

Helping Consumers Understand and Use Health Insurance in 2014

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INTRODUCTION

We are entering a critical time in health care in the United States. The Patient Protection and Affordable Care Act (ACA) changes the American health care system in many ways. Of major importance is the fact that it expands access to health insurance for millions of Americans. But do Americans understand the changes that are coming? Do they understand their options for health insurance or how to choose the insurance plan that best meets their needs? And will they know how to use that insurance plan once they have it? Many people don't have this understanding, and they have a hard time getting reliable information when they try to learn more.

This paper presents basic information that can be used to help people understand their health insurance options and guide them through enrollment. It is a resource for those who will be helping consumers make important decisions—for patient navigators, community organizations, employers, media, educators, and any individual or organization working to improve understanding of options for health insurance.

The ACA will be implemented January 1, 2014, making it critical that Americans have a working understanding of health insurance and coverage. With some changes already in place, and others coming soon, it's important to learn about the options.

EXPLAINING HEALTH INSURANCE

Some consumers will be getting health insurance for the first time and may not be familiar with how it works. It is important to fill them in on the basics and explain what health insurance terms mean.

How can health insurance help? Not many people can afford medical costs without health insurance—a single trip to the hospital could wipe out a family's savings! As a result, those without health insurance often do not get the care they need when they need it. When consumers purchase a health insurance plan, they pay a certain amount each month. In return, the insurance company helps cover the cost of doctor visits, procedures, hospital visits, and immunizations, etc.

Health Insurance vs. Car Insurance

Car insurance is different from health insurance. Car insurance protects against unanticipated financial loss, but will not pay for routine expenses. For example, car insurance will cover consumers in the event of a collision but will not pay for oil changes, new tires, etc. Health insurance helps pay for both high cost expenses and routine screenings and tune-ups.

¹ Participants in the Collaborative on Health Literacy and Access, Health Care Coverage, and Care of the Institute of Medicine Roundtable on Health Literacy

When explaining health insurance to consumers, it is critical to confirm that they understand what was said. However, consumers may well nod their heads in understanding, even if they are still confused. The only way to be sure they understand is to ask them to explain the

Healthcare.gov has a [glossary](#) that explains these terms in plain language.¹

concepts back, using their own words. If they still don't understand, it is important to use different language or examples to try to clarify meaning.

WHO'S WHO AND WHAT'S WHAT IN HEALTH INSURANCE

The **subscriber** is the person who purchases the health insurance plan. **Dependents** are the subscriber's spouse or children who receive coverage through the same plan. A **beneficiary** is an individual (subscriber or dependent) enrolled in a health insurance plan.

A **provider** is an individual or facility that helps identify, treat, or prevent an illness. Doctors, nurses, hospitals, clinics, and community health centers are all examples. **In-network providers** contract with the insurance company and agree to get paid lower rates for their services. **Out-of-network providers** have not contracted with the insurance company and charge higher rates. Consumers may have to pay a bigger part of the bill if they use an out-of-network provider.

No health insurance plan covers everything, and it's important to understand what is covered and what is not. **Benefits** are the services covered by a plan. It works the same way for prescription drugs. A **formulary** is a list of drugs that a plan covers. Consumers will pay more for health services and prescription drugs not covered by a plan.

Paying for Health Care

Consumer cost sharing is any payment consumers make toward the cost of health care. Consumers pay for health insurance in advance of the service and again when they see a doctor, get a treatment, or fill a prescription. Here are some examples of consumer cost sharing.

