

Health Insurance Basics and the Federal Marketplace in Indiana

Module #3
Training Resource for
Indiana Navigators



Module #3 Overview



- **After reviewing this module, you will be able to:**
 - Explain basic health insurance concepts
 - Help a consumer identify and understand the key costs and benefits on a health insurance plan description
 - Understand the key concepts of the Affordable Care Act (ACA) and how those concepts will impact consumers
 - Understand what the federal Marketplace is, who can use it, and its key features
 - Help a consumer identify whether or not the consumer may be eligible for coverage and cost assistance programs through State programs or on the federal Marketplace

Module #3 Terminology



Term	What it Means
Federal Poverty Level (FPL)	A measure released every year by the federal government that estimates the minimum amount an individual or family would need to make to cover basic living expenses. Measure reflects income and household size, and changes annually.
Marketplace, federal Marketplace	A federal website where consumers can shop for and purchase health coverage and apply for cost assistance. May also be called an Exchange.
Large Group, Small Group, Individual Market or Plan	In Indiana, the large group market is for employers with >50 employees, the small group market is for employers with 2 - 50 employees, and the individual market for individuals and their dependents. Federal law defines small group as 1 – 50 common law employees
Health Insurer, Health Insurance Issuer, Health Insurance Carrier	All of these terms refer to the insurance company that issues health insurance plans or policies.
Grandfathered, non-grandfathered health plan	Grandfathered health plans are plans that were in existence prior to the Affordable Care Act (ACA) and have not had substantial changes. These plans do not have to comply with many ACA requirements. Non-grandfathered plans are required to comply with all ACA requirements. (unless that are grandmothersed/transitional plans)
Grandmothered Plan	An health insurance policy that is not compliant with ACA rules but that the federal government allowed to be extended on a limited basis until 2016. Indiana's guidance on these policies can be found at http://www.in.gov/idoi/files/Bulletin_205.pdf .

Module #3 Terminology (cont.)



Term	What it Means
Individual & Employer Mandates	Individual Mandate is a tax penalty for an individual that does not have sufficient health coverage (defined by federal government); and Employer Mandate (DELAYED until 2015) is a tax penalty for large employers that do not offer sufficient health coverage (as defined by federal government). Also referred to as the Individual and Employer Shared-Responsibility requirements.
Qualified Health Plan (QHP)	A health insurance plan that has passed a federal certification process to be offered on a Marketplace.
Minimum Essential Coverage (MEC)	The type of coverage an individual must have to meet the Individual Mandate (shared-responsibility) requirement under the Affordable Care Act (ACA).
Premium Tax Credit (PTC); Cost-Sharing Reductions (CSRs)	ACA provisions that lower the amount some eligible consumers pay for premiums, copayments, coinsurance, and/or deductible. May also be called Insurance Affordability Programs.



Health Insurance Basics

- Premiums
- Cost Sharing (Copayment, Coinsurance, Deductible)
- Cost Limits (Out-of-pocket maximum)
- Features of the Affordable Care Act (ACA)



Health Insurance Basics: Premiums

- A fee is paid to an organization offering health insurance (**INSURER**). The Insurer offers a contract to the person or persons covered by the fee (**ENROLLEE(S)**). This contract guarantees coverage for approved health services.
- Insurer:
 - Talks to healthcare providers and negotiates better prices for goods and services
 - Pays for enrollee medical care as specified by the contract
- The fee is a **PREMIUM**
 - Individuals pay the premium regardless of whether or not they use the health insurance
 - Premiums are usually paid on a monthly basis



Health Insurance Basics: Cost Sharing

- In addition to monthly premiums, individuals may have to pay part of the cost of care when they visit a healthcare provider
- Individuals may have to pay a flat fee before they are seen by the healthcare provider. This fee is called a **COPAYMENT**
- After the visit, individuals may receive a bill from their health care provider for a percentage of the cost of care, known as **COINSURANCE**
- Individuals may also have to pay for the full cost of healthcare until they reach their **DEDUCTIBLE**. The deductible is a set amount that the individual will spend toward care before the insurer begins to make payments
- Once the deductible is met, the insurer may require only copayments, may split costs of care with the individual (coinsurance) or may pay for the entire cost of care
- Cost-sharing is a common feature of different health insurance plans, and the specific requirements vary between plans



Health Insurance Basics: Cost Limits

- “In-network” healthcare providers* (those covered by a certain insurance policy) may only charge cost sharing up to an **OUT-OF-POCKET MAXIMUM** amount. This amount is the maximum cost sharing a plan may charge in a year.
- The out-of-pocket maximum amounts for allowable costs are:

	Medical Insurance	Dental Insurance
2014	Individual Plan: \$6,350	Individual Plan: \$700
	Family Plan: \$12,700	Family Plan: \$1,400
2015	Individual Plan: \$6,600	Individual Plan: \$350
	Family Plan: \$13,200	Family Plan: \$700

*Out-of-network providers are not subject to cost sharing limits



Health Insurance Basics

- **Not all health insurance is set up the same way**
 - Health insurance plans may use any or all of the following:
 - Premium
 - Copayment
 - Coinsurance
 - Deductible
 - Out-of-pocket maximum
 - Health insurance plans may have different rules about how these key terms are applied, for example:
 - Some plans may charge copayments for some services and coinsurance for others
 - A health plan's cost-sharing policy can be found in the plan's Summary of Benefits and Coverage



Features of the Affordable Care Act (ACA)

- **Goal: Increase Number of Individuals with Health Insurance Coverage**
 - Subsidized coverage for lower incomes
 - Cannot be denied coverage for preexisting conditions
 - Institutes penalties for:
 - Individuals that do not have health insurance coverage
 - Large employers that do not offer health insurance coverage
 - Delayed until 2015
- **Requires consumer considerations**
 - Review of insurance rate increases by state insurance department
 - Requires insurance companies spend a certain percentage of premiums on direct medical care
 - Insurance policies are:
 - Guaranteed to be available and
 - Guaranteed to be renewable



Carrying out the Affordable Care Act (ACA)

