TO UNDERSTANDING THE AFFORDABLE CARE ACT

eHealth®

STEPS TO UNDERSTANDING
THE AFFORDABLE CARE ACT (ACA)

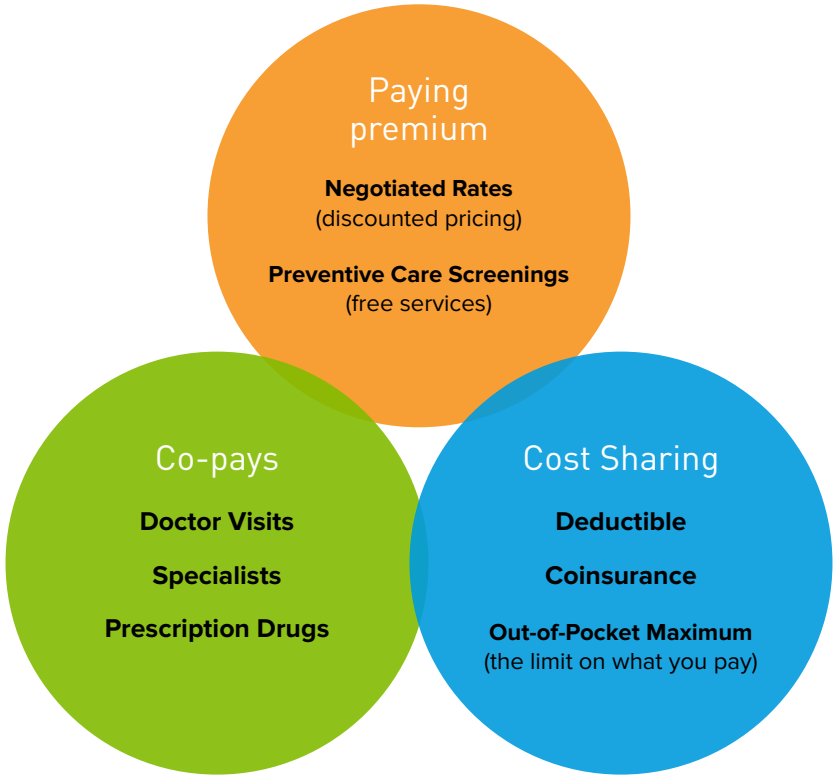
Want to know more about the health reform law and what it means for people without employer-based health insurance? The Affordable Care Act (ACA) is a complex piece of legislation but we've compiled this workbook to help you understand the basics. We'll walk you through it all in three steps.

What's Inside

STEP 1

Understand What You're Buying

The three pillars of a health insurance plan



What do you get for paying monthly premiums?

Negotiated Rates: It's not unheard of for hospitals to charge $1.50 for one Tylenol (an entire bottle costs $1.49 on Amazon.com); or $1,200 an hour for a nurse's services. When you have health insurance, your insurance company has negotiated prices between hospitals, doctors and insurance companies and can typically lower the initial bill anywhere from 20%-50%. (*Statistic courtesy of Bills.com)

Preventive Care Screenings: All new major medical heath plans provide certain specific screenings and benefits with no out of pocket costs; like dietary counseling and screenings for weight management; tobacco and alcohol screenings, counseling and help quitting, and recommended mental health and illness prevention tests and screenings -- to name a few.

Co-pays

Co-pays are not available on every plan, but in most areas you'll have plans that include them as an option.

What's a co-pay?: A co-pay is a flat rate you'll pay for a specific service. Once the co-pay is paid, an insurance company usually handles the remainder of the covered medical expenses.

How does a co-pay work?: In 2011, the average cost of doctor's office visit was $104, according to the American Medical Association. If your medical plan includes $25 doctor visit co-pays, you'll be responsible for the $25 co-pay and the insurance company would pay the rest.

What types of cost-sharing are typical on a health insurance plan?

Deductible: The first, and usually the most critical, item you want to look at when shopping for a health plan is the deductible. A deductible is the amount of money that you must pay before the insurance company will start to assist with your medical bill.

Coinsurance: Some plans have coinsurance, a cost-sharing requirement you're responsible for once your deductible has been met. It's usually defined as a percentage of the total cost of your medical expenses. The insurance company pays the remaining percentage of the covered medical expenses.

Out-of-Pocket Maximum: As a part of the Affordable Care Act, all major medical health insurance plans cannot have an out-of-pocket maximum larger than $6,750 in 2015 and $6,850 in 2016 on individual plans, $12,900 in 2015 and $13,200 in 2016 for a family plan. Therefore, once a deductible is met, an individual is only responsible for the coinsurance percentage until the out-of-pocket maximum is reached.

