Health Insurance Basics and the Federally-Facilitated Marketplace

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 impact consumers
  ▫ Understand what the Federally-facilitated Marketplace (FFM) 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 FFM
## Module #3 Terminology (1 of 2)

<table>
<thead>
<tr>
<th>Term</th>
<th>What It Means</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Federal Poverty Level (FPL)</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Federally-facilitated Marketplace (FFM)</strong></td>
<td>A federal program and website (<a href="http://www.healthcare.gov">www.healthcare.gov</a>) where consumers can shop for and purchase health coverage and apply for cost assistance. May also be called an Exchange.</td>
</tr>
<tr>
<td><strong>Large Group, Small Group, Individual Market or Plan</strong></td>
<td>In Indiana, the large group market is for employers with &gt;50 employees, the small group market is for employers with 1 - 50 employees, and the individual market for individuals and their dependents.</td>
</tr>
<tr>
<td><strong>Health Insurer, Health Insurance Issuer, Health Insurance Carrier</strong></td>
<td>All of these terms refer to the insurance company that issues health insurance plans or policies.</td>
</tr>
<tr>
<td><strong>Grandfathered; Non-grandfathered health plan</strong></td>
<td>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. (except those that are grandmothered/transitional plans).</td>
</tr>
<tr>
<td><strong>Grandmothered Plan</strong></td>
<td>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 October 1, 2016. Indiana’s guidance on these policies can be found at <a href="http://www.in.gov/idoi/files/Bulletin_205.pdf">www.in.gov/idoi/files/Bulletin_205.pdf</a>.</td>
</tr>
</tbody>
</table>
## Module #3 Terminology (2 of 2)

<table>
<thead>
<tr>
<th>Term</th>
<th>What It Means</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual &amp; Employer Mandates</strong></td>
<td>Individual Mandate is a tax penalty for an individual that does not have Minimum Essential Coverage (MEC); and Employer Mandate is a tax penalty for large employers that do not offer MEC. Also referred to as the Individual and Employer Shared-Responsibility requirements.</td>
</tr>
<tr>
<td><strong>Qualified Health Plan (QHP)</strong></td>
<td>A health insurance plan that has passed a federal certification process to be offered on the Federally-facilitated Marketplace.</td>
</tr>
<tr>
<td><strong>Essential Health Benefit (EHB)</strong></td>
<td>A benefit that insurance carriers in the individual and small group markets must cover. Within each of the 10 EHB categories established by the ACA, exact benefits may vary by state as provided in the state’s “benchmark plan.”</td>
</tr>
<tr>
<td><strong>Minimum Essential Coverage (MEC)</strong></td>
<td>The type of coverage an individual must have to meet the Individual Mandate requirement under the Affordable Care Act (ACA).</td>
</tr>
<tr>
<td><strong>Premium Tax Credit (PTC); Cost-Sharing Reduction (CSR)</strong></td>
<td>ACA provisions that lower the amount some eligible consumers pay for premiums, copayments, coinsurance, and/or deductibles. May also be called Insurance Affordability Programs.</td>
</tr>
<tr>
<td><strong>Open Enrollment Period; Special Enrollment Period</strong></td>
<td>Open Enrollment Period is the annual period when people can enroll in a QHP through the FFM. Outside of FFM open enrollment, a person may qualify for a Special Enrollment Period if the person has a certain life event, such as change in household, income, location, or loss of health coverage.</td>
</tr>
</tbody>
</table>
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 healthcare 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 **2017** out-of-pocket maximum amount limits for plans on the Federally-facilitated Marketplace are:
  - $7,150 for individual plans
  - $14,300 for family plans

*Out-of-network providers are not subject to cost-sharing limits.
Health Insurance Basics

• Not all health insurance is set up the same
  ▫ 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: To Increase the 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

- **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 provided new requirements and options that impact:
  - The state Medicaid agency
  - Commercial health insurance

- It gives states three options for setting up a new health insurance marketplace:

<table>
<thead>
<tr>
<th>Option</th>
<th>Federal Responsibility</th>
<th>State Responsibility</th>
<th>Indiana and Surrounding State Decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>State-based Marketplace</td>
<td>Sets guidelines</td>
<td>Uses federal guidelines to set up marketplace; runs marketplace</td>
<td>Kentucky</td>
</tr>
<tr>
<td>Partnership Marketplace</td>
<td>Sets guidelines; sets up marketplace</td>
<td>Uses federal guidelines to either:</td>
<td>Illinois Michigan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Oversee plans;</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>2. Manage consumer assistance; or</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Both 1 and 2</td>
<td></td>
</tr>
<tr>
<td>Federally-facilitated Marketplace (FFM)</td>
<td>Sets guidelines; sets up marketplace</td>
<td>Observes federal guidelines; maintains oversight of state-regulated insurance products</td>
<td>Indiana Ohio</td>
</tr>
</tbody>
</table>
Affordable Care Act: Requirements for Individuals and Employers

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

- **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
  - 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 the 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**

<table>
<thead>
<tr>
<th>Year</th>
<th>Subject to the maximum, penalty is the greater of:</th>
<th>Maximum Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Dollar Penalty</strong></td>
<td><strong>Percent Penalty</strong></td>
</tr>
<tr>
<td><strong>2016</strong></td>
<td>Adult: $695</td>
<td>2.5% of annual household income</td>
</tr>
<tr>
<td></td>
<td>Under 18: $347.50</td>
<td></td>
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<tr>
<td></td>
<td>Maximum: $2,085</td>
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</tr>
</tbody>
</table>

*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
  - Qualified Health Plans (QHPs)
  - Medicare Part A or Part C
  - Most Medicaid Programs
  - Children’s Health Insurance Program (CHIP)
  - Refugee Medical Assistance
  - Veterans Administration programs: including TriCare and CHAMP VA
  - Department of Defense nonappropriated Fund Health Benefit Program
  - Coverage for Peace Corps volunteers
- Any job-based coverage
- Qualifying individual market health coverage
- Grandfathered health plan
- Coverage under a parent’s plan
- Most student health plans
- State high-risk pools

...or they will need to receive an exemption or pay the tax penalty.
NOT Minimum Essential Coverage

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

- **Certain Medicaid Programs**
  - Examples:
    - Optional family planning services
    - Emergency Medicaid
    - Tuberculosis services
    - Outpatient hospital services

- **Certain limited-scope 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 cost of coverage is more than 8.13% of household income
  ▫ Premium Tax Credit (PTC)*
    • IF household income at 100-400% of the Federal Poverty Level (FPL)

• Eligibility for the Affordability Exemption & PTC varies for those with access to employer-sponsored insurance (ESI)

<table>
<thead>
<tr>
<th></th>
<th>Employee Only</th>
<th>Employee and Dependents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Affordability Exemption</strong></td>
<td>If contribution for ESI is more than 8.13% of income</td>
<td>If contribution for ESI for employee &amp; dependents is greater than 8.13% of income, <strong>dependents</strong> may receive exemption (but not employee)</td>
</tr>
<tr>
<td><strong>Premium Tax Credit</strong></td>
<td>If contribution for ESI is more than 9.66% of income</td>
<td>If contribution for ESI that covers only the employee is greater than 9.66% of income</td>
</tr>
</tbody>
</table>

*Typically someone that already has MEC cannot get a PTC*
Other Possible Exemptions

• **Individuals may send an exemption application to:**
  ▫ The Federal-facilitated Marketplace (FFM) **OR**
  ▫ The Internal Revenue Service (IRS)

• **In addition to unaffordable coverage, exemptions may be allowed for:**

<table>
<thead>
<tr>
<th>Religious Conscious</th>
<th>Hardship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household income below filing limit</td>
<td>Healthcare Sharing Ministry</td>
</tr>
<tr>
<td>Indian Tribe</td>
<td>Incarceration</td>
</tr>
<tr>
<td>Not lawfully present</td>
<td>Short coverage gaps</td>
</tr>
</tbody>
</table>

**For more information about exemptions:**
• Call the FFM call center: 1-800-318-2596
• Online: [www.healthcare.gov/exemptions](http://www.healthcare.gov/exemptions)
Employer Mandate

• **Effective January 1, 2015:**
  - Employers with more than 50 full-time employees *plus* full-time equivalent employees (FTEs) are subject to the Employer Shared-Responsibility Payment if at least one FTE receives a Premium Tax Credit (PTC).