- **The ACA has new requirements and options that impact:**
 - The state Medicaid agency
 - Commercial health insurance
- **Gives States three options for setting up a new health insurance Marketplace:**

Option	Federal Responsibility	State Responsibility	Indiana and Surrounding State Decisions
State-based Marketplace	Set guidelines	Use federal guidelines Set up Marketplace Run Marketplace	Kentucky
Partnership Marketplace	Set guidelines Set up Marketplace Run Marketplace	Use federal guidelines to: <ol style="list-style-type: none"> 1. Oversee health insurance plans 2. Manage consumer assistance 3. Both 1 and 2 	Illinois Michigan
Federal Marketplace	Set guidelines Set up Marketplace Run Marketplace	Observe federal guidelines Maintain oversight of state-regulated health insurance products	Indiana Ohio



Affordable Care Act: Requirements for Individuals and Employers

- Minimum Essential Coverage (MEC)
- Individual Mandate
- Exemptions
- Employer Mandate

The Individual Mandate and Minimum Essential Coverage (MEC)



- Individual Mandate
 - Affordable Care Act (ACA) requirement
 - All individuals must maintain health coverage for themselves and their dependents
 - **Must have Minimum Essential Coverage (MEC)**
- Understanding MEC
 - List of coverage types determined by the federal government
 - Coverage types may change
 - **Some coverage types only classified as MEC in 2014**
 - Types of coverage not currently considered MEC may apply for recognition as MEC
- Exemptions from MEC
 - Certain individuals may receive an exemption from the requirement to maintain MEC



Individual Mandate

- Individual Mandate, also called Shared-Responsibility requirement
- Individuals who do not maintain Minimum Essential Coverage (MEC) must obtain an exemption or pay a tax penalty for themselves and all uncovered dependents
- Tax penalty varies, as shown in the table below:

	Subject to the maximum, penalty is the greater of:		Maximum Penalty
	Dollar Penalty*	Percent Penalty	
2014	Adult: \$95	1% of annual household income	National average premium for a Qualified Health Plan (QHP) Bronze Plan that would cover the applicable individual(s)
	Under 18: \$48		
	Maximum: \$285		
2015	Adult: \$325	2% of annual household income	National average premium for a Qualified Health Plan (QHP) Bronze Plan that would cover the applicable individual(s)
	Under 18: \$163		
	Maximum: \$975		
2016	Adult: \$695	3% of annual household income	National average premium for a Qualified Health Plan (QHP) Bronze Plan that would cover the applicable individual(s)
	Under 18: \$348		
	Maximum: \$2,085		

*Assessed for every household member without MEC



Federal List of Minimum Essential Coverage Types

In order to meet Individual Mandate requirements, all Americans must have at least one of the following:

- Government sponsored health coverage
 - Medicare Program
 - Medicare Advantage Plan
 - Most Medicaid Programs
 - Children's Health Insurance Program
 - Refugee Medical Assistance
 - Veterans Administration programs: including TriCare and CHAMP VA
 - Coverage for Peace Corps Volunteers
- Employer-sponsored health coverage
- Individual market health coverage
- Grandfathered health plan
- Self-funded student health coverage – **Limited to 2014**
- Non-appropriated Fund Health Benefit Program
- Additional Coverage as specified
 - Any health coverage not recognized may apply to be minimum essential coverage. The federal government will maintain a list of recognized types of minimum essential coverage.

...or they will need to receive an exemption or pay the tax penalty.

NOT Minimum Essential Coverage (MEC)



Many Americans may have coverage that is not considered MEC, such as:

- **Certain Medicaid Programs**
 - **Examples:**
 - Optional family planning services
 - Pregnancy related services
 - Emergency medical services
 - 1115 demonstration waiver services (i.e. Healthy Indiana Plan (HIP))
- **Limited-scope coverage**, or offered on a separate policy from primary health coverage
 - **Examples:**

Accidental death and dismemberment coverage	Benefits provided under certain health flexible spending arrangements	Coverage for employer-provided on-site medical clinics
Automobile liability insurance	Workers' compensation	Long-term care benefits
Disability insurance	Credit-only insurance	Vision benefits
General liability insurance	Fixed indemnity insurance	Medicare supplemental policies
TRICARE supplemental policies (i.e. Line of Duty Care, Space Available)	Similar supplemental coverage for a group health plan	Separate policies for coverage of only a specified disease (example: cancer only policies)

They will need to either:

Obtain coverage that **IS** MEC

Obtain an exemption

Pay the tax penalty



Exemptions for Unaffordable Coverage

- An individual may have Minimum Essential Coverage (MEC), but the individual may still qualify for:
 - **Affordability Exemption**
 - **IF Unaffordable Coverage:** Cost of coverage is more than 8% of household income
 - **Premium Tax Credit (PTC)***
 - **IF Cost of coverage is more than 9.5% of household income**
- Eligibility for the Affordability Exemption & PTC varies for those with access to employer-sponsored insurance (ESI)

	Employee Only	Employee & Dependents
Affordability Exemption	If contribution for ESI is more than 8% of income	If contribution for ESI for employee & dependents is greater than 8% of income, dependents may receive exemption (but not employee)
Premium Tax Credit	If contribution for ESI is more than 9.5% of income	If contribution for ESI that covers only the <i>employee</i> is greater than 9.5% of income

*Typically someone that already has MEC cannot get a PTC



Other Possible Exemptions

- Individuals may send an exemption application to:
 - The federal Marketplace ([Healthcare.gov](https://www.healthcare.gov)) **OR**
 - The Internal Revenue Service (IRS)
- In addition to Unaffordable Coverage, exemptions may be allowed for:

Religious Conscientious	Hardship
Household income below filing limit	Healthcare Sharing Ministry
Indian Tribe	Incarceration
Not lawfully present	Short coverage gaps

For more information about exemptions:

- Call the federal Marketplace call center: 1-800-318-2596
 - Online: <https://www.healthcare.gov/exemptions>



Employer Mandate*

- **Delayed until 2015:**
 - Employers with more than 50 full-time equivalent employees (FTEs) will be subject to penalties if at least one FTE receives a Premium Tax Credit (PTC)*
- **Eligibility:**
 - Employees can only receive a PTC if:
 - Income between 100% and 400% Federal Poverty Level (FPL)
 - AND
 - Employer coverage is not available
 - OR
 - Employer coverage does not provide minimum value (coverage paying at least 60% of health care costs)
 - OR
 - Single coverage costs more than 9.5% household income

*Provision delayed by the federal government and will now begin in 2015. Employers with over 50 FTEs that have employees receive PTC in 2015 will owe a penalty payment.