Here is an example of how insurance cost-sharing works:

Let's assume you have health plan with a $1,000 deductible, 20% coinsurance, and a $6,000 out-of-pocket maximum.

$1,000
Deductible

1 Deductible

If you incur a $50,000 medical bill, you will first need to pay your $1,000 deductible. That would leave you with $5,000 left before you reach your $6,000 out-of-pocket maximum.

20%
Coinsurance

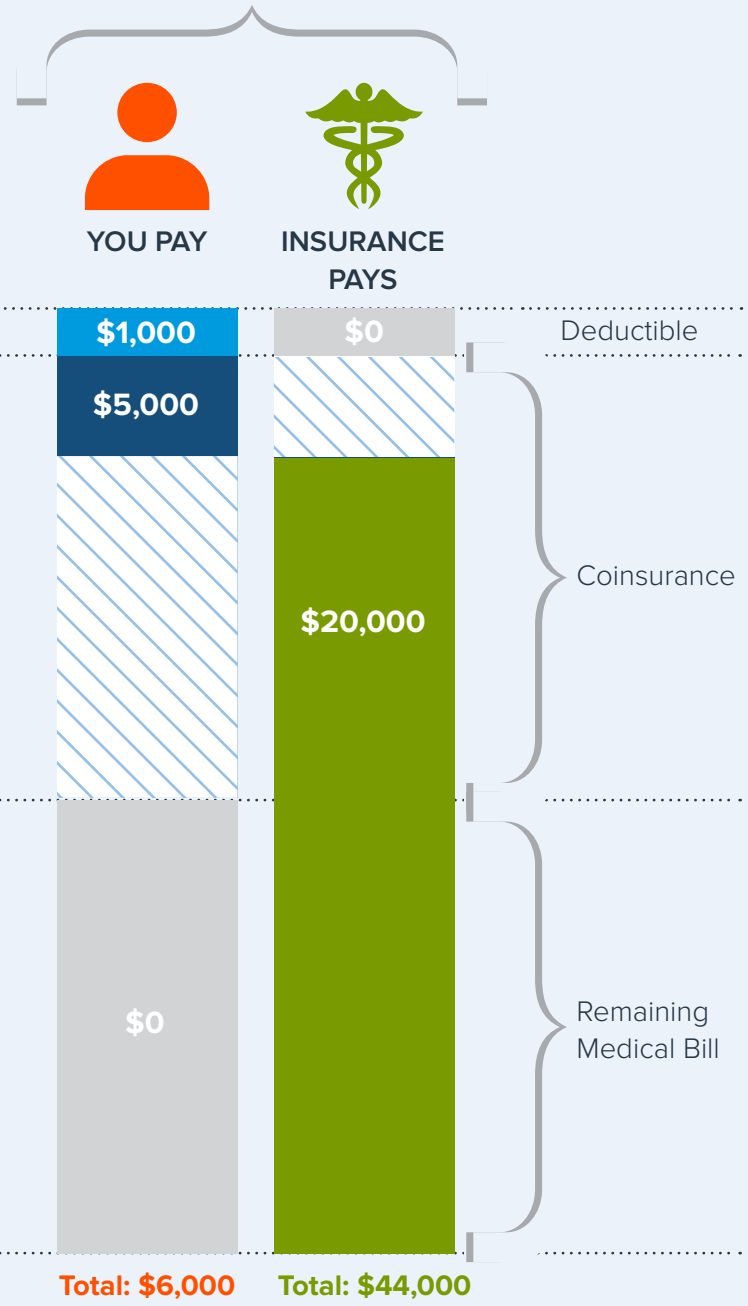
2 Coinsurance

With 20% coinsurance, you would pay $1,000 for every $4,000 paid by your insurance company. That means, for the next $25,000 in covered medical expenses you would pay $5,000 and your insurer would pay $20,000.

$6,000
Out-of-Pocket Maximum

3 Out-of-Pocket Maximum

Once you've paid your $1,000 deductible and $5,000 in coinsurance, you've reached your $6,000 out of pocket maximum. Altogether, with this $50,000 medical bill, you will have paid $6,000 and your insurer will have paid the remaining $44,000.



What's covered by Major Medical Health Insurance plans and "Qualified Health Plans" (QHPs):

What do you need to know?

The way health insurance benefits are structured changed in 2014.