• **PTC Eligibility:**
  - Employees can only receive a PTC if:
    - Income between 100%-400% Federal Poverty Level (FPL)
    - Employer coverage is not available
    - Employer coverage does not provide Minimum Value (coverage paying at least 60% of health care costs)
    - Single coverage costs more than 9.5% household income
### Employer Shared-Responsibility Payment

- **Employer penalties will vary**
  - Based on whether coverage is offered to 95% of employees

<table>
<thead>
<tr>
<th>Employers offering coverage to at least 95% of full-time employees</th>
<th>Employers not offering coverage to at least 95% of full-time employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pay a penalty of the lesser of:</td>
<td>• Pay $2,000 for every full-time and full-time equivalent employee, excluding the first 30 employees</td>
</tr>
<tr>
<td>• $3,000 per employee receiving a PTC, <strong>OR</strong></td>
<td></td>
</tr>
<tr>
<td>• The penalty for employers not offering coverage</td>
<td></td>
</tr>
</tbody>
</table>
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 (1 of 3)

• **Ensure Premiums Pay Healthcare Costs**
  • Insurers with low Medical Loss Ratio (MLR) are 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 (2 of 3)

• **Adult Dependent Coverage until 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 markets 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 (3 of 3)

• **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

• **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:

<table>
<thead>
<tr>
<th></th>
<th>Large Group</th>
<th>Small Group</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MLR Requirement</strong></td>
<td>85%</td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

• **If insurance company does not meet MLR requirement:**
  ▫ Individuals and small businesses will receive a refund
Rating Rules for *Non-Grandfathered Health 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

*Plans certified for 2014 and beyond*
Modified Adjusted Gross Income

- Eligibility based on Modified Adjusted Gross Income (MAGI) for:
  - Some Indiana Health Coverage Program (IHCP) populations
  - All Federally-facilitated Marketplace (FFM) 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

• **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, including oral and vision care

  ▫ Exact benefits offered within each EHB category may vary by state
  ▫ Each state selects its own “benchmark plan”
    
    • Plan sets a baseline of benefits that must be covered by other plans
    • EHB benefits are set for 2016 and 2017 – will change in 2018
Actuarial Value

- **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 grandmothered/transitional)
  - In the individual and small group markets
  - On and off the Federally-facilitated Marketplace (FFM)
  - Required to offer Essential Health Benefits (EHBs)

<table>
<thead>
<tr>
<th>Plan Level</th>
<th>Estimated/target total costs covered by health plan*</th>
<th>Estimated/target total costs covered by enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>Silver</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td>Gold</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Platinum</td>
<td>90%</td>
<td>10%</td>
</tr>
</tbody>
</table>

**Premium Tax Credit is 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 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)
- **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 Federally-facilitated Marketplace (FFM)
  - 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)
Federally-facilitated Marketplace Qualified Health Plans

- **All health insurance plans sold on the Federally-facilitated Marketplace (FFM) are certified by federal and state agencies to:**
  - 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 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 FFM are exempt from AV requirements*
Premium Tax Credits

• **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 on Federally-facilitated Marketplace (FFM) for PTC
  ▫ FFM determines individual PTC eligibility and maximum PTC amount

• **Limitation:**
  ▫ Available *only* when coverage is purchased through FFM

• **Amount of PTC depends on:**
  ▫ Cost of the FFM’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?*

- 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/OR**

- No other Minimum Essential Coverage (MEC) is available
  - Such as Medicare, Medicaid, or Employer Sponsored Insurance (ESI)

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

*Individuals must file taxes to be eligible for insurance affordability programs*
Three Options for Using the Premium Tax Credit

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

*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

Consumer completes application through Federally-facilitated Marketplace (FFM)

FFM estimates PTC amount and informs consumer*

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

Consumer selects a health coverage plan through the FFM

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

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
Option 3: Claim Premium Tax Credit with Tax Filing