Employer Penalties

- Delayed until 2015
- Occurs when one or more employees apply for and receive Premium Tax Credit (PTC)
- Employer penalties will vary
 - Based on whether coverage offered to 95% of employees

Employer Penalties	
Employers <u>offering</u> coverage to at least 95% of full-time employees	Employers <u>not offering</u> coverage to at least 95% of full-time employees
<ul style="list-style-type: none"> • Pay a penalty of the lesser of: <ul style="list-style-type: none"> • \$3,000 per employee receiving a PTC, <u>OR</u> • The penalty for employers not offering coverage 	<ul style="list-style-type: none"> • Pay \$2,000 for every full-time and full-time equivalent employee, excluding the first 30 employees



Affordable Care Act: Insurance Market Changes

- Medical Loss Ratio (MLR)
- Rating Rules
- Modified Adjusted Gross Income (MAGI)
- Essential Health Benefits (EHBs)
- Actuarial Value (AV)
- Catastrophic Plans



Insurance Market Changes

- **Ensure Premiums Pay Healthcare Costs**
 - Insurers with low Medical Loss Ratio (MLR) will be required to issue refunds to enrollees
- **State continues to review all premium rate increases to ensure they are acceptable**
- **Rating Rules for Non-Grandfathered Plans**
 - Premiums based on age, location, smoking status, and family status
 - No rating based on health history or health status
- **Guaranteed Availability and Renewability in Non-Grandfathered Plans**
 - Health insurance companies required to issue and renew policies during open or special enrollment periods
 - Consumers cannot be denied for pre-existing conditions



Insurance Market Changes (cont.)

- **Adult dependent coverage to age 26**
 - Since 2010, insurers are required to offer the option for members to include adult dependents up to age 26 on their health coverage plan
- **Expanded coverage of preventive services**
 - Many preventive services required to be covered without cost sharing
- **Essential Health Benefits (EHBs)**
 - List of benefits that insurers in the individual and small group market are required to cover
- **Elimination of lifetime and annual maximum coverage limits**
 - Insurers may no longer put dollar limits on coverage that are part of the EHBs



Insurance Market Changes (cont.)

- **Actuarial Value (AV)**
 - Individual and Small Group Plans must have a standard AV that is displayed to the consumer
 - AV is a number that indicates the average percent of plan charges the insurer expects to pay for *all* enrollees in that plan
 - In general, plans with higher AV will have higher premiums and lower cost sharing
- **Minimum Value (MV)**
 - Employer-sponsored insurance must offer MV, or a plan that has an AV of at least 60%
 - If employer-sponsored insurance does not offer MV, employees may be eligible for Insurance Affordability Programs (i.e., Premium Tax Credits (PTCs) or Cost-sharing Reductions (CSRs)) and the employer may be subject to a fine



Medical Loss Ratio (MLR)

- Definition of MLR:
 - Percent of premiums collected by an insurance company and spent on medical services and quality improvement
- New requirement of the Affordable Care Act (ACA):
 - Health insurance companies must maintain a certain MLR
 - MLR requirements vary by market segment:

	Large Group	Small Group	Individual
MLR Requirement	85%	80%	80%

- If insurance company does not meet MLR requirement:
 - Individuals and small businesses will receive a refund

Rating Rules for Non-Grandfathered* Health Insurance Plans



To determine health insurance premiums:

- Health insurance plans may **only use three factors**:
 - Age – limited to 3 to 1 ratio
 - Tobacco use – limited to 1.5 to 1 ratio
 - Geographic area
 - Family Status
- Health insurance plan premiums **CANNOT** be based on:
 - Gender
 - Health status
 - Insurers may not exclude individuals or health conditions from their health coverage based on pre-existing conditions



Modified Adjusted Gross Income (MAGI)

- Eligibility based on Modified Adjusted Gross Income (MAGI) for:
 - Some Indiana Medicaid populations
 - All federal Marketplace programs
- MAGI is a way to count household income
 - Adjusted Gross Income as reported on federal tax return with the addition of:
 - Amounts excluded as foreign earned income (section 911)
 - Tax-exempt interest
 - Tax-exempt Title II Social Security benefits
 - May use current income information if:
 - No taxes filed or
 - Tax information no longer reflects current income

Essential Health Benefits (EHBs)



- **Starting in 2014:**

- The Affordable Care Act (ACA) requires health plans to cover certain Essential Health Benefits (EHBs)
- Must offer benefits in each of the following 10 EHB categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance abuse disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, with oral and dental



Essential Health Benefits (EHBs) (cont.)

- Within each of the 10 EHB categories:
 - Exact benefits may vary by state
- State selects a “benchmark” plan
 - Selected plan sets a baseline of benefits that must be covered by other plans
 - Indiana's EHB benchmark plan benefits:
 - http://www.in.gov/idoi/files/Policy_17575IN054_Cert_5BlueAccessPPO.pdf
- EHB benefits are set for 2014 and 2015
 - Will change in 2016

Actuarial Value (AV)



- **Actuarial Value (AV) is:**
 - The average percentage of allowed medical cost expected to be paid by the health plan over *all* covered enrollees
- **Beginning in 2014, AV applies to health plans that are:**
 - Non-grandfathered (excluding grandmothers/transitional)
 - In the individual & small group markets
 - On and off the federal Marketplace
 - Required to offer Essential Health Benefits (EHBs)

Plan Level	Estimated/target total costs covered by health plan*	Estimated/target total costs covered by enrollees
Bronze	60%	40%
Silver	70%	30%
Gold	80%	20%
Platinum	90%	10%

Premium Tax Credit based on the premium of the 2nd lowest cost Silver Plan

*At each plan level, the actual total costs covered by the health plan must be within two percentage points of the following estimates/targets (i.e. for Bronze plan, health plan costs must be 58-62% of total costs)



Exception: Catastrophic Plans

- Catastrophic plans are **exempt** from the Actuarial Value (AV) requirements that apply to other health plans
 - Eligibility to purchase Catastrophic Plans:
 - Individual under age 30, **OR**
 - Individual received exemption from requirement to maintain Minimum Essential Coverage (MEC)



Exception: Catastrophic Plans (cont.)