- **Premium:** A premium is the amount the consumer pays for health insurance on a monthly basis.
- **Deductible:** A deductible is the amount the consumer pays before the insurance company pays anything. Until this amount is met, the consumer will pay the full price for most services. Deductibles are calculated per person and by plan year. Services not covered by a plan, monthly premiums, and co-pays are not counted toward the deductible. Additionally, there may be different deductibles for in-network and out-of-network providers.
- **Co-pay (or co-payment):** A co-pay is a fixed amount paid for a covered service when the consumer gets care. Office visits, emergency room visits, and prescription drugs may require a co-pay. For example, the consumer may pay \$10 to visit a doctor and the insurance company may pay the remainder of the bill.
- **Co-insurance:** Co-insurance is similar to a co-pay. However, instead of paying a fixed amount, the consumer pays a percentage of the total cost. For example, the consumer may pay 20 percent of the total cost of a service, while the insurance company pays the remaining 80 percent. Co-insurance for out-of-network providers is often higher than it is for in-network providers.

Co-pays, deductibles, and co-insurance are commonly referred to as **out-of-pocket expenses**, meaning the consumer pays these costs separately from monthly premium fees. Most plans offer **out-of-pocket limits**, which is the maximum amount the consumer will be required to pay in out-of-pocket fees. Once the consumer hits the out-of-pocket limit, the insurance company will pay 100 percent of costs for services that are in-network and covered by the plan for the rest of the plan year.

Let's use "Jane" as an example. Jane is a 30-year-old, single woman who purchased health insurance for herself. She pays a monthly premium of \$215. In addition, Jane has a \$500 deductible per year, \$30 co-pays for office visits, 20 percent co-insurance (sometimes called an 80/20 co-insurance plan), and a \$2,500 limit on out-of-pocket expenses.

Jane's Plan
Premium: \$215/month
Deductible: \$500
Co-pay for office visits: \$30
Co-insurance: 20 percent
Out-of-pocket maximum: \$2,500

One day, Jane isn't feeling well and decides to visit her doctor. She pays a \$30 co-pay for the office visit. During the visit, the doctor performs several lab tests that cost \$500. Because she has not yet exceeded her \$500 deductible, Jane pays the full price of the lab tests.

Later that year, Jane goes back to the doctor for a few more tests. Because Jane has already spent \$500 in out-of-pocket costs, she has met the deductible. Jane now pays 20 percent of the lab costs, while the insurance company pays the remaining 80 percent. The doctor also gives Jane a prescription for antibiotics. Jane pays 20 percent of the cost for her antibiotics. Once Jane has spent \$2,500 in out-of-pocket expenses, she will have reached her annual out-of-pocket limit and the insurance company will cover 100 percent of all costs for services that are covered by her plan.

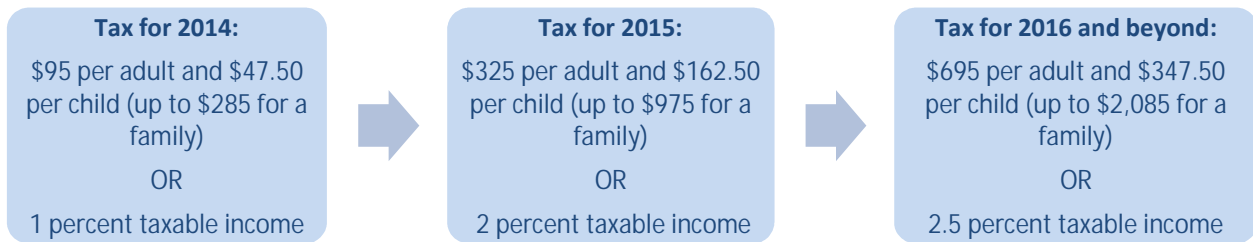
Summary of Benefits and Coverage

Understanding which benefits are covered and how much different services cost is complicated. Insurance companies now provide a **Summary of Benefits and Coverage** for every health plan that they offer. The Summary of Benefits and Coverage explains the health plan in language that is easy to understand. It includes consumer cost-sharing requirements and examples that illustrate the different benefits included in the plan.