1. Consumer completes application through Federally-facilitated Marketplace (FFM)
2. FFM estimates PTC amount and informs consumer
3. Consumer selects health coverage plan through FFM and declines advanced payments of PTC
4. Consumer pays the full cost of the premium to the insurance company
5. Consumer files taxes annually
6. Consumer’s tax liability is reduced by the amount of the PTC or consumer tax refund is increased by amount of the PTC
Premium Tax Credit Calculation

Annual premium of the 2nd-lowest cost Silver plan covering Essential Health Benefits (EHBs) 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 is based on the cost of coverage for EHBs only, and will not increase to cover additional benefits
Premium Tax Credit
Application to Premium Costs

• PTC amount is based on the second lowest-cost Silver plan on the Federally-facilitated Marketplace (FFM)

• Can be used to purchase any plan on the FFM
  ▫ 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
Cost-Sharing Reduction

• **Purpose:**
  ▫ Increase the Actuarial Value (AV) of health coverage plans for low-income consumers
  ▫ Reduce out-of-pocket costs for consumers

• **Receiving CSR:**
  ▫ CSRs are offered **in addition to** Premium Tax Credits (PTCs) on the Federally-facilitated Marketplace (FFM)
  ▫ Qualifying individuals do **NOT** have to apply for CSR separately
Who is Eligible for Cost-Sharing Reductions?*

- Meet all requirements for Premium Tax Credits (PTCs) AND
- Enroll in a Silver Plan (70% Actuarial Value (AV)) on the Federally-facilitated Marketplace (FFM) AND
- Household income between 100% and 250% of the 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
Cost-Sharing Reductions 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.

<table>
<thead>
<tr>
<th>FPL</th>
<th>AV of Silver plan after CSR (Originally 70%)</th>
<th>Individual Annual Out-of-Pocket Maximum (2017)*</th>
<th>Family Annual Out-of-Pocket Maximum (2017)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-150%</td>
<td>94%</td>
<td>$2,350</td>
<td>$4,700</td>
</tr>
<tr>
<td>150-200%</td>
<td>87%</td>
<td>$2,350</td>
<td>$4,700</td>
</tr>
<tr>
<td>200-250%</td>
<td>73%</td>
<td>$5,700</td>
<td>$11,400</td>
</tr>
</tbody>
</table>

*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.
Affordable Care Act: Health Insurance Marketplaces

- Federally-facilitated Marketplace (FFM) in Indiana
- Who can use (individuals, small employers)
- Enrollment Periods
- Indiana Navigators and the FFM
- When Coverage Begins
- Redetermining Eligibility and Re-enrollment
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
    - Regulated by the Indiana Department of Insurance (IDOI)
    - Serves individuals, small groups, and large groups
  - The Federally-facilitated Marketplace (FFM)
    - Administered by the federal Department of Health and Human Services (HHS)
    - Serves individuals and small groups
      - Individuals: FFM ([healthcare.gov](http://healthcare.gov))
      - Small groups: Small Business Health Options Program (SHOP) ([healthcare.gov/small-businesses](http://healthcare.gov/small-businesses))
The Federally-Facilitated Marketplace

- The FFM is a federal program/website for individuals and small businesses to compare and purchase health insurance
  - **Assesses** eligibility for:
    - Medicaid
      - If consumer may be eligible for Medicaid, FFM will send application to state Medicaid agency
    - Premium Tax Credits (PTCs)
    - Cost-Sharing Reductions (CSRs)
    - Individual Mandate Exemptions
  - **Manages** eligibility appeals
  - **Facilitates** enrollment in Qualified Health Plans (QHPs)
  - **Ensures** appropriate PTC and CSR payments to insurance plans
  - **Collects and publishes** quality data on health plans
  - **Operates** consumer assistance call center
  - **Collects** premiums for small businesses
Who Can Use the FFM 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 apply for coverage through the individual FFM in Indiana

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

• Individuals and families can still purchase coverage outside of the Federally-facilitated Marketplace (FFM)
  ▫ About the plans:
    • Regulated by the Indiana Department of Insurance (IDOI)
    • Benefit packages:
      • Some may be identical to those available on the FFM
      • Some not offered on the FFM
    • Cannot use Premium Tax Credits (PTCs) and/or Cost-Sharing Reductions (CSRs)
  ▫ How to purchase:
    • Contact a licensed health insurance agent or broker for assistance
    • Shop for coverage directly through insurance companies
Small Business Health Options Program (SHOP)

