Health Insurance Basics and the Federally-Facilitated Marketplace

Health Insurance Basics

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

Premiums

Definition: A fee 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 for the individual is a **PREMIUM**
  - Individuals pay the Premium regardless of whether they ever use the health plan
  - Premiums on Qualified Health Plan offered on the Federally-Facilitated Marketplace are paid on a monthly basis

Cost Sharing

In addition to monthly premiums, individuals may have to pay part of the cost of care when they visit a healthcare provider. These are known as Cost Sharing.

- 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 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.

Out-Of-Pocket Max

"In-network" healthcare providers (those covered by the 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.

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

Out-Of-Pocket Max

The out-of-pocket limit doesn't include:

- Your monthly premiums
- Anything you spend for services your plan doesn't cover
- Out-of-network care and services
- Costs above the allowed amount for a service that a provider may charge

The out-of-pocket limit for health plans vary but can’t go over a set amount each year.

For the 2020 plan year: The out-of-pocket limit can’t be more than $8,150 for an individual and $16,300 for a family.

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

The Patient Protection and Affordable Care Act (ACA)

Goal: To Increase the Number of Individuals with Health Insurance Coverage

Key Features of the ACA

- Financial assistance to purchase coverage and expanded coverage under Medicaid
- Cannot be denied coverage for preexisting conditions
- Mandates individuals to have or for employers to provide coverage
- Healthcare Coverage Marketplaces created

Administering the ACA Marketplace

There are three options for how states run their Marketplace

- State-Based
- Partnership
- Federally-Facilitated Marketplace

Which type of Marketplace does Indiana have?

Type of Marketplace	Federal Responsibility	State Responsibility	Indiana and Surrounding State Decisions
State-based Marketplace	Sets guidelines	Uses federal guidelines to set up marketplace; runs marketplace	Connecticut
Partnership Marketplace	Sets guidelines; sets up marketplace; runs marketplace	Uses federal guidelines to either: 1. Oversee plans; 2. Manage consumer assistance; or 3. Both 1 and 2	Illinois Michigan
Federally-facilitated Marketplace (FFM)	Sets guidelines; sets up marketplace; runs marketplace	Observes federal guidelines; maintains oversight of state-regulated insurance products	**Indiana** Ohio

ACA Mandates

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

The Individual Mandate & Minimum Essential Coverage (MEC)

- **Individual Mandate**
  - Affordable Care Act (ACA) requirement
  - All individuals must maintain health coverage for themselves and their dependent 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

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

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)

Exemptions to the Mandate

- **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:**

Religious Conscious	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 FFM call center: 1-800-318-2596
- Online: www.healthcare.gov/

Employer Mandate

Employers with **more than 50** full-time employees must provide MEC to their staff or they may receive a Tax Penalty.

ACA Insurance Market Features

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

covering kids & families of Indiana

Insurance Market Features (1 of 2)

- **Rating Rules (Premium Rates) for ACA Compliant Health Plans or MEC.**
  - Premium rates can only be based on:
    - Age
    - Location
    - Tobacco Use
    - Family Status
  - CANNOT base on:
    - Pre-existing Conditions
    - Gender
- **Guaranteed Availability and Renewability**
  - Health insurance companies required to issue and renew policies during Open Enrollment and Special Enrollment Periods
  - Consumers cannot be denied for Pre-Existing Conditions

Insurance Market Features (2 of 2)

- **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

- **10 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 10 EHBs

covering kids & families of Indiana

Rating Rules for 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

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

10 Essential Health Benefits

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”

covering kids & families of Indiana

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

- **AV applies to health plans that are:**
  - In the individual and small group markets
  - On and off the Federally-facilitated Marketplace (FFM)
  - 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%

There are no Platinum Plans Offered in Indiana

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 Coverage on the Marketplace

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

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

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 obtained 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 **OR**
- 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

For all three options, the PTC is only available for coverage purchased on the FFM	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 and 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.

Cost-Sharing Reductions

- **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

CSRs and Out-of-Pocket Maximums

Silver Plans will have an increased Actuarial Value (AV) which leads to reduced Out-of-Pocket costs for covered individuals. To receive CSRs and the reduced out-of-pocket maximum amount, consumers *must* select a Silver plan.

FPL%	AV of Silver plan after CSR (Originally 70%)
100-150%	94%
150-200%	87%
200-250%	73%

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:

- **There are 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)
      - Small groups: Small Business Health Options Program (SHOP) (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?

If

- ☑ **Individual is a citizen, national, or legal resident of the United States, <u>AND</u>**
- ☑ **Individual is a resident of Indiana, <u>AND</u>**
- ☑ **Individual is not incarcerated**

Then

Then the individual (and dependents)* are eligible to apply for coverage through the individual FFM in Indiana

*<u>**NOTE**</u>: 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.