The Kaiser Family Foundation created a [flowchart](#) that illustrates the health insurance requirement.²

BUY HEALTH INSURANCE OR PAY THE TAX

After January 1, 2014, **all Americans will be required to purchase health insurance**. Those without coverage will have to pay an additional tax, which will be tracked with income tax filing. In 2014, the tax will be \$95 per adult or 1 percent of the individual's income, whichever is greater. By 2016, it will increase to \$695 per adult or 2.5 percent of income. The tax for dependent children without health insurance is half the cost of the adult tax (e.g., \$47.50 in 2014). For families, the maximum tax is three times the per-adult dollar tax.



There are some exceptions to the individual mandate, including those who have religious objections, American Indians, those who have been uninsured for less than 3 months, undocumented immigrants, incarcerated individuals, people for whom the lowest-cost health plan would exceed 8 percent of their income, and people whose income is below the tax-filing threshold.

The Kaiser Family Foundation created a [guide](#) to help consumers discover the different ways they can get coverage.³

So, Americans Are Required to Buy Health Insurance—What Next?

Consumers need to be familiar with their health insurance options. However, it is not easy to understand the American health care system. Federal and state governments help fund and administer public health insurance plans, while private companies administer and manage private health insurance plans. The rest of this paper explains the different insurance options and the changes made by the ACA. Let’s review, starting with public health insurance.

PUBLIC INSURANCE

Funded by the federal and/or state governments, public health insurance programs are an important source of coverage for many Americans. Just over one-third of Americans get insurance through Medicare, Medicaid, and the Children’s Health Insurance Plan. However, these programs have specific eligibility requirements and it is hard to understand who can get insurance through these programs.

This section explains eligibility, enrollment, and how the ACA changes public health insurance programs, focusing on

- Medicare
- Medicaid and the Children’s Health Insurance Plan
- Other public programs: Veterans Administration Health Benefits Program, TRICARE[®], and Indian Health Services

Medicare

Most Americans are familiar with Medicare, which was designed with the primary purpose to provide coverage for people **65 years old or older**. However, Medicare also covers a few special populations:

- People with **Lou Gehrig's disease (ALS)** are eligible when they begin receiving Supplemental Security Income disability.
- **Disabled individuals** who have received disability benefits from Social Security for a minimum of 24 months are eligible for Medicare.
- People with **end-stage renal disease** are eligible for Medicare if they have worked long enough to receive benefits under Social Security, the Railroad Retirement Board, or as a Medicare-qualified government employee. However, people with end-stage renal disease only receive Medicare benefits during specific treatment and/or recovery periods. For example, Medicare coverage begins after the third full month of hemodialysis treatment and ends 12 months after dialysis is complete. Alternatively, Medicare coverage begins in the first month of a kidney transplant and ends 36 months after the transplant.

Supplemental Security Income is available for disabled adults and low-income children. The Social Security Administration developed a 5-minute [survey](#) to help consumers find out if they are eligible.⁴

Consumers can find an [online application](#) on the Social Security website. They can also call the toll-free service line at 1-800-772-1213.⁵

How do consumers enroll in Medicare? Consumers who receive Social Security checks are **automatically enrolled**. Consumers with Lou Gehrig's disease are automatically enrolled as soon as they begin receiving Supplemental Security Income disability benefits, as are individuals who have been receiving

Social Security disability benefits for 2 years.

All other eligible consumers must **sign up for Medicare**. Consumers with end-stage renal disease must contact Social Security Administration to enroll. Individuals who are 65 years old or older must sign up for Medicare by filling out an online application or appearing in person at a Social Security office. Consumers can sign up for Medicare as early as 3 months before turning 65 years old. If consumers don't enroll 3 months before or after they turn 65, there is another general enrollment period that starts January 1 and ends March 31.

What documents do consumers need to enroll? Consumers will need to present the following documents to enroll in Medicare: birth certificate, proof of U.S. citizenship or documented immigrant status, copy of U.S. military service papers for those who served in the military, and copy of their W-2 form and/or self-employment tax return.

When signing up for Medicare, consumers can choose from a few options. All consumers can receive traditional Medicare, which includes Parts A and B.