The Affordable Care Act (ACA) requires each plan to cover **10 "essential health benefits" (EHBs)** and have a "metallic" benefit level starting at a minimum of 60% of their "actuarial value" or average annual costs, per person. Catastrophic plans for people under 30 with fewer benefits will also be available.

Laboratory Services

Emergency Services

Prescription Drugs

Mental Health & Substance Use Disorder Services

Maternity & Newborn Care

Pediatric Services, Including Oral & Vision Care

Rehabilitative & Habilitative Services & Devices

Ambulatory Patient Services

Preventive & Wellness Services & Chronic Disease Management

Hospitalization

* Copays and deductibles may apply to these services.

The law also limits out-of-pocket costs, deductibles and other forms of cost-sharing, in part, based on your household income.

What's covered?

Long before the ACA became law (back around 2005), eHealth built its own list of eight "essential" benefits and tracked the percentage of plans that covered them.

This table breaks down the new list, the old list, and how often the new benefits would be covered:

ACA 10 Essential Health Benefits	% of Qualified Plans Covering EHBs	eHealth's Comprehensive Benefits in 2012	% of Plans Sold by eHealth in 2012 Covering Comprehensive Benefits
Laboratory Services	100%	Laboratory and X-Ray	99.2%
Emergency Services	100%	Emergency Services	99.7%
Prescription Drugs	100%	Prescription Drugs	88.1%
Mental Health & Substance Use Disorder Services	100%	Chiropractic	70.9%
Maternity & Newborn Care	100%	Maternity	18.9%
Pediatric Services, Inlcluding Oral & Vision Care	100%	Well Baby Care	87.1%
Rehabilitative & Habilitative Services & Devices	100%	OB/GYN	90.5%
Ambulatory Patient Services	100%	Periodic Exams	88%
Preventive & Wellness Services & Chronic Disease Management	100%		
Hospitalization	100%		

How much coverage is provided?

All of the new reformed plans will have a "metallic" benefit level designed to allow consumers to make more informed decisions when comparing plans.

These metallic benefit levels start with a minimum benefit level of 60% and go up to 90% of the plan's "**actuarial value**."

> *"The actuarial value is equal to the percentage of total average costs for covered benefits that a plan will pay."*

If your plan has a 60% actuarial value your insurer would pay an average of 60% of all of the covered medical costs on that plan and you would be responsible for 40% of covered medical costs, until you reach your plan's cost-sharing or "out-of-pocket" limit.

These are the metallic designations:

Catastrophic	Bronze	Silver	Gold	Platinum
actuarial value	actuarial value	actuarial value	actuarial value	actuarial value
60%	**60%**	**70%**	**80%**	**90%**

How does cost-sharing work?

The law also limits out-of-pocket costs like coinsurance, co-pays and deductibles. If your income is below 400% of the Federal Poverty Level (FPL), the ACA places tighter restrictions on your cost-sharing and uses additional subsidies to cap your out-of-pocket costs.

The ACA restricts the out-of-pocket limit on all plan's to the amount allowed for health plans with Health Savings Accounts (HSAs): $6,850 for an individual and $13,200 for a family in 2015.

These numbers may seem high, but if your income is at or below 400% of FPL then your out-of-pocket liability is capped. Cost-sharing that exceeds the limits set for your household income are subsidized at the levels outlined in this chart:

2016 Federal Poverty Level Income*	Reduction in Out-of-Pocket Liability*
138 - 200% FPL	**Two-thirds of the HSA maximum**
Individual Income: $16,243 to $23,540	Max Out of Pocket: $2,250
Family of Four Income: $33,465 to $48,500	Max Out of Pocket: $4,500
200 - 250% FPL	**One-half of the HSA maximum**
Individual Income: $23,540 to $29,425	Max Out of Pocket: $5,450
Family of Four Income: $48,500 to $60,625	Max Out of Pocket: $10,900
Over 250% FPL	**One-third of the HSA maximum**
Individual Income: $29,425 to $47,080	Max Out of Pocket: $6,850
Family of Four Income: $60,625 to $97,000	Max Out of Pocket: $13,200

*This table uses 2015 HSA limits and FPL income levels.

These reductions in out-of-pocket liability will be achieved in new plans through a variety of cost-sharing methods, including co-pays, deductibles, and coinsurance. As such, two plans with the 60% bronze "actuarial value" may have the same out-of-pocket limit, but be structured differently.

What types of health insurance plans can you buy?

Major Medical Plans
plans not eligible for subsidies

Qualified Health Plans

Catastrophic Plans

Plans that help you **avoid the tax penalty**

Under the ACA, people who do not qualify for or want a subsidy, but who want to avoid the tax penalty, can buy major medical health plans that meet ACA coverage standards on or off of government-run state exchanges.