- Characteristics of Catastrophic Plans:
 - Deductible is close to out-of-pocket maximum
 - Individual responsible for most of healthcare cost until deductible/out-of-pocket maximum is met
 - Sold on and off the federal Marketplace
 - Qualifies as Minimum Essential Coverage (MEC)
 - NOT eligible for insurance affordability programs (Example: Premium Tax Credits (PTCs); Cost-sharing Reductions (CSRs))



Affordable Care Act: Affordable Coverage

- Qualified Health Plans (QHPs)
- Premium Tax Credits (PTCs)
- Cost-Sharing Reductions (CSRs)



Marketplace Qualified Health Plans (QHPs)

- **All health insurance plans sold on the federal Marketplace are certified by federal and state agencies to be sure they:**
 - Provide Minimum Essential Coverage (MEC)
 - Cover Essential Health Benefits (EHBs)
 - Meet Actuarial Value (AV) standards*
 - **Appear as metal levels**
 - **i.e. Bronze, Silver, Gold, Platinum**
 - Meet provider network standards
 - **The number of doctors and types of doctors in an area accepting that insurance**
 - **Health insurance plans must try to contract with essential community providers in an area**
- **Limitation:**
 - Like all other non-grandfathered plans, **CANNOT** consider the health status for the purposes of plan eligibility or plan cost

***NOTE:** Catastrophic plans sold on the Marketplace are exempt from the AV requirements



Premium Tax Credits (PTC)

- **Purpose:**
 - Reduces premium costs for eligible individuals
 - Can be paid directly to insurance company to reduce premiums (referred to as Advanced Premium Tax Credit (APTC)), **OR**
 - Consumers can claim the credit later when taxes are filed
- **Procedure:**
 - Individual applies at federal Marketplace for PTC
 - Federal Marketplace determines individuals PTC eligibility and maximum PTC amount
- **Limitation:**
 - Available **only** when coverage is purchased through federal Marketplace
- **Amount of PTC depends on:**
 - Cost of the Marketplace's second lowest-cost Silver plan that would cover the applicant and their dependents
 - Household income and family size
- **Amount of PTC does not depend on:**
 - Tobacco use
 - Premiums can be higher for tobacco users
 - Amount of PTC will not increase for tobacco users



Who is Eligible for Premium Tax Credits (PTCs)?*



Citizen, National or legal resident of the U.S. , Indiana resident, and non-incarcerated,

AND



Household income between 100% and 400% of the Federal Poverty Level (FPL)

AND



No other Minimum Essential Coverage (MEC) is available

- Such as Medicare, Medicaid or Employer Sponsored Insurance (ESI)

OR

Available MEC:

- With individual premium more than 9.5% of household income
- **OR**
- Does not provide minimum value (at least 60% actuarial value)

*Individuals must file taxes to be eligible for insurance affordability programs in coming years



Three Options for using the Premium Tax Credit (PTC)

<i>For all three options, the PTC is only available for coverage purchased on the federal Marketplace</i>	Option #1: Full Advanced Payment	Option #2: Partial Advanced Payment*	Option #3: Claim Later
Advantage	Reduces the amount consumer pays in premium costs	Reduces amount consumer pays in premium costs & likelihood of PTC overpayment	Ensures that PTC is not overpaid, and that consumer will not owe at tax filing
Disadvantage	If income increases during the year, consumer may owe some or all of PTC back at tax filing	Consumer bears more of the premium cost immediately than if full advanced payment is taken	Consumer bears the full cost of the premium immediately

***NOTE:** Consumers do not have to take the full amount of PTC offered to them. Option #2 may be advisable if an income increase is expected during the year, to avoid owing taxes at filing.



Options 1 & 2: Advanced Full or Partial Payment of Premium Tax Credit (PTC)

Consumer completes Insurance Affordability Programs application through Marketplace



Federal Marketplace estimates PTC amount & informs consumer*



Consumer decides whether to apply full or partial amount of PTC to premium costs



Consumer selects a health coverage plan through federal Marketplace



IF TOO MUCH PTC:
Consumer may have to pay additional tax
IF TOO LITTLE PTC:
Consumer may get tax refund



Consumer files taxes. Actual annual income will tell consumer how much PTC he or she should have gotten