- **Part A (hospital insurance):** Part A includes inpatient hospital care, skilled nursing facility care, and hospice or home health care.
- **Part B (insurance for doctor's visits, medical equipment, and medical assistance):** Part B includes outpatient care, home health care, durable medical equipment (e.g., oxygen and wheelchairs), and some preventive care (e.g., depression and alcohol misuse screenings, mammograms, cancer screenings, cardiovascular disease screenings, certain immunizations, and type 2 diabetes screenings). Beneficiaries must pay an additional premium for Part B.

In addition, consumers can enroll in a prescription drug coverage plan by purchasing additional private health insurance.

- **Part D (prescription drugs):** Part D is an optional prescription drug benefit for Medicare beneficiaries. Although Part D is optional, there is a penalty if you sign up late.

Consumers may also choose to purchase a Medicare Advantage Plan, or Part C, administered by a private insurance company. It's important to note that the enrollment period for a Medicare Advantage plan is different. Open enrollment for Part C begins October 15 and ends December 7.

- **Part C (Medicare Advantage):** Medicare Advantage plans include Part A and Part B and typically include Part D. They can also have programs targeted for persons with special health needs. The ACA bans Medicare Advantage plans from increasing co-pays and deductibles on certain services.

How Does the ACA Change Medicare for Consumers?

Certain **preventive services are now available without co-pays or deductibles**, including cancer screenings, vaccinations, blood pressure screenings, cholesterol screenings, counseling to quit smoking, and birth control. An annual wellness visit is included as part of Medicare at no charge. This is an important way for consumers to take advantage of being healthy and using insurance to prevent and screen for certain diseases.

Healthcare.gov provides a full [list of preventive services](#) that are now free for Medicare beneficiaries.⁶

For those who purchase Medicare Part D, the drug coverage benefit, the law provides relief for Medicare beneficiaries who find themselves within the **prescription drug coverage gap (or donut hole)**. What is the donut hole? Before the ACA, Medicare Part D covered all drug costs up to \$2,700 per year, but would not pay any more until an individual spent \$6,100. Under the ACA, pharmaceutical companies are now required to provide a 50 percent discount on brand-name drugs for beneficiaries beyond the full benefit of \$2,700. By 2020, the plan is for beneficiaries to not have any out-of-pocket expenses.

Medicaid and the Children's Health Insurance Program

Medicaid is a joint federal–state program that provides coverage for many low-income individuals. States and the federal government share the cost of providing services to Medicaid beneficiaries. The federal government sets down general rules that define eligibility and coverage minimums that the states must follow. Although the federal government provides funding and outlines general guidelines, each state runs and administers its own program. As a result, specific eligibility and benefit details vary from state to state.

Medicaid may be known by different names across states. For example, the Massachusetts Medicaid program is MassHealth, while Connecticut's is HuskyHealth. In addition, some states use a commercial plan to run the Medicaid program. It's important to research each state's program for specifics.

Similar to Medicaid, the **Children's Health Insurance Program (CHIP)** is a joint federal–state undertaking run by each state. CHIP aims to extend health coverage for children up to age 19 whose families' incomes are too high to qualify for Medicaid.

How do eligible consumers enroll in Medicaid? Consumers can enroll in person by visiting their local Department of Family and Child Services, their local health department, a com-

munity health center, and other selected locations. Consumers should look online at Medicaid.gov to find specific eligibility and enrollment criteria for each state.

What documents will consumers need to enroll in Medicaid? Requirements may vary by state, but consumers will generally need to bring proof of citizenship, proof of residency, a valid Social Security number, proof of income (e.g., a W-2 form or a pay stub), and documentation for children, if needed.

How Does the ACA Expand Medicaid Eligibility?

