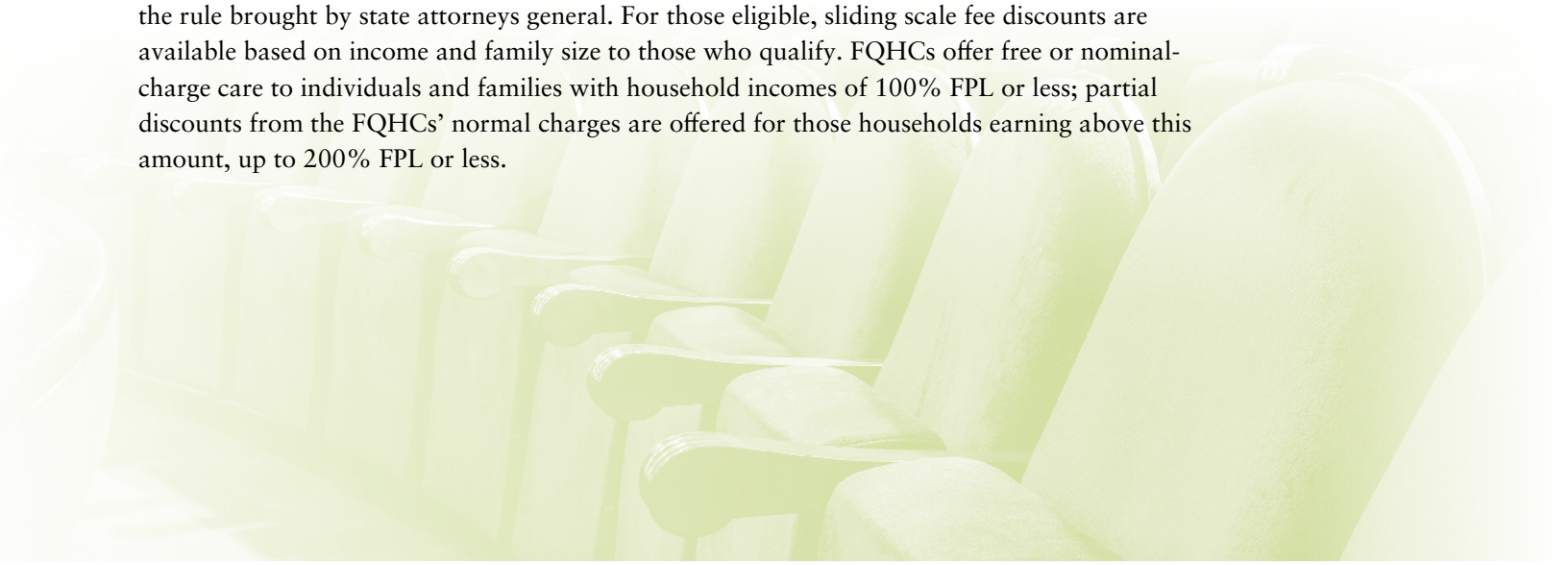
Under the state minimum standards, financial assistance is available to patients, regardless of immigration status, in households with incomes at or below 400% of the Federal Poverty Level (FPL). Care is free for patients below 200% FPL, and sliding scale discounts apply above that level and up to 400% FPL, based on a percentage of what a hospital would receive for a Medicaid patient. Income is the only criterion used to determine eligibility for assistance. It is important to keep in mind that these discounts are for the hospital bill alone and not for bills submitted by physicians or other providers not employed by the hospital.

In addition to financial assistance, the HFAL includes many consumer protections. Among them: eligible patients are entitled to pay bills over time, and payments made under installment plans cannot exceed 5% of a patient's gross income each month; interest rates on unpaid bills are capped at 2%; legal actions are prohibited to recover debts against patients earning less than 400% FPL; hospitals cannot place liens on patients' homes or garnish wages to collect debts; and medical debt cannot be reported to credit agencies.

Many hospitals exceed the HFAL standards, providing assistance at incomes up to 500% or 600% of the FPL as well as discounts for outpatient and clinic services too. This makes it important to take the time to review your hospital's financial assistance policy when you are considering or have received services, and to ask questions. The NYS Department of Health recently released a summary of the new law and the financial assistance application that all hospitals must now use, both available here.