Consumer pays the remainder of premium to the health insurance company

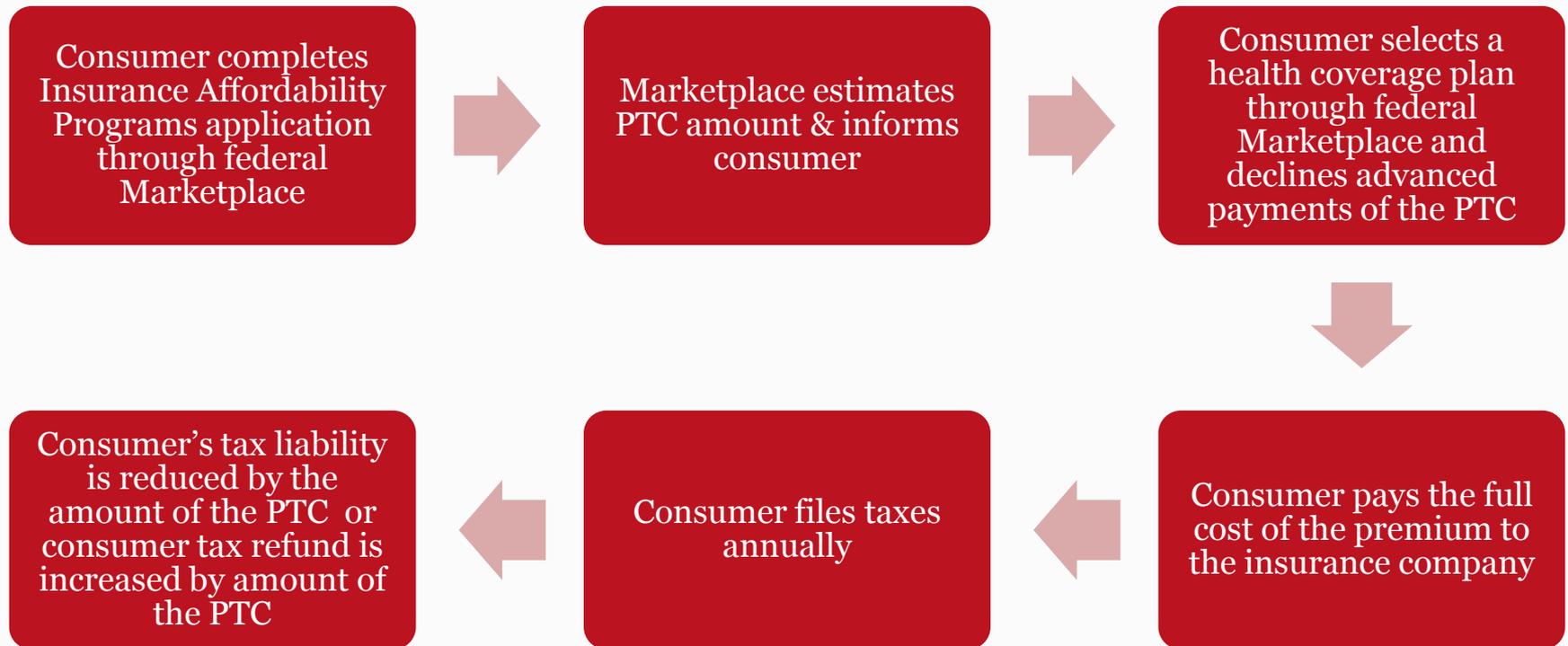


Federal government pays full or partial amount of PTC directly to the health insurance company of the chosen plan

***NOTE:** If income, household size, or location changes during the year, consumers must report to federal Marketplace so PTC amount can be adjusted.



Option 3: Claim Premium Tax Credit (PTC) with tax filing





Premium Tax Credit (PTC) Calculation

Annual premium of
the second-lowest
cost Marketplace
Silver plan that would
cover essential health
benefits for the
applicant and
dependents*



Consumer's
annual
required
contribution
(sliding scale
based on %FPL)



Amount of
consumer's PTC

All individuals and families who have any level of income may be required to pay a portion of the chosen plan's premium cost, dependent on plan selection

* PTC based on cost of coverage for Essential Health Benefits (EHBs) only, and will not increase to cover additional benefits



Premium Tax Credit (PTC): Required Premium Contribution

2014 FPL	Estimated Annual Income*	PTC required % of income contribution	Estimated annual contribution*
100-133%	\$11,670 - \$15,521	2%	\$233 - \$310
133-150%	\$15,522 - \$17,505	3% to 4%	\$466 - \$700
150-200%	\$17,506 - \$23,340	4% to 6.3%	\$700 - \$1,470
200-250%	\$23,341 - \$29,175	6.3% to 8.05%	\$1,470 - \$2,349
250-300%	\$29,176 - \$35,010	8.05% to 9.5%	\$2,349 - \$3,326
300-400%	\$35,011 - \$46,680	9.5%	\$3,326 - \$4,435
>400%	>\$46,680	Not eligible for PTC	N/A

***NOTE:** This estimated contribution is for the second lowest-cost Silver plan available on the federal Marketplace; estimated annual contribution could change based on plan metal tier selected. Estimated annual income and contribution based on 2014 FPL.



Premium Tax Credit (PTC) Application to Premium Costs

- PTC amount is based on the second lowest-cost Silver plan on the federal Marketplace
- Can be used to purchase *any* plan on the federal Marketplace
 - Choosing a bronze plan:
 - Apply Silver plan level of PTC to a cheaper premium
 - *Lowers* consumer's premium contribution
 - Choosing a gold plan:
 - Apply Silver plan level of PTC to a more expensive premium
 - Consumer has to make up the cost difference
 - *Increases* consumer's premium contribution

Example: Premium Tax Credit (PTC) Application to Premium Costs



For 2014, in Marion County, IN, the estimated premium costs for a 35-year old non-smoker are:

- Second-lowest cost **Silver plan: \$3,912* annually,**
- Lowest cost **Bronze plan: \$3,120* annually,** and
- Lowest cost **Gold plan: \$4,872* annually.**

Note how the PTC amount stays the same, based on the second-lowest cost Silver Plan, and how this impacts the amount someone would pay for his/her premiums, based on the selected plan.

Plan cost - PTC amount = Individual Contribution.

% FPL	2014 Estimated PTC Amount	2014 Estimated Individual Contribution: Bronze Plan**	2014 Estimated Individual Contribution: Silver Plan**	2014 Estimated Individual Contribution: Gold Plan**
100%	\$3,679	\$0	\$233	\$1,193
150%	\$3,212	\$0	\$700	\$1,660
200%	\$2,442	\$678	\$1,470	\$2,430
250%	\$1,563	\$1,557	\$2,349	\$3,309
300%	\$586	\$2,534	\$3,326	\$4,286
400%	\$0	\$3,120	\$4,435	\$4,872

*Source: Indiana Department of Insurance

**Contribution information calculated on previous slides (2014 FPL)



Cost-Sharing Reductions (CSR)

- **Purpose:**
 - Increase the Actuarial Value (AV) of health coverage plans for low-income consumers
 - Reduce out-of-pocket costs for consumers
- **Receiving CSR:**
 - CSR are offered **in addition** to Premium Tax Credits (PTC) on the federal Marketplace
 - Qualifying individuals do **NOT** have to apply for CSR separately

Who is Eligible for Cost-Sharing Reductions (CSRs)?*



Meet all requirements for Premium Tax Credits (PTCs)