People who qualify for and want to use a subsidy to pay for a QHP will be able to research QHP plan data on some private exchanges and enroll in a plan if the private exchange meets the requirements for offering QHP plans. In some states it is anticipated that you'll be able to do this online, while in others a person may have to help you enroll offline. You can also purchase a QHP through your state's government-run health insurance exchange or marketplace.

Catastrophic plans for people under age 30 will also be available. These plans cannot be purchased with a subsidy. Those who buy a catastrophic plan will not have to pay tax penalties for being uninsured but their plans provide the bare minimum benefits allowed under the law.

Supplemental Plans

Gap (Short-Term) Plans

Plans that **fill gaps** in coverage

Many consumers want benefits beyond what's provided in a major medical health insurance plan. Benefits like life, dental, vision, critical illness, and accident insurance are a popular part of benefits packages offered by employers and will be available for individuals on private exchanges. Some government exchanges may offer some of these products as well.

- **Life Insurance**
- **Dental Insurance**
- **Vision Insurance**
- **Critical Illness Insurance**
- **Accident Insurance**

The ACA allows people to be uninsured for up to 3 months without being subject to a tax penalty. The ACA also creates new enrollment periods when a person can enroll in major medical insurance. Outside of an enrollment period, people may have to wait to get coverage. Gap insurance products like short-term medical insurance may be helpful if you need limited coverage outside of the enrollment window.

What should you KNOW about these different types of products?

	Major Medical Plans	Qualified Health Plans	Catastrophic Plans	Supplemental Plans	Gap (Short-Term) Plans
1. When can coverage start?	Usually within 45 days	Usually within 45 days	Usually within 45 days	Usually within 2 weeks	Usually within 2 weeks
2. Will I be subject to a tax penalty in 2016?	No	No	No	Yes*	Yes
3. Can I buy it on a state exchange?	No	Yes	Yes	In some states	Typically no
4. Can my application be declined for pre-existing conditions?	No	No	No	Yes	Yes
5. Will it cover ACA mandated benefits?	Yes	Yes	Yes	No	No
6. Can it be purchased with a government subsidy?	No	Yes	No	No	No

* In some states a person cannot enroll in certain types of supplemental plans without certifying that they're already enrolled in a major medical health insurance plan or a qualified health plan.

If you like your plan, can you keep it?

You may have major medical health insurance today, but do you know if it needs to change in 2016?

When the Affordable Care Act (ACA) was signed into law, it effectively created

3 **classes of individually-purchased major medical health insurance plans:**

1. Grandfathered Plans:

Health insurance plans that were in effect before March 23, 2010 - when the ACA was signed into law. If you have one of these, you have a grandfathered plan. These plans do not have to meet all the requirements of the law (unless the plan's coverage has changed significantly since you purchased it).

2. Non-grandfathered Plans:

If you bought major medical health insurance after March 23, 2010, with coverage in effect before January 1, 2014 you have a non-grandfathered plan. You bought this plan during the transition to a federally regulated individual health insurance market. All non-grandfathered plans meet some of the new benefit standards required by the ACA, and some plans include them all. Plans that don't meet all of the new benefit standards may need to be updated at some point in 2014, 2015, 2016 or 2017.

3. New Plans:

If you bought an individual or family health insurance with an effective coverage date of January 1, 2014 or later, your plan meets all of the mandatory benefits required by ACA.

Here's how the three types of plans differ:

Mandated Plan Benefits	Grand-fathered Plans	Non-grand-fathered Plans	New Plans
Access to Lost Coverage Due to Exceeded Limits: Those who lost coverage after exceeding a policy's lifetime limit may re-enroll in the same plan or one comparable.	✓	NA	NA
Lifetime Coverage Limits: No lifetime dollar limits on essential benefits.	✓	✓	✓
Rescission Protection: Insurers cannot rescind coverage unless intentional fraud is committed.	✓	✓	✓
Rescission Appeals: If insurers try to rescind coverage, customers have thirty days to appeal.	✓	✓	✓
Children up to age 25: Adults under 26 may rejoin a parent's plan under certain circumstances.	✓	✓	✓
No Annual Coverage Limits: Annual dollar limits on coverage go away.	✗	✓	✓
No Cost-sharing for Preventive Services: Insurers are required to cover certain preventive medical services without cost-sharing.	✗	✓	✓
Community Rating: Plans are no longer priced individually, based on a person's health.	✗	✗	✓
Guaranteed Issue: An individual's application for insurance can't be declined because of a pre-existing medical condition.	✗	✗	✓
Essential Health Benefits: Each plan must cover health benefits in ten categories deemed to be essential.	✗	✗	✓
Actuarial Values: Plans cover at least 60% of the total average annual costs an insurer expects to incur per customer.	✗	✗	✓

Required: ✓ Not Required: ✗

What do you need to know if you're a "Non-grandfathered" policyholder

Although the timing is uncertain, the new health care law requires non-grandfathered plans to be updated to the new benefits standards at some point. The table below outlines why, how and when some people in non-grandfathered plans may need to update their coverage:

Why might you need to change this plan?