Federally Qualified Health Centers

Reduced-cost outpatient services may also be available at federally qualified health centers (FQHCs), also known as community health centers or clinics. These facilities provide comprehensive primary care and preventive services to all individuals, regardless of immigration status at present; federal courts recently blocked a new federal rule seeking to limit access to FQHC services for certain categories of noncitizens in a lawsuit challenging the legality of the rule brought by state attorneys general. For those eligible, sliding scale fee discounts are available based on income and family size to those who qualify. FQHCs offer free or nominal-charge care to individuals and families with household incomes of 100% FPL or less; partial discounts from the FQHCs' normal charges are offered for those households earning above this amount, up to 200% FPL or less.



Sliding scale discounts may vary from one health center to another, and so may the proof a center requires to determine income and family size. However, most health centers simply require an attestation of income (which does not include assets) and family size.

To find one of the over 800 health center sites in New York State, visit this link: If you are a non-New Yorker or on the road, you can visit this national listing of over 15,000 FQHCs. There are no residency requirements for FQHC services.

Another resource for outpatient care is the Samuel Friedman Health Center, also known as the Friedman Center for the Performing Arts, a program of Mt. Sinai Doctors and the Entertainment Community Fund. Located in Manhattan's Theater District, the Center tailors its services and hours to the needs of arts and entertainment industry professionals. Eligibility requirements for subsidies for the uninsured or under-insured can be found here.

NYC Health + Hospitals

The nation's largest municipal health system, NYC Health + Hospitals (H+H), sponsors its own health care plan (MetroPlus) that offers low-cost insurance coverage, and also provides a wide array of financial assistance through its 11 hospitals, 29 Gotham Health medical centers, and other facilities. Discounted health care services are available at these hospitals and health centers for eligible patients under state and federal rules. The innovative NYC Care program takes a step further by providing eligible NYC residents with a member ID card, a primary care physician, access to specialty and behavioral health care, and low-cost prescriptions. NYC Care features a sliding scale fee for a broad range of inpatient and outpatient services. Eligibility for NYC Care, which counted about 140,000 members in 2025, is limited to NYC residents who do not qualify for any health insurance plan in the state or are not able to afford health insurance based on federal guidelines. A recent federal rule seeks to limit access for certain categories of noncitizens seeking care at health centers, but that rule has been stayed in federal court. At this time, H+H services are available to individuals regardless of immigration status who are otherwise eligible. Residents of neighboring counties may also be eligible for financial assistance through the H+H options program. Dramatists and other theater workers can learn about H+H's programs and check on eligibility by calling 1(844) 692-2692 and selecting option 3, or by speaking with counselors at H+H facilities. A summary of the H+H programs is available here, and this table summarizes the sliding scale fees which may be available.

Dental and Vision Care

Finding affordable dental and vision care can also be a difficult challenge. Many FQHCs (see above) offer affordable dental and vision services. The City of New York provides this useful resource for oral health, including low-cost dental clinics. NeedyMeds, a national nonprofit that helps connect people to programs that increase the affordability of medications and other health care costs, maintains a database of clinics that provide free, low-cost, or sliding scale discount dental service. This database can also be used to find medical, mental health, and substance use disorder clinics. Finally, the National Eye Institute provides this resource for free or low-cost eye care.

Discount Drug Programs

Doctor's appointments often result in having to pick up medications that can be costly at full price. GoodRx is a popular free website and mobile app that compares the different prices of a drug at your local pharmacies and generates free coupons. SingleCare, a similar program, is also free to use. The main difference between the two is that GoodRx tends to include more pharmacy options, while SingleCare tends to find the lowest prices. Finally, Cost Plus Drugs helps patients find generic drugs at a low cost. To take advantage of Cost Plus Drugs, you should confirm that the generic drug is listed on the Cost Plus Drugs website and then request that your doctor send your prescription to one of the pharmacy partners of Cost Plus Drugs.

Financial Assistance for Insured Patients with Chronic Disease

For patients with chronic or life-altering diseases, the HealthWell Foundation is a nonprofit that provides financial assistance for prescription copays; health insurance premiums, deductibles, and coinsurance; pediatric treatment costs; travel costs; and behavioral health services. Patients are eligible for funds if they are being treated for a disease on this list, have some form of health insurance that covers part of the cost of treatment, and have an income up to 400-500% FPL. In 2024, the HealthWell Foundation reported providing over $1.2 billion in financial assistance nationally for premium subsidies and copayments.