AND



Enroll in a Silver Plan (70% Actuarial Value) on the federal Marketplace

AND



Household income between 100% and 250% Federal Poverty Level (FPL)

OR



Household income between 100% and 300% FPL for Native Americans

*Individuals must file taxes to be eligible for insurance affordability programs in coming years



Cost-Sharing Reductions (CSRs) and Out-of-Pocket Maximums

- To benefit from the increased Actuarial Value (AV) provided by the CSR and the reduced out-of-pocket maximum amount, consumers *must* select a Silver plan

2014 FPL	Estimated Annual Income (Individual)	AV of Silver plan after CSR (Originally 70%)	Individual Annual Out-of-Pocket Maximum (2014)*	Individual Annual Out-of-Pocket Maximum (2015)*
100-133%	\$11,670 - \$15,521	94%		\$2,250
133-150%	\$15,522 - \$17,505	94%		\$2,250
150-200%	\$17,506 - \$23,340	87%		\$5,200
200-250%	\$23,341 - \$29,175	73%	\$6,350	\$6,600

*Insurance companies do not have to charge less than the listed out-of-pocket maximum for their plans, but they cannot charge more than these amounts.



Premium Tax Credits (PTCs)* & Cost-Sharing Reductions (CSRs)

Estimating how much an individual applicant may expect to pay for a plan, following application for the PTC:

FPL	Estimated Annual Income**	PTC required % of income contribution	Estimated annual contribution**	Cost Sharing Reduction: Silver Plan AV
100-133%	\$11,670 - \$15,521	2%	\$233 - \$310	94%
133-150%	\$15,522 - \$17,505	3% to 4%	\$466 - \$700	94%
150-200%	\$17,506 - \$23,340	4% to 6.3%	\$700 - \$1,470	87%
200-250%	\$23,341 - \$29,175	6.3% to 8.05%	\$1,470 - \$2,349	73%
250-300%	\$29,176 - \$35,010	8.05% to 9.5%	\$2,349 - \$3,326	70%
300-400%	\$35,011 - \$46,680	9.5%	\$3,326 - \$4,435	70%
>400%	>\$46,680	Not eligible for PTC	N/A	70%

*Administered by the Internal Revenue Service

**Estimated income and contribution based on 2014 FPL for an individual selecting the second lowest cost Silver Plan



Affordable Care Act: Health Insurance Marketplaces

- Federal Marketplace in Indiana
- Who can use (individuals, small employers)
- Enrollment Periods
- Indiana Navigators and the Marketplace
- When Coverage Begins
- Re-enrollment and Renewing Eligibility



Health Insurance in Indiana

An employer may offer health insurance to its employees. If no employer-sponsored insurance is available:

- **In Indiana, there will be two ways for individuals to buy health insurance:**
 - **The commercial health insurance market**
 - Overseen by the Indiana Department of Insurance (IDOI)
 - Serves individuals, small groups, and large groups
 - **The federal Marketplace**
 - Administered by the federal Department of Health and Human Services (HHS)
 - Serves individuals and small groups
 - Individuals: federal Marketplace ([Healthcare.gov](https://www.healthcare.gov))
 - Small groups: Small Business Health Options Program (SHOP) ([Healthcare.gov/small-businesses](https://www.healthcare.gov/small-businesses))



Other functions of the federal Marketplace

- **The federal Marketplace is a website for individuals and small businesses to compare and purchase health insurance**
 - **Assesses** eligibility for:
 - **Medicaid**
 - If consumer may be eligible for Medicaid, will send application to state Medicaid agency
 - **Advance Premium Tax Credits (APTCs)**
 - **Cost-Sharing Reductions (CSRs)**
 - **Individual Mandate Exemptions**
 - **Manages** eligibility appeals
 - **Facilitates** enrollment in Qualified Health Plans (QHPs)
 - **Ensures** appropriate APTC and CSR payments to health insurance plans
 - **Collects and publishes** quality data on health plans
 - **Operates** consumer assistance call center
 - **Starting in 2015:** Collects premiums for small businesses



Who can use the federal Marketplace in Indiana?

- Individual is a citizen, national, or legal resident of the United States, and**
- Individual is a resident of Indiana, and**
- Individual is not incarcerated**



**Individual* (and dependents)
eligible to buy coverage
through the individual federal
Marketplace in Indiana**

***NOTE:** Even if an individual is ineligible to use the Marketplace, the individual can use it to apply for coverage on behalf of any eligible dependents



Buying Coverage off the federal Marketplace

- Individuals and families can still purchase coverage outside of the federal Marketplace
 - About the plans:
 - Regulated by the Indiana Department of Insurance (IDOI)
 - Benefit packages:
 - Some may be identical to those available on federal Marketplace
 - Some not offered on federal Marketplace
 - Cannot use Premium Tax Credit (PTC) and/or Cost-Sharing Reductions (CSRs)
 - How to purchase:
 - Contact an agent or broker for assistance, OR
 - Shop for coverage directly through insurance companies



Small Business Health Options Program (SHOP)

- Eligible Employers
 - 2014-2015: Employers with <50 employees
 - 2016 & after: Employers with <100 employees
- Employers using the SHOP
 - Can use brokers **OR** can use SHOP independently
 - Qualifying employers can receive a tax credit if less than 25 employees and meet financial requirements
 - **Starting in 2015, employers may be able to:**
 - Choose a plan level for employees or a specific plan or plans
 - Choose a reference plan to set employer contributions

Open Enrollment Period



Individual Marketplace Enrollment

- Initial Enrollment Period (2013-2014)
 - October 1, 2013-March 31, 2014
- Next open enrollment period (starting in 2014)
 - November 15, 2014-February 15, 2015
- Annual open enrollment period
 - To be determined by Centers for Medicare and Medicaid Services (CMS)
- Available to assist with enrollment:
 - Indiana Navigators
 - Health Insurance Agents and Brokers
 - Authorized Representatives
- Special Enrollment Periods
 - Due to loss of minimum essential coverage (MEC), change in family size, change in location, etc.
- Off-federal Marketplace enrollment:
 - Plans may conform to open enrollment requirements
 - Individuals that do not enroll during the open enrollment period may not have the chance to enroll in coverage



Special Enrollment Circumstances

- Individuals may enroll in coverage outside of the open enrollment period if they have a special enrollment event including:
 - Loss of Minimum Essential Coverage (MEC)
 - Gain or lose a dependent; or become a dependent due to:
 - Change in marital status
 - Birth
 - Adoption
 - Foster care placement
 - Consumer and/or dependent gains citizen, national, or lawful presence status

NOTE: Individuals already enrolled in a QHP should report all special enrollment circumstances to the Marketplace.