• **Eligible Employers**
  ▫ Employers with less than 50 full-time 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 are 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

- **Annual period individuals may apply for coverage through the Federally-facilitated Marketplace (FFM)**
  - Determined each year by Centers for Medicare and Medicaid Services (CMS)

- **Next FFM Open Enrollment Period (for 2017 coverage)**
  - November 1, 2016 - January 31, 2017

- **Other Coverage**
  - Small Business Health Options Program (SHOP): may apply at any time, unless employer does not meet minimum participation requirement, in which case there will be a once annual open enrollment period for those employees
  - Other job-based plans: may have different open enrollment periods (check with employer)
  - Indiana Health Coverage Programs (*i.e.*, Medicaid, HIP 2.0. CHIP): may apply any time of year
Special Enrollment Period (1 of 2)

- Individuals may enroll* in coverage outside of the FFM Open Enrollment Period if they have a certain life event, such as:
  - Loss of Minimum Essential Coverage (MEC)
  - Gain or lose dependent, or become dependent due to:
    - Marriage, Divorce, or Legal Separation
    - Birth or Death
    - Adoption or Foster Care Placement
  - Consumer and/or dependent gains citizen, national, or lawful presence status
  - Permanent move to another state or service area

*As part of the enrollment process, individuals are required to provide documentation proving their eligibility for a special enrollment period.
Special Enrollment Period (2 of 2)

- Other life events that may qualify someone for a Special Enrollment Period on the FFM:
  - Becomes eligible or loses eligibility for Premium Tax Credits (PTCs) or Cost-Sharing Reductions (CSRs)
  - Is a member of a federally-recognized tribe or is an Alaskan Native Claims Settlement Act (ANCSA) Corp. shareholder
  - Accidentally enrolls or fails to enroll in QHP due to action/inaction of an affiliate of the Department of Health and Human Services (HHS) or another enrollment/plan error
  - Can demonstrate another exceptional circumstance

**NOTE:** Individuals already enrolled in a QHP should report all life changes to the FFM
Indiana Navigators and the Marketplace

• **Completing an application**
  ▫ Indiana Navigators may help individuals complete the application for the Federally-facilitated Marketplace (FFM)

• **Selecting a plan**
  ▫ Indiana Navigators may assist individuals with plan selection on the FFM by providing **general information** on all plans available to the consumer
    • Indiana Navigators may **NOT** offer advice or recommendations on what plan to select

• **Directing consumer inquiries**
  ▫ Indiana Navigators may direct questions about federal programs to the FFM
    • FFM website: [www.healthcare.gov](http://www.healthcare.gov)
    • FFM call center: 1-800-318-2596
When Health Coverage Begins

• The start date for Federally-facilitated Marketplace (FFM) coverage:
  ▫ Based on the date a consumer completes enrollment in a Qualified Health Plan (QHP) through the FFM
  ▫ A consumer is not considered enrolled in a QHP until they pay their portion of the first month’s 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 month after next

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Effective Coverage Date</td>
<td>January 1, 2017</td>
<td>February 1, 2017</td>
<td>March 1, 2017</td>
</tr>
</tbody>
</table>
Marketplace Re-enrollment

- Qualified Health Plan (QHP) enrollment lasts for one calendar year.
- Before next open enrollment begins, issuer will send consumer renewal notice stating consumer’s option to be automatically re-enrolled in current plan and what coverage will look like if consumer chooses to stay on current plan. **IMPORTANT NOTE: consumer may be eligible for larger tax credit and/or lower premium in different plan than if consumer auto-enrolls in current plan. Consumer should be sure to check his/her different options on the Marketplace.**

Marketplace provides notice detailing the individual’s current information

Individual will correct any incorrect information, sign, and return notice*

Marketplace will check eligibility for QHPs, Premium Tax Credits (PTCs), and Cost-Sharing Reductions (CSRs), based on available information

If consumer does NOT respond to notice of eligibility, the Marketplace may require individual to reapply**