Grant Programs for Dramatists and Other Theater Workers

Grant support is also available for dramatists to help meet medical needs, daily life expenses, and emergencies. The Dramatists Guild Foundation (DGF) is a national charity that supports playwrights, composers, lyricists, and book writers through educational and fellowship programs and various grants. Although it was initially tied to the Dramatists Guild of America, the Foundation now operates separately as a "cousin" organization of the Guild. Services are available for all dramatists, whether or not they are Guild members. For a dramatist who may need non-emergency assistance with daily life expenses (including medications, utilities, accessibility support, transportation, dependent care, holistic health care, mental health care, groceries, and reproductive care), the Dramatists Guild Foundation provides a one-time, need-based "bridge grant" of up to $500. For a dramatist in dire need of funds due to unexpected financial, personal, or medical crises, the Dramatists Guild Fund offers crisis relief grants. To apply, you must be at least 18 years old and meet the DGF's financial and professional eligibility requirements. Once grants are awarded, use of the funding is flexible and up to grantees' discretion. In 2023, the Dramatists Guild Foundation gave out nearly $75,000 in bridge grants and over $400,000 in crisis relief grants.

The Entertainment Community Fund (ECF), formerly known as the Actor's Fund, offers a wide array of services to dramatists and other theater and entertainment professionals and also provides emergency financial assistance to people in the entertainment industry who are unable to meet immediate basic living expenses. These grants can help dramatists and other theater workers meet housing, food, utility bills, and health care expenses. Eligibility is based on documentation of past professional performing arts and entertainment earnings. Once granted, use of the funding is flexible and discretionary. The ECF grant page also includes links to other entertainment industry and union funds.

Health Care Consumer Assistance

Health care and health insurance are complicated, but there are many places to go for help resolving problems or filing complaints. The NYS Department of Health has a summary of your rights as a managed care consumer and a directory of state and federal government agencies that can help. Below are a few highlights:

The NYS Department of Health regulates health care providers and facilities and managed care plans. For complaints related to any aspect of care during a hospital stay, issues related to financial assistance, and information on patients' rights, you can either call the helpline at 1(800) 804-5447 or submit an online complaint form. For problems with a managed care plan, you can call the Managed Care Consumer Complaint Unit at 1(800) 206-8125 or email managedcarecomplaint@health.ny.gov. For questions or complaints related to mental health programs or services, you can call 1(800) 597-8481 or email: NYSDOH.BCS.Behavioral.Health.Complaints@health.ny.gov.

The NYS Department of Financial Services handles complaints about insurance companies, managed care plans, and other financial services and products. The agency also handles appeals when an insurance company denies coverage for health care services, as well as in disputes in the case of surprise bills for emergency services or out-of-network care. You can contact the Consumer Assistance Unit at 1(800) 342-3736 or consumers@dfs.ny.gov. This page offers helpful tips on how to file a complaint with DFS.

The Office of the New York State Attorney General has a special bureau to help consumers who experience problems with a health care plan, such as a denial of coverage for treatment or an improper charge. You can either call the helpline at 1(800) 428-9071 or file an online health care complaint. Your complaint will be received by a helpline intake specialist, after which you will be assigned an advocate who will work with you to resolve the issue with your health plan.