Coverage Outside 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
  - **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)
- **Dates**
  - November 1 – December 15*
- **Other Coverage**
  - Other job-based plans: may have different open enrollment periods (check with employer)
  - Indiana Health Coverage Programs (*i.e.*, Medicaid, HIP, CHIP): may apply any time of year

*These are not official dates and are subject to change

Special Enrollment Periods (SEP) (1 of 2)

- **Individuals may enroll* in coverage outside of the FFM Open Enrollment Period if they have a Qualifying 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 FFM

- **Assist with applications**
  - Indiana Navigators may help individuals complete the application for the Federally-Facilitated Marketplace (FFM)
- **Educate**
  - 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 inquires**
  - Indiana Navigators may direct questions about federal programs to the FFM
    - FFM website: www.healthcare.gov
    - FFM call center: 1-800-318-2596

Coverage Start Dates

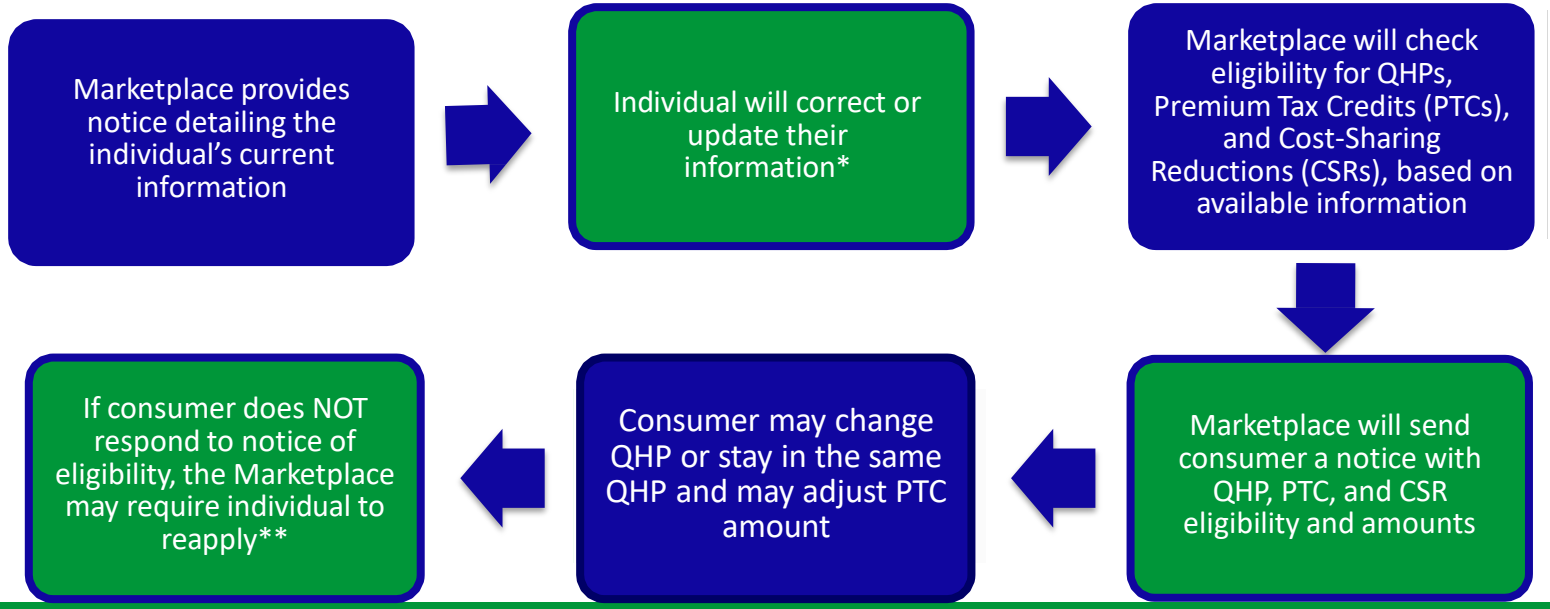
- **The start date for Federally-Facilitated Marketplace (FFM) coverage:**
  - Based on the date a consumer completes enrollment in a Qualified Health Plan (QHP) through the FFM
  - A consumer is not considered enrolled in a QHP until they pay their portion of the first month's premium

  In general:
  - Coverage purchased on or 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

Date Coverage Purchased	November 1 to December 15	December 16 to January 15	January 16 to January 31
Effective Coverage Date	January 1	February 1	March 1

Marketplace Re-enrollment

- Qualified Health Plan (QHP) enrollment lasts for one calendar year
- Before next open enrollment begins, the Marketplace will notify the consumer about actions they need to take to update their information and enroll in a plan for the next policy year.
- ***<u>IMPORTANT NOTE:</u> 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.***



*If individual updates information, the 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.

Terminology (1 of 2)

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.
Federally-facilitated Marketplace (FFM)	A federal program and website (www.healthcare.gov) 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 1 - 50 employees, and the individual market for individuals and their dependents.
Health Insurer, Health Insurance Issuer, Health Insurance Carrier	All of these terms refer to the insurance company that issues health insurance plans or policies.

Terminology (2 of 2)

Term	What It Means
Qualified Health Plan (QHP)	A health insurance plan that has passed a federal certification process to be offered on the Federally-facilitated Marketplace.
Essential Health Benefit (EHB)	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.
Minimum Essential Coverage (MEC)	The type of coverage an individual must have to meet the Individual Mandate requirement under the Affordable Care Act (ACA).
Premium Tax Credit (PTC); Cost-Sharing Reduction (CSR)	ACA provisions that lower the amount some eligible consumers pay for premiums, copayments, coinsurance, and/or deductibles. May also be called Insurance Affordability Programs.
Open Enrollment Period; Special Enrollment Period	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.