Consumer may change QHP or stay in the same QHP and may adjust PTC amount

Marketplace will send consumer a notice with QHP, PTC, and CSR eligibility and amounts

*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.
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

• Offers several different programs
  ▫ Eligibility criteria varies by group
Changes to Medicaid by ACA

- Changes to Medicaid by the Affordable Care Act (ACA) of 2013 include:
  - A 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

• What is Modified Adjusted Gross Income (MAGI)?
  ▫ Standardized income counting across all states
  ▫ Used in both Federally-facilitated Marketplace (FFM) and Medicaid to determine eligibility
  ▫ Medicaid changed the way it counts:
    • Number of people in the household
    • Income
    • Assets

<table>
<thead>
<tr>
<th>Immediate MAGI Impact</th>
<th>Delayed MAGI Impact</th>
<th>No MAGI Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>• New applicants</td>
<td>• Those approved for Medicaid before December 31, 2013</td>
<td></td>
</tr>
<tr>
<td>• Adults</td>
<td>• Were subject to new income counting when:</td>
<td></td>
</tr>
<tr>
<td>• Parents and caretaker relatives</td>
<td>• Redetermined for Medicaid eligibility OR</td>
<td></td>
</tr>
<tr>
<td>• Children</td>
<td>• A change was reported</td>
<td></td>
</tr>
<tr>
<td>• Pregnant women</td>
<td></td>
<td>• Those exempt from MAGI calculation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Examples: Aged, Blind, Disabled</td>
</tr>
</tbody>
</table>
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 under age of 19
    - Up to 255% Federal Poverty Level (FPL)
    - Indiana already covers this group
New ACA-Created Medicaid Categories

• With the implementation of the Modified Adjusted Gross Income (MAGI) methodology:
  ▫ Some Medicaid eligibility categories ("aid categories") have changed
    • Certain categories were combined and given new names
    • Category name changes have not impacted benefits
Changes to Presumptive Eligibility

**Presumptive Eligibility (PE) is:**
- Short-term coverage while a Medicaid application is pending
- For certain, low-income populations

**Prior to 2014:**
- State only operated PE for Pregnant Women

**Beginning January 1, 2014:**
- Hospitals may be authorized by the state to operate PE as
  - Qualified Providers (QPs)
- QP Hospitals may determine PE for:
  - Children under 19
  - Low-income parents/caretakers
  - Family Planning Eligibility Program
  - Former foster care children up to age 26

**Beginning July 1, 2015:**
- Pursuant to Indiana House Enrolled Act 1269 (2015), Hospital QPs may operate PE for
  - Inmates
    - From a correctional facility operating under the memorandum of understanding or contract with FSSA, and admitted to inpatient hospitalization (not for labor/delivery)
Affordable Care Act: Consumer Assistants
Types of Consumer Assistants Established under ACA

- Consumer assistants established under the ACA and trained and certified by the federal government
  - Federal Navigators
  - Certified Application Counselors (CACs)
  - Non-Navigator Assistance Personnel
  - Health insurance agents and brokers

- Trained and certified to assist with the Federally-facilitated Marketplace (FFM) only

- Training and certification is done by the Centers for Medicare and Medicaid Services

- Must also be certified or licensed with the state of Indiana
Types of Consumer Assistants Established under Indiana Law

- Consumer assistants established under Indiana law and certified or licensed by state of Indiana
  - Indiana Navigators
    - Certified by the Indiana Department of Insurance (IDOI) to assist with *Federally-facilitated Marketplace (FFM) and/or Indiana Application for Health Coverage (IAHC)*
  - Application Organizations (AOs)
    - Registered with Indiana Department of Insurance (IDOI) if it has employees and/or volunteers assisting with *FFM and/or IAHC*
  - Authorized Representatives (ARs)
    - Enter into AR agreement with Family & Social Services Administration (FSSA) to assist with *IAHC only*
  - Health insurance agents and brokers
    - Licensed with IDOI. May sell insurance products *on or off FFM*. Must also be registered with FFM to assist on FFM.
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 impact consumers
  - Understand what the Federally-facilitated Marketplace (FFM) is, who can use it, and its key features
  - Help a consumer identify whether the consumer may be eligible for coverage and cost assistance programs through the FFM or state public health insurance programs