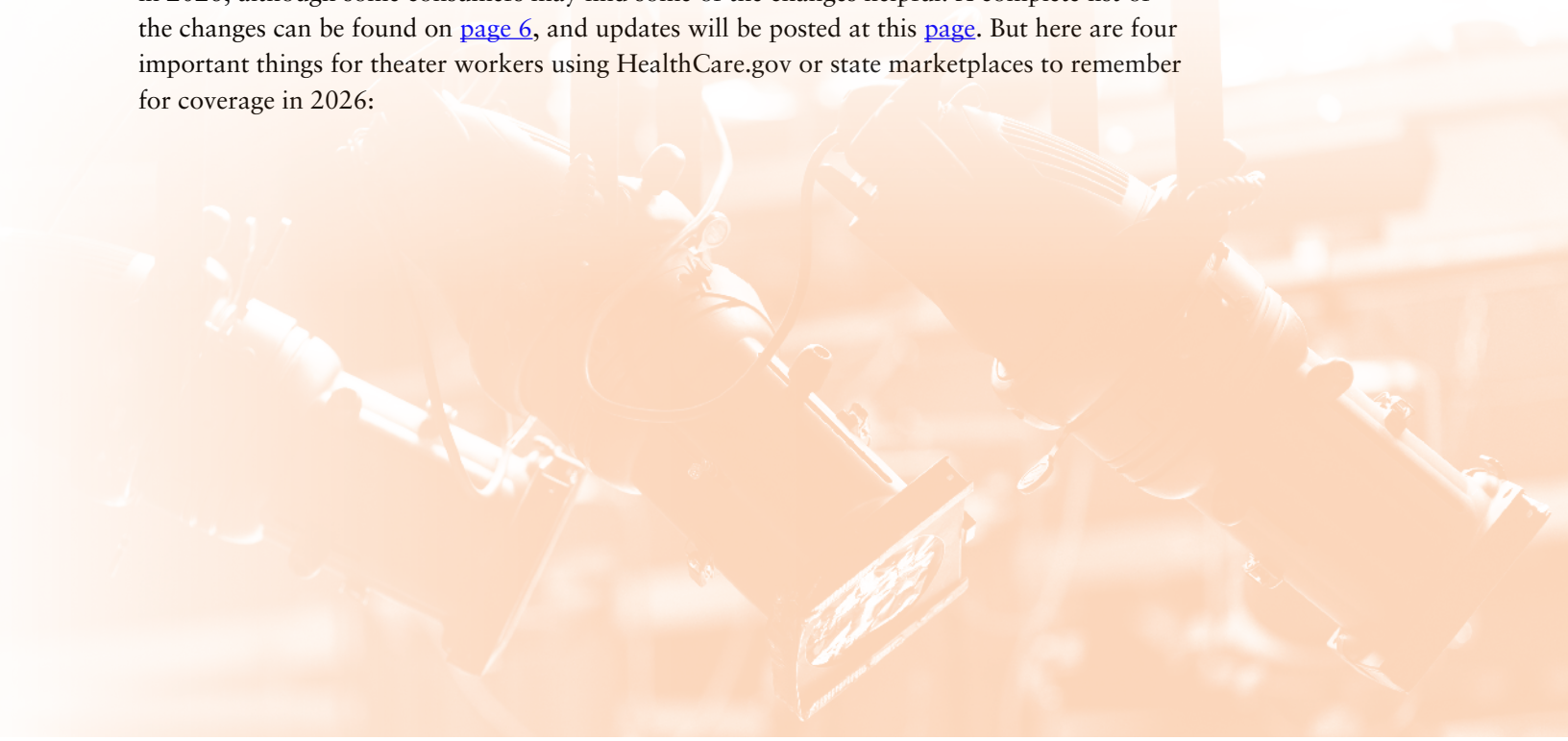
Consumers are also encouraged to turn to the Community Health Advocates (CHA), a statewide network of nonprofit organizations organized by the Community Service Society that helps individuals and families use their health insurance or access the care they need. CHA experts can help you fight a claim or service denial by a health plan, apply for financial assistance at a hospital, handle a confusing medical bill, or find free or low-cost care. The CHA website features great advice on how to appeal claims denials and benefit decisions. Even if you aren't 100% sure that they have the answer to your question, it's worth giving them a call—it's free to do so, and they will be able to point you in the right direction. Consumers can contact CHA at 1(888) 614-6400, email them at cha@cssny.org, or use this tool to find an organization near you.

On the federal level, as part of its duties overseeing the federal No Surprises Act, the Centers for Medicare & Medicaid Services (CMS) administers a dispute resolution system for people accessing medical care without insurance coverage. Information and consumer tips are available here.

Act V. Other States

In this Act, the spotlight is on theater workers seeking health coverage in states outside of New York—call it "way off Broadway." Under the 2014 Affordable Care Act (ACA), states were given the ability to "opt in" to expanded eligibility for Medicaid, the joint state-federal health insurance program for low-income people, and to open their own "marketplace." The alternative is relying on the federal marketplace (known as HealthCare.gov), where residents can purchase and enroll in new Qualified Health Plans (QHPs), with premium tax credits (PTCs) available to lower costs for eligible consumers who earn too much for Medicaid. The tax credits can be accessed in the form of a tax refund or applied in advance (Advanced Premium Tax Credits or APTCs) to reduce monthly costs. In 2021, enhanced premium tax credits (ePTCs) were layered on top of the original affordability subsidies to further reduce premiums. Eligibility for QHP tax credits, Medicaid, and the Children's Health Insurance Program is based on household income and an annual government index called the Federal Poverty Level (FPL, see page 5).