Does Not Cover All Essential Health Benefits

Starting in 2014, people on a Non-Grandfathered plan that does not cover all 10 essential health benefits may not be exempt from the individual mandate tax described above.

Does Not Meet Actuarial Value Requirements

Starting in 2014, all non-grandfathered plans must cover at least 60% of the total average annual costs an insurer expects to incur per customer. If a plan doesn't cover at least 60% of the actuarial value, it may need to be updated for policyholders to avoid the individual mandate tax.

How will your plan be changed?

Passive Reenrollment

Some insurers may choose to proactively move customers to new plans that meet Affordable Care Act requirements, without requiring a signature or active reenrollment into a new plan.

Active Reenrollment

Some insurers may require customers to actively opt into a new plan, which may even include acquiring new signatures.

Active Communication, Non-Enrollment

Although many insurance companies are allowing customers to keep their existing plans as long as possible, current law only allows those plans to stay in place until 2017, at the latest.

When will your plan be changed?

During the Open Enrollment Period

Some insurers may use passive reenrollment or active reenrollment to transition people from non-grandfathered plans to new plans between November 1, 2015 and January 31, 2016. This open enrollment period has been put in place because 2014 was the first year that major provisions of the law went into effect. But, changes to the law allowed some consumers to keep their plans for an extended period of time.

On a Plan's Renewal Date/Anniversary

Some insurers may seek to conduct an active or passive reenrollment when that plan is up for renewal. Adoption of this approach may vary from insurer-to-insurer and from state-to-state*, based in part upon that state's regulations.

* With changes to the legislation, in some states and with some insurers, a plan bought as late as December of 2013 could remain in effect with 2013 benefits until 2017.

STEP 2

How Can You Buy Health Insurance?

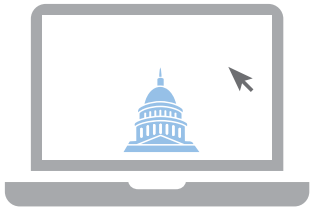
Enrollment

If you're uninsured or buy your own health insurance, the Affordable Care Act (ACA) gives you multiple ways to buy coverage that meets the minimum coverage standards of the law.

The chart below show you what types of plans you can purchase through licensed priviate exchanges like eHealth versus through government exchanges:

Option 1 Enrollment through licensed private channels:

Under the ACA, consumers can buy health insurance from licensed agents, online or off, or direct from insurance companies. Private enrollment channels are typically staffed with licensed health insurance agents.



Option 2 Enrollment through government exchanges:

Under the ACA, consumers also have the option to purchase certain kinds of health insurance through government run "exchanges" or marketplaces. Some states have created their own exchanges while others use the federal government's exchange. Exchanges are typically staffed with "Navigators."

	Major Medical Plans	Qualified Health Plans	Catastrophic Plans	Supplemental Plans	Gap (Short-Term) Plans
Option 1	✓ Yes	✓ Yes	✓ Yes	✓ Yes	✓ Yes
Option 2	✗ No	✓ Yes	✓ Yes	Possibly	Possibly

How do the licensed agents stack up to Navigators?

LICENSED AGENTS	VS.	EXCHANGE NAVIGATORS
No	Cost you money to use one?	No
Yes (in ceratin cases)	Help you apply for a subsidy?	Yes
Yes (in ceratin cases)	Help you understand plans on a government exchange?	Yes
Yes	Help you understand plans NOT on a government exchange?	No
Yes	Recommend a plan based on your individual needs?	No
Yes	Act as your advocate if you have a problem with your insurance company?	No
Yes	Required to be licensed in your state?	No (Some states require licensing)
Yes In some states (All eHealth agents undergo background checks)	Undergone criminal background checks?	No
Yes	Passed strict insurance licensing exams?	No

Payment

The ACA tries to reduce the amount of uncompensated care the average U.S. family pays for by requiring everyone to have health insurance or pay a tax penalty.

The ACA's new tax penalties for