Before the ACA, poverty alone did not qualify someone for Medicaid. Instead, individuals had to have certain financial requirements and belong to one of these eligible groups: parents with dependent children, pregnant women, seniors, people with disabilities, and children. Adults who were not disabled and did not have children were not included in the federal categories of people states must cover through Medicaid. States could only provide coverage to these adults through a Medicaid waiver or a fully state-funded program. Although almost half of all states do offer some coverage to these adults, many of these programs limit enrollment and provide few benefits.

The Coalition of Community Health Clinics has a [tool](#) that calculates whether a consumer is within the federal poverty level.⁷

The ACA allows an **expansion in Medicaid eligibility** to all legal residents who earn up to 133 percent of the federal poverty level (FPL). States can now receive federal funding by making Medicaid available to all adults who are not covered by Medicare and make less than 133 per-

cent of the FPL. In 2012, 133 percent of the FPL was equal to \$14,856/year for an individual and \$30,675/year for a family of four.

This is not a required expansion. States can decide whether they would like to accept this broad definition of eligibility, or keep the old, pre-ACA rules. It's important for consumers to find out about a state's specific eligibility requirements and whether it will participate in the Medicaid expansion.

The Advisory Board Company has a [map](#) that tracks state decisions on the Medicaid expansion.⁸

Other Public Programs

Department of Veterans Affairs Health Benefits

Apply [online](#) at the Department of Veteran Affairs.⁹

The VA Health Benefits program is not an insurance plan, but it provides coverage for pre-specified benefits. These medical benefits depend on a number of factors (e.g., length of service, injuries, illness, income, etc.) and will not be the same for each veteran. Benefits vary from year to year based on federal funding. However, there are some benefits that are available to all veterans regardless of eligibility. With Americans required to purchase health insurance beginning in 2014, many eligible consumers will look to the VA Health Benefits program for coverage.

TRICARE®

The TRICARE Health Benefit Program is for all seven uniformed services (Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration). The following individuals and their families are eligible for TRICARE:

- Active-duty service members
- Uniformed service retirees
- Medal-of-honor recipients
- Families of those who lost their spouse during active duty
- Reservists activated for more than 30 consecutive days

Visit the TRICARE [website](#) to learn more.¹⁰

Uniformed service members and their families must be registered in the Defense Enrollment Eligibility Reporting System (DEERS) to be eligible for TRICARE. Uniformed service members are automatically registered in DEERS, but family members must be registered manually. Some TRICARE plans require consumers to enroll, while others are automatic. There are several options, so be sure to check out the TRICARE website to learn more.

Indian Health Services (IHS)

Although not an insurance plan or benefits program, the IHS is a federal health care provider system that offers primary care and inpatient services to Native Americans who are enrolled members of a federally recognized tribe. Typically, one must live on a reservation to have access to these services. The ACA made the IHS permanent and allows the IHS to update the services offered to meet the needs of the Native American population. New IHS services will include mental and behavioral health treatment and prevention, long-term care services, dialysis service, care for Indian veterans, and health programs

Summary: Public Health Insurance

Time to recap. It's important for consumers to understand how the ACA changes public insurance programs. Here's a list of the changes discussed above.

- Some preventive services are now available without co-pays or deductibles for Medicare beneficiaries.
- The ACA closes the prescription drug donut hole to help Medicare beneficiaries with prescription drug out-of-pocket expenses.
- The ACA bans Medicare Advantage plans from increasing co-pays and deductibles on certain services.
- States can choose to expand Medicaid eligibility to everyone under 133 percent of the federal poverty level.
- Indian Health Services can offer new services to the Native American population.

PRIVATE INSURANCE

Private health insurance is coverage that is administered and managed by an insurance company or other private organization. Two-thirds of the nonelderly have private insurance. Alt-

though the majority of this population gets private insurance through an employer, a small percentage purchases insurance individually.

This section explains private health insurance and how the ACA expands access to private health insurance, focusing on both employer-sponsored and individual health insurance.