The federal and state marketplaces are the only places to buy comprehensive QHPs with PTCs that can lower premiums and out-of-pocket costs. Some states with their own marketplaces (state-based marketplaces or SMBs) have further enhanced coverage options—so coverage terms and rules can vary from state to state. This section describes how the federal exchange and state exchanges work. Actions (and inaction) by federal regulatory agencies and Congress will generally make coverage more difficult to obtain, harder to maintain, and more expensive in 2026, although some consumers may find some of the changes helpful. A complete list of the changes can be found on page 6, and updates will be posted at this page. But here are four important things for theater workers using HealthCare.gov or state marketplaces to remember for coverage in 2026:



Four Important Considerations

Log in to your account. Consumers who are renewing coverage through HealthCare.gov or state exchanges should log in to their accounts, make sure contact information is correct, and keep an eye out for important messages—and mail. With the potentially expiring ePTCs, many consumers will be auto-renewed into the same or similar coverage they can no longer afford—this means they'll need time to make decisions about less expensive plans before their current plan renews on January 1.

Data Matching Issues (DMIs). Fluctuating income is an occupational hazard of theater work. Consumers applying for tax credits are notified of income-based DMIs when there is a large difference between *estimated* income for the upcoming year and the actual income for the previous year available from federal or state data sources. For 2026, consumers who receive DMIs may be asked to submit additional paperwork to qualify for credits and will have less time to do it. Information about resolving DMIs can be found here.

Reconciliation. Consumers who receive advanced premium tax credits in 2026 are required to "reconcile" the amount they received based on their estimated income, compared to the amount they *should* have received based on their actual income for the year, when they file their taxes. Consumers who received less than the amount for which they were eligible receive a refund; consumers who received tax credits greater than the amount for which they were eligible must repay the excess credit through their taxes. Up until now, the additional amount was capped at certain income-based levels; for the 2026 tax year (filed in 2027), the caps have been removed so consumers who received excess tax credit must repay the entire difference between what they received and what they should have received. To avoid unexpected tax liabilities, all consumers should update their accounts whenever things change, particularly income estimates and household composition. Risk-averse consumers (who can afford it) can defer collecting their credits until they file their returns.

Special Enrollment Periods. Federal rules allow consumers who didn't enroll in the regular Open Enrollment periods to claim a Special Enrollment Period for certain qualifying events, such as the loss of employer-sponsored coverage, marriage, childbirth, or moving. In the past, consumers could usually "attest" to the change, but for 2026 coverage, consumers may have to provide written proof or documents to HealthCare.gov and some state marketplaces.

Federal and State Marketplaces

The federal marketplace, HealthCare.gov, administers the ACA for the 28 states without their own marketplaces and shares responsibilities with three more. This map shows the distribution of SBMs vs. the federal marketplace. All of the SBMs follow the core ACA provisions, such as recruiting health plans that provide essential health benefits to enrollees and following consumer protection rules. They also administer federal financial help to make QHPs more affordable. QHPs can be purchased during the annual open enrollment period at HealthCare.gov and SBMs—usually between November 1 and January 15 each year—and during special enrollment periods (SEPs). Across the U.S., enrollment in Medicaid and CHIP coverage is open year-round, and people who are part of a federally recognized tribe can enroll in any health insurance coverage at any point throughout the year.

HealthCare.gov – the Federal Marketplace

Over 15 million Americans enrolled in ACA coverage in 2025 through the federal exchange, HealthCare.gov. Dramatists and other theater workers living in states without SBMs must use the federal marketplace to find and enroll in coverage. HealthCare.gov effectively operates as 29 state marketplaces rolled into one, tailoring its administrative, regulatory, and enrollment functions to each state. It chooses the health plans that are available in that state and determines eligibility for coverage and the income-based financial assistance. Special filters help you narrow choices by type of plan (organized by high value to low value in Platinum, Gold, Silver, and Bronze categories), participating providers, and tradeoffs between premiums and cost sharing.

For 2026, the federal marketplace will also offer a special "hardship" application. This will allow consumers who do not qualify for PTCs and are over the age of 30 to enroll in "catastrophic" plans, which have lower premiums but sky-high deductibles. Catastrophic plans are not eligible for tax credits. Consumers can enroll in QHPs by mailing an application, creating an account on the website, or calling the consumer hotline at 1(800) 318-2596 (TTY: 1(855) 889-4325). The federal platform also helps consumers find local enrollment counselors or insurance brokers that can guide you through the process. Dramatists living in the western region may find a friendly and experienced ear by seeking enrollment assistance through Entertainment Health Insurance Solutions, a joint program of the Entertainment Community Fund and the Motion Picture & Television Fund that provides enrollment support to the entertainment and performing arts community.