Special Enrollment Circumstances (cont.)

- **Reasons for a special enrollment period include:**
 - ❑ Accidentally enroll or fail to enroll in a Qualified Health Plan (QHP) due to the action/inaction of an affiliate of the US Department of Health and Human Services (HHS)
 - ❑ Consumer becomes newly eligible or loses eligibility for the Premium Tax Credit (PTC) or Cost-Sharing Reductions (CSRs)
 - ❑ Permanent move to/from another state or service area
 - ❑ Consumers with American Indian/Alaskan Native status can enroll in or change QHPs one time per month
 - ❑ Consumer can demonstrate any other exceptional circumstances
- **Reasons for a limited enrollment period include:**
 - ❑ QHP significantly violates its contract in relation to the consumer

NOTE: Individuals already enrolled in a QHP should report all special enrollment circumstances to the Marketplace.

SHOP Enrollment Periods



Small Business Health Options Program (SHOP) Enrollment

- Rolling enrollment
 - Does not conform to individual open enrollment periods; may apply at any time
 - Requires employer to meet participation rate requirement
- Open enrollment: November 15-December 15
 - During open enrollment, small employers do not need to meet participation rate requirement



Indiana Navigators and the Marketplace

- **Completing an application**
 - Indiana Navigators may help individuals complete the application for the federal Marketplace
- **Selecting a plan**
 - Indiana Navigators may assist individuals with plan selection on the Marketplace by providing **general information** on the available plans
 - Indiana Navigators may **NOT** offer advice on what plan to select
- **Directing consumer inquires**
 - Indiana Navigators may direct questions about federal programs to the federal Marketplace
 - Federal website: <http://www.healthcare.gov>
 - Federal call center: 1-800-318-2596



When Health Coverage Begins

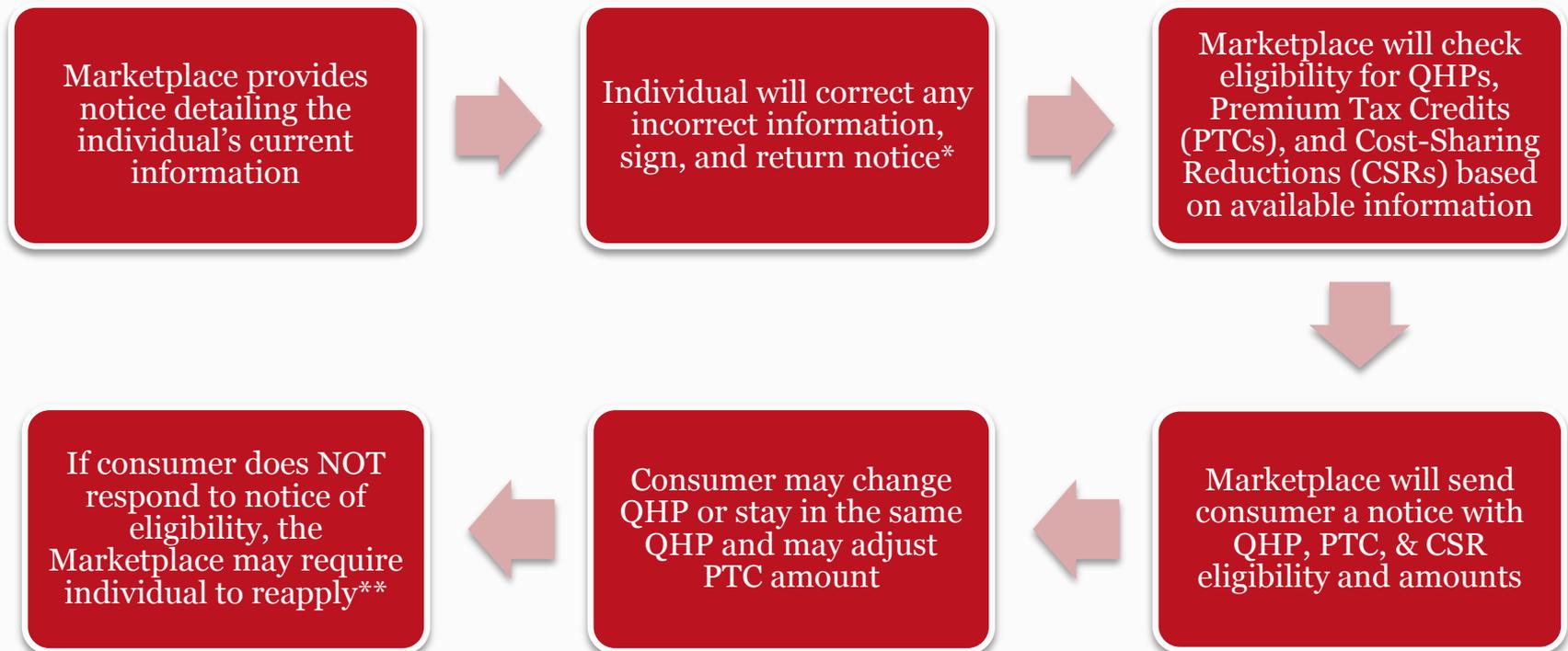
- **The start date for federal Marketplace coverage:**
 - Based on the date a consumer completes enrollment in a Qualified Health Plan (QHP)
 - A consumer is not considered enrolled in QHP until they pay their portion of the first months premium
 - In general:
 - Coverage purchased before the 15th of the month is effective the 1st of the next month and
 - Coverage purchased after the 15th is effective the 1st of the following month

2014/2015 Enrollment Date	November 15, 2014 to December 15, 2014	December 16, 2014 to January 15, 2015	January 16, 2015 to February 15, 2015
Effective Coverage Date	January 1, 2015	February 1, 2015	March 1, 2015



Marketplace Reenrollment

- **Qualified Health Plan (QHP) enrollment lasts for one calendar year**
- **During federal Marketplace Open Enrollment: Individuals may not have to reapply to reenroll in a QHP**



*If individual does not sign and return notice, process continues. Marketplace will use available information to check eligibility.