Employer-Sponsored Health Insurance

Many Americans get health insurance through their employers. Employers contract with an insurance company to enroll their employees in a health plan. The insurance company takes on the responsibility of providing access to health care to its employees, negotiating the cost of physician visits and procedures, and paying the employer portion of expenses to health care providers. Employees share in the cost by paying premiums each month, often subtracted from their paychecks, and through co-pays and co-insurance.

Individual Health Insurance

Americans who cannot obtain insurance through an employer (e.g., the unemployed, the self-employed, early retirees, those working for employers that do not offer health insurance, many part-time employees) can buy insurance for themselves. However, because the cost of insurance is not shared with an employer, consumers find these plans to be very expensive.

Changes to Private Insurance

Several new coverage options and financial protections are now required of private health insurance plans, both employer-sponsored and individual.

Easier Enrollment for Full-Time Employees

Employees usually have more than one choice of health plans and employers are required to inform employees of their options for health insurance. Employers with 51-200 full-time employees will have to offer health coverage to all full-time employees. Employers with 200 or more full-time employees will soon have to automatically enroll new full-time employees into a default health plan and automatically continue existing health plans for current full-time employees.

Coverage Options for Most Young Adults and People with Pre-Existing Conditions

Most plans that offer coverage for dependent children must now extend that coverage to **children under the age of 26**. This applies to young adults who may have moved out, are self-supporting, and can no longer be claimed as dependents on their parents' income taxes. It also applies to young adults who are married or unmarried, in school or out of school. There is one exception. Any health plan that existed before March 23, 2010, does not have to extend coverage for young adults under the age of 26 if they are eligible for coverage through their employers.

More than 3 million young adults (aged 19-25) now have health insurance coverage through their parents' insurance plans.

What Is a Pre-Existing Condition?

Any health condition that exists before someone applies for health insurance. Examples could range from cancer and heart disease to asthma and high blood pressure.

Before the ACA, those with **pre-existing medical conditions** could be denied health insurance or be forced to pay high premiums and higher out-of-pocket expenses. People with pre-existing conditions can no longer be denied health insurance. To help with the transition, a temporary insurance plan (called the Pre-Existing Condition Insurance Plan) will help cover those uninsured individuals. People with a Pre-Existing Condition Insurance Plan will be transitioned to the health insurance marketplace in 2014.

Financial Protections

There are also new financial protections to help consumers with the high cost of health care.

- **No co-payments or deductibles for some preventive services:** Certain preventive services (e.g., depression and alcohol misuse screenings, blood pressure screenings, colorectal cancer screenings, certain immunizations, and type 2 diabetes screenings) are now covered by every plan and will be available at no additional cost.
- **New premium limitations and guidelines:** Premium increases will be limited based on new guidelines and rate reviews.
- **No lifetime monetary caps and a limit on the use of annual caps:** People will not lose insurance because they reached a certain cost limit on medical expenses.
- **New out-of-pocket maximum:** There is an upper limit on the out-of-pocket costs an individual has to pay. For any individual at or above 400 percent of the FPL, the out-of-pocket maximum is approximately \$6,000 per year. This maximum is even lower for individuals below 400 percent of the FPL.

Healthcare.gov has [full list of preventive services](#) now covered under the ACA.¹¹

New Health Insurance Marketplaces

The ACA mandates the creation of health insurance marketplaces (also known as health insurance exchanges) to make the purchasing of health insurance easier. The state-based marketplaces will be open to individuals buying their own coverage, small businesses with fewer than 100 employees, and the self-employed. The marketplaces are meant to be

- **Efficient:** Marketplaces must be watchful of costs for consumers, employers, and the government. Competition among plans on price and quality as well as policies to prevent waste, fraud, and abuse will promote efficiency within the marketplaces.
- **Easy to access and enroll:** Marketplaces will determine eligibility and provide a standard enrollment process for Medicaid, CHIP, and other public programs. The Centers for Medicare & Medicaid Services recently announced the completion of a streamlined form to use to apply for health insurance.