HealthCare.gov only offers enrollment in QHPs; users must contact their local state agencies to determine eligibility for the Medicaid and Children's Health Insurance Programs (CHIP). Medicaid is the joint state and federal health insurance program for low-income adults, pregnant persons, elderly adults, and people with disabilities; CHIP covers kids. States have some discretion on benefits and eligibility levels for both programs. This handy state Medicaid directory is a good place to start, and this page can help you find health and dental coverage for kids in all states. Trying to track down Medicaid coverage at some of these state agencies might be a fool's errand; despite generous federal funding, not all states elected to expand Medicaid eligibility. The "non- expansion" states include: Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, South Carolina, Tennessee, Texas, and Wyoming. This page provides a summary of state Medicaid programs and expansion status. This federal tool provides a quick way to learn about the affordability of coverage in individual states. The annual Open Enrollment period for QHPs at HealthCare.gov begins on November 1 and runs through January 15.

If your state uses the HealthCare.gov marketplace, you can window shop for QHP coverage in your state through their "See plans & prices" tool. Another helpful tool to check premium and tax credit estimates for QHPs (based on age, family size, and household income) is available here through a well-regarded nonprofit foundation.

State-Based Marketplaces (SBMs)

Here are capsules for coverage under the state marketplaces. It is important to verify that you engage with the official state marketplace and not one of the many counterfeit scam outfits that have sprung up to lure consumers into purchasing cheaper but substandard benefit plans that often lack ACA consumer protections and benefit standards and coverage for pre-existing conditions (i.e., "junk coverage" as explained on page 11 in Act III). One good sign of an official marketplace: its website address will end in ".gov" in the url. It is possible (and a good idea) to window shop for coverage at a particular state marketplace before opening an account and beginning the process of enrolling in a plan. This chart includes links for window shoppers at all the state exchanges. Some SBMs may allow consumers over the age of 30 to enroll in catastrophic plans (without tax credits).

California

With nearly 2 million enrollees in 2025, California's Covered California exchange is the largest of the SBMs. CoveredCA is a one-stop shop that can determine eligibility and facilitate enrollment in ACA coverage and state public programs. California's Medicaid program (Medi-Cal) is open to any income-eligible resident under the age of 19 or over the age of 65, regardless of immigration status; budget constraints and federal changes have forced the state to pare back eligibility for full-scope Medi-Cal benefits for most new applicants between ages 19 and 65. This chart summarizes the current status and coming changes for 2026 and beyond, and this FAQ has helpful answers to common Medicaid questions. State subsidies for "enhanced silver" QHPs reduce cost sharing for eligible enrollees. Of note, California is one of five states that require residents to pay a tax penalty if they don't either maintain health coverage or obtain an exemption. This chart summarizes 2026 program eligibility for Californians across the income spectrum in a clear way but will be updated in 2026. Covered California invites residents to visit this webpage to see recent information on how federal changes are affecting coverage options.

Covered California (Coveredca.com), 1(800) 300-1506

Colorado

Connect for Health Colorado is the one-stop shop for QHPs, Health First Colorado (Medicaid), Child Health Plan Plus (CHIP), and OmniSalud, which helps undocumented immigrants enroll in coverage with special confidentiality safeguards and limited affordability subsidies. Colorado also enhances ACA premium subsidies for QHP enrollees in Silver plans earning up to 200% FPL. Colorado PEAK, a state website, enables connection to public health and benefits programs, including SNAP, transit, energy, and cash assistance.

Connect for Health Colorado (https://connectforhealthco.com/, 1(855) 752-6749
(TTY: 855-695-5935)

Connecticut

Access Health CT is a one-stop shop for QHPs, HUSKY Health Programs (Medicaid and CHIP), and the Covered Connecticut Program, which provides Medicaid-like coverage to residents ages 19-64 who have a household income higher than the 138% FPL cutoff for Medicaid but below 175% FPL.