** If individual does not respond and QHP is unavailable, individual will NOT have coverage for the next year.



Reviewing and Renewing Eligibility

- **For each annual open enrollment period the federal Marketplace will:**

- Check if individuals are still eligible for Qualified Health Plans (QHP), Premium Tax Credits (PTC), and Cost-Sharing Reductions (CSR); and
- Recalculate the next year's amount of PTC and level of CSR

QHP Eligibility Check

Is QHP enrolled individual still:
 A U.S. Citizen/ National/ legal resident?
 An Indiana resident? And
 Not incarcerated?

PTC & CSR Eligibility Check

Did the individual file taxes?
 Is individual Marketplace coverage an individual's *only* coverage option? or
 Is other coverage unaffordable (costs > 9.5% of income) or
 Does the coverage not provide minimum value (actuarial value > 60%)?
 PTC: Is individual between 100% and 400% of federal poverty level (FPL)?
 CSR: Is the individual under 250% of FPL?

PTC & CSR Amount

For PTC-eligible, calculate the maximum amount of available PTC for the next enrollment year.
 For individuals also eligible for CSR, calculate the level of CSR.



Affordable Care Act: Medicaid Changes



What is Medicaid?

- Funded by state and federal government
- Provides free or low-cost health insurance to low-income:
 - Children
 - Parents and caretakers
 - Pregnant women
 - Aged
 - Blind
 - Disabled
- Offer many different programs
 - Eligibility criteria varies by group



Changes to Medicaid

- Affordable Care Act (ACA) requirements mean changes for Medicaid, as well, including:
 - New way of counting income
 - **Modified Adjusted Gross Income (MAGI)**
 - New eligibility groups
 - New Medicaid categories
 - New Presumptive Eligibility (PE) procedures

Modified Adjusted Gross Income (MAGI)



- **What is MAGI?**
 - Standardized income counting across all states
 - Used in both Medicaid and federal Marketplace program to determine eligibility for tax credits
 - Medicaid will change the way it counts:
 - Number of people in the household
 - Income
 - Assets

Immediate MAGI impact	Delayed MAGI impact	No MAGI impact
<ul style="list-style-type: none"> • New applicants <ul style="list-style-type: none"> • Adults • Parents and caretaker relatives • Children • Pregnant women 	<ul style="list-style-type: none"> • Those approved for Medicaid before December 31, 2013 <ul style="list-style-type: none"> • Will be subject to new income counting when: <ul style="list-style-type: none"> • Redetermine Medicaid eligibility OR • Change reported 	<ul style="list-style-type: none"> • Those exempt from MAGI calculation <ul style="list-style-type: none"> • Examples: Aged, Blind, Disabled, etc.



New ACA-Created Eligibility Groups

- The Affordable Care Act (ACA) created new Medicaid groups the states must cover, including:
 - Former foster children
 - Under age 26
 - Receiving Indiana Medicaid when aged out of the system
 - Not subject to income limits until age 26
 - Children age 6-18
 - Up to 133% Federal Poverty Level (FPL)
 - Indiana already covers this group

New ACA-Created Medicaid Categories



- With the implementation of the Modified Adjusted Gross Income (MAGI):
 - Some eligibility categories (“aid categories”) will change
 - Some categories will be combined and given new names
 - Category name changes will not impact benefits



Changes to Presumptive Eligibility (PE)

- **Presumptive Eligibility is:**
 - Short-term coverage while a Medicaid application is pending
 - For limited, low-income populations
- **NOW:**
 - State operates PE for Pregnant Women
- **STARTING 1/1/2014:**
 - Hospitals may be authorized by the State to operate PE
 - “Qualified Providers” (QPs)
 - QP Hospitals will determine PE for:
 - Children under 19
 - Low-income parents/caretakers
 - Family Planning Eligibility Program
 - Former foster care children up to age 26



Affordable Care Act: Consumer Assistants



Types of Consumer Assistants Who May Help Hoosiers

- **Indiana Navigators**
- **Application Organizations (AOs)**
- **Authorized Representatives (ARs)**
- **Health insurance agents and brokers**
- Other consumer assistant titles consumers may see:
 - Federal Navigators
 - Certified Application Counselors (CACs)



Who needs to be certified as an Indiana Navigator?

- **Individuals working directly with consumers to complete health coverage applications for:**
 - Federal Marketplace
 - Indiana Health Coverage Programs (IHCPs)
- **May include:**
 - Federally-funded, federally-selected Navigators
 - Federally-designated Certified Application Counselors (CACs)
 - Medicaid Enrollment Center staff or volunteers
 - Staff or volunteers of other organizations



Who Needs to Register as an Application Organization (AO)?

- **Organizations with employees and/or volunteers assisting consumers with:**
 - Applications on the federal Marketplace
 - Qualified Health Plans (QHPs) (insurance coverage)
 - Cost-lowering programs
 - Examples: Premium Tax Credits (PTCs), Cost-Sharing Reductions (CSRs)
 - Indiana Health Coverage Programs
 - Examples: Medicaid, Healthy Indiana Plan (HIP), and Children's Health Insurance Program (CHIP)



Module #3 Review

- **Having completed this module, you should feel prepared to:**
 - Explain basic health insurance concepts
 - Help a consumer identify and understand the key costs and benefits on a health insurance plan description
 - Understand the key concepts of the Affordable Care Act (ACA) and how those concepts will impact consumers
 - Understand what the federal Marketplace is, who can use it, and its key features
 - Help a consumer identify whether or not the consumer may be eligible for coverage and cost assistance programs through State programs or on the federal Marketplace