The streamlined application forms can be found [online](#).¹²

- **Transparent:** Marketplaces will require data be reported on price, quality, and benefits. Marketplaces will rate health plans based on the quality and price of benefits and will have an electronic calculator so that consumers can calculate the cost of different plans.
- **Consumer-friendly:** Marketplaces must supply data about plans, benefits, and cost in plain language for the consumer to understand.

Each marketplace will have a **website** (something like Travelocity.com) where consumers can find, compare, and choose health plans offered by different insurance companies. Individuals will fill in information on age, family size, number of dependents, and income. The website will then list the options based on the information recorded. Websites will allow consumers to search and compare plans on monthly premiums, annual deductibles, and benefit packages. Enrollment through a marketplace will begin in October 2013. Health insurance coverage bought through the marketplace will start January 1, 2014.

An estimated 7 million Americans will participate in the marketplaces by 2014 and 24 million by 2016.

All plans offered through a marketplace will have to offer minimum medical coverage and prescription drug benefits, called **essential health benefits**. Essential health benefits include health care from doctors' offices and clinics, emergency and overnight care in a hospital, pregnancy and newborn care, mental health services, substance abuse services, prescription drugs, rehabilitative services, laboratory services, preventive/wellness services, and pediatric services.

Cost-Sharing Limitations

Platinum: 90 percent of costs are covered by the plan, 10 percent by the consumer

Gold: 80 percent of costs are covered by the plan, 20 percent by the consumer

Silver: 70 percent of costs are covered by the plan, 30 percent by the consumer

Bronze: 60 percent of costs are covered by the plan, 40 percent by the consumer

The plans offered in each marketplace are meant to be affordable. Insurance companies will have to compete on cost and quality and must meet certain **limits on total cost sharing**. There will be four tiers of plans that offer different levels of coverage: platinum, gold, silver, and bronze.

Consumers might immediately think that a platinum plan or gold plan is the best option. The platinum and gold plans will have generous coverage benefits with low out-of-pocket costs, but they will likely have higher premiums. Consumers might want to consider such plans if they use a lot of health services in a year and want to limit their out-of-pocket expenses. Those who do not use a lot of health services

and do not worry about having higher out-of-pocket expenses might want to consider plans in the silver or bronze tiers.

Plans are likely to cover different services and providers even if they are in the same tier, so it's important to determine each plan's specific benefits before selecting it.



Health Navigators and Consumer Assistants

In order to help consumers use the new marketplaces and understand Medicaid and CHIP changes, every marketplace will have consumer assistants to guide consumers through the insurance process. There are three kinds of consumer assistants: **Health Navigators, In-Person Assistors (IPAs), and Certified Application Counselors (CACs)**. In order for them to best meet specific needs that may arise, these consumer assistants will have connections with the local communities using the marketplaces.

Health Navigators provide objective information about different health plans, help with plan enrollment, and help consumers reach the appropriate agency to address any questions or complaints they may have about their health plan. Navigators will be available in every marketplace and will be trained and licensed according to guidelines and standards set by the Department of Health and Human Services (HHS). Federal regulations also state that all navigators must be free of conflicts of interest with an insurance company. HHS will provide the funding to begin these programs.

IPAs and CACs are similar to Health Navigators and will help fill in any gaps. However, IPAs will only be available in states that have chosen to start their own marketplace or in a joint federal–state marketplace. They will not be available in states that have a federally run marketplace. CACs will be started by groups in local communities and will target specific areas of need. Unlike Health Navigators, CACs will not receive any federal funding. Health Navigators and IPAs are scheduled to be available beginning October 1, 2013.

Tax Credits and Subsidies

Tax credits and subsidies are available for specific low-income individuals and families to help them pay for health insurance. They will average an estimated \$4,600 per person in 2014.