Access Health CT (https://www.accesshealthct.com), 1(855) 805-4325

District of Columbia

DC Health Link, currently busy helping laid-off federal workers find coverage, is the marketplace for QHPs, and, beginning in 2026, a Basic Health Plan (BHP). For enrollees in standardized QHPs, deductibles are limited for in-network providers, and treatment for diabetes and cardiovascular diseases is exempt from cost-sharing; co-payments for children's mental health visits are capped at $5 per visit. DC Health Link is implementing its Basic Health Plan for enrollees earning between 138 to 200% of the FPL in 2026; there are $0 premiums for BHP enrollees and limited cost-sharing. The Department of Health Care Finance administers the Healthy Families program (Medicaid and CHIP), and its DC Healthcare Alliance and Immigrant Children's Program provide coverage for lower-income adults and children, regardless of immigration status. Eligible residents can also enroll in these public health programs through District Direct and can also connect to SNAP, cash assistance, and other public benefits. DC residents must pay a tax penalty if they don't either maintain health coverage or obtain an exemption.

DC Health Link (https://www.dchealthlink.com/), 1(855) 532-5465

Georgia

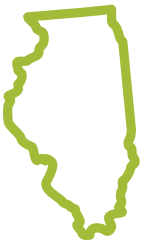
The Georgia Access marketplace launched in 2025. The website includes options for enrollment in QHPs as well as information about finding coverage for children (PeachCare) and the state's limited Medicaid program. Income-eligible adults can enroll in Medicaid through the Georgia Pathways for Coverage program by engaging in 80 hours per month in "Qualifying Activities," such as work, job training, or community service. Enrollment in health and other state public benefit programs is available through the Georgia Gateway.

GeorgiaAccess (https://georgiaaccess.gov/), 1(888) 687-1503.

Idaho

Your Health Idaho is the state's marketplace for QHPs. The enrollment process for Medicaid and CHIP resides on idalink, the state's online portal for public benefits, including food, cash, and child-care assistance.

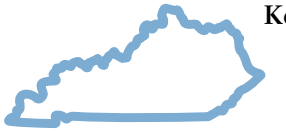
Your Health Idaho (https://www.yourhealthidaho.org/), 1(855) 944-3246



Illinois

Illinois is preparing for the launch of its new SBM for enrollment in QHPs for the 2026 policy year; GetCovered Illinois formerly used the federal platform. The Department of Healthcare and Family Services oversees enrollment in Illinois Medicaid and All Kids (CHIP). Consumer can use the ABE portal to enroll in health programs and access other benefits available in Illinois,

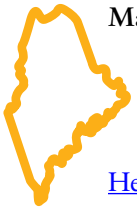
GetCoveredIllinois (https://getcovered.illinois.gov/); 1(866) 311-1114



Kentucky

The Kentucky Health Benefit Exchange is part of kynect, the site where Kentuckians can enroll in QHPs, Medicaid, and CHIP (KCHiP) and gain access to other public benefits like food, cash, and childcare assistance.

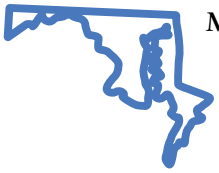
kynect (https://kynect.ky.gov/), (855) 459-6328 for health coverage and 1(855) 306-8959 for other benefits.



Maine

CoverME.gov handles enrollment for Mainers in QHPs, and MaineCare (Medicaid and CHIP). You can also apply directly for MaineCare and food and cash assistance at My Maine Connection. A Maine nonprofit, Consumers for Affordable Health Care, also provides free enrollment assistance (1-800-965-7476)

CoverMe.gov (https://www.coverme.gov/), 1(866) 636-0355



Maryland

Maryland Health Connection is Maryland's one-stop shop for QHPs, Medicaid, and the Maryland Children's Health Program. A state program called Young Adult Premium Assistance can lower costs for young adults ages 18 to 37.

Maryland Health Connection (https://www.marylandhealthconnection.gov/), 1(855) 642-8572

Massachusetts

Massachusetts Health Connector is the one-stop shop for QHPs and MassHealth (Medicaid and CHIP). For residents whose incomes do not qualify for MassHealth, the Connector Care Program enhances ACA subsidies to further reduce premiums and eliminates deductibles entirely for residents earning below 500% FPL; please note this limit will be reduced to 400% FPL if Congress fails to extend the enhanced premium tax credits (ePTCs) set to expire in December 2025. Other federal changes will eliminate coverage for residents earning less than 100% of the FPL who are ineligible for MassHealth. The Connector is providing a special webpage where residents can track new developments and also check eligibility for other programs, such as the Health Safety Net. Residents of Massachusetts are required to have health insurance or pay a tax penalty.

Massachusetts Health Connector (https://www.mahealthconnector.org/), 1(877) 623-6765

Minnesota

MNsure is Minnesota's one-stop shop for QHPs and Medical Assistance (Medicaid and CHIP). Residents with incomes above eligibility for Medical Assistance but less than 200% FPL are eligible for MinnesotaCare, available through the MN Department of Human Services with monthly premiums for the low-cost sharing coverage ranging from $0 to $80 per person based on household income and family size.

MNsure (https://www.mnsure.org/), 1(855) 366-7873

Nevada

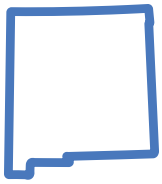
Nevada Health Link, under the supervision of the newly created Nevada Health Authority, is Nevada's exchange for enrolling in a QHP. For 2026 the Nevada exchange rolled out Battle Born State Plans, specially designed to reduce premiums for consumers who choose this option. Access Nevada is the portal where residents can apply to Medicaid and the Nevada Check Up (CHIP) program, as well as food, cash, and child-care assistance.

Nevada Health Link (https://www.nevadahealthlink.com/), 1(800) 547-2927

New Jersey

GetCoveredNJ is the state's marketplace for QHPs, and the New Jersey Health Plan Savings (NJHPS) program reduces premiums further for eligible residents with household incomes of up to 600% FPL. Residents who qualify for NJ FamilyCare (Medicaid and CHIP) can enroll and apply through GetCoveredNJ and on the NJ FamilyCare website. Residents of New Jersey are liable for a tax penalty if they don't either maintain health coverage or obtain an exemption.

GetCoveredNJ (https://www.nj.gov/getcoverednj/), 1(833) 677-1010



New Mexico

BeWellnm is New Mexico's marketplace for QHPs and features state subsidies in tandem with ACA tax credits to further reduce premiums and out-of-pocket costs for different categories of eligible enrollees earning up to 400% FPL. State policymakers provided funding to backfill potential federal cuts to ACA premium subsidies if not extended for 2026. Residents who qualify for Medicaid or CHIP (Turquoise Care) can enroll on the YES New Mexico portal. This 2024 chart summarizes coverage options at different income levels. The Yes New Mexico portal also facilitates enrollment in a number of health care and other assistance programs.

BeWellnm (https://bewellnm.com/), 1(833) 862-3935

Pennsylvania

Pennsylvanians enroll in QHPs through the state marketplace, Pennie, but must visit the Commonwealth of Pennsylvania Department of Human Services to apply for Medicaid (HealthChoices) and CHIP. Pennsylvania also maintains a comprehensive online tool, COMPASS, to apply for health programs and other benefits, such as assistance for food, energy bills, rent, and other areas.

Pennie (Home | Pennie), 1(844) 844-8040

Rhode Island

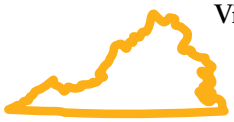
HealthSource RI coordinates eligibility and enrollment for both ACA programs and Medicaid and CHIP coverage, sometimes known as RIte Care. Rhode Island requires individuals to maintain health coverage or pay a tax penalty, although exemptions are available.

HealthSource RI (https://healthsourceri.com/), 1(855) 840-4774

Vermont

Vermont Health Connect is Vermont's one-stop shop for QHPs, Medicaid, and Dr. Dynasaur (Medicaid coverage for pregnant people and children). Vermont Premium Assistance enhances federal premium tax credits for families earning up to 300% FPL.

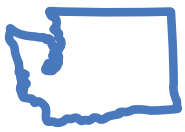
Vermont Health Connect (https://portal.healthconnect.vermont.gov/), 1(855) 899-9600



Virginia

Virginia's Insurance Marketplace is where residents can enroll in a QHP, while CoverVA administers Medicaid and children's coverage (FAMIS). Virginians can learn about and sign up for health and other benefits at Virginia CommonHelp.

Virginia's Insurance Marketplace (https://www.marketplace.virginia.gov/), 1(888) 687-1501



Washington

Washington's HealthPlanFinder is the state's one-stop shop for QHPs and Apple Health (Medicaid and CHIP). The state recently capped enrollment in an Apple Health Expansion program for noncitizens, but eligible enrollees can still apply. A specially designed set of QHPs called Cascade Care plans is designed to reduce out-of-pocket costs and can be coupled with Cascade Care Savings for additional premium assistance for residents earning less than 250% FPL, subject to available funding. Unsubsidized QHPs from HealthPlanFinder are open to all state residents regardless of immigration status.

Washington Healthplanfinder (https://www.wahealthplanfinder.org/), 1(855) 923-4633

United Hospital Fund

Improving Health Care for Every New Yorker

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