Income	Premium Maximum as a % of Income
Up to 133% FPL	2-3% of income
133-150%FPL	3-4% of income
150-200% FPL	4-6.3% of income
200-250% FPL	6.3-8.05% of income
250-300% FPL	8.05-9.5% of income
300-400% FPL	9.5% of income

Tax credits: Individuals and families earning between 100 and 400 percent of the FPL can get a tax credit if their health insurance premium is above a certain percentage of their income. The exact amount of the tax credit depends on an individual's or family's income. For example, someone with an income between 133 and 150 percent of the FPL is not expected to pay more than 4 percent of his/her income for an insurance premium. If the premium for the benchmark plan (or the second-lowest-cost silver plan)

within a marketplace is more than 4 percent of the individual's income, then he/she will receive a tax credit for the difference. This tax credit is an advanced monthly payment made by the government directly to the insurer. Eligible consumers will submit income information (e.g., paystubs or W-2 forms) when they fill out the application to get insurance through the marketplaces.

Cost-sharing subsidies: Cost-sharing subsidies limit the amount individuals and families with incomes at or below 250 percent of the FPL pay in out-of-pocket expenses. For example, out-of-pocket expenses for individuals and families with incomes between 100 and 150 percent of the FPL would be capped at 6 percent. The subsidies are paid directly by the government to the insurer, who then lowers deductibles, co-payments, and other out-of-pocket costs.

Income	% of Costs Covered by Insurance
100-150 % FPL	94%
150-200 %FPL	87%
200-250% FPL	73%

Summary: Private Health Insurance

Time to recap. It's important for consumers to understand how the ACA changes private health insurance. Here's a list of the changes discussed earlier in the section.

- Easier enrollment for employees
- New coverage options for young adults and those with pre-existing conditions
- New financial protections
- New marketplaces to buy health insurance
- New subsidies and tax credits available to low-income individuals and families

FOUR QUESTIONS

Here are four questions consumers should ask when enrolling in an insurance plan:

1. What are my choices for health insurance?
2. How do I get it?
3. How do I use it?
4. How much will it cost me?

RESOURCES

Website and links provided in the text:

1. *Glossary*. Healthcare.gov. U.S. Department of Health and Human Services. <http://www.healthcare.gov/glossary/a>
2. *The Requirement to Buy Coverage Under the Affordable Care Act Beginning in 2014*. Kaiser Family Foundation. <http://kff.org/infographic/the-requirement-to-buy-coverage-under-the-affordable-care-act/>
3. Levitt, L., J. Jankiewicz, and D. Rousseau. *Health Coverage Under the Affordable Care Act*. Journal of the American Medicine Association. December 2012; 308(24):2556. <http://jama.jamanetwork.com/article.aspx?articleid=1487506>
4. *Benefit Eligibility Screening Tool (BEST)*. U.S. Social Security Administration. <http://www.benefits.gov/ssa>
5. *Social Security Benefit Application*. U.S. Social Security Administration. <https://secure.ssa.gov/iCLM/rib>
6. *Medicare Preventive Services*. Healthcare.gov. U.S. Department of Health and Human Services. <http://www.healthcare.gov/law/features/65-older/medicare-preventive-services/index.html>
7. *Federal Poverty Level Guidelines*. Coalition of Community Health Clinics. <http://www.coalitionclinics.org/fpl.html>
8. *Where each state stands on ACA's Medicaid expansion*. The Advisory Board Company. <http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap>
9. *Health Benefits*. Department of Veteran Affairs. <http://www.va.gov/healthbenefits/online>
10. *Tricare*. Tricare Management Activity. <http://www.tricare.mil/Welcome/Enrollment.aspx>
11. *Preventive Services Covered Under the Affordable Care Act*. Healthcare.gov. Department of Health and Human Services. <http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html>
12. *Application forms for health insurance exchanges shrink to 3 pages*. Fierce Government. <http://www.fierceregovernment.com/story/application-forms-health-insurance-exchanges-shrink-3-pages/2013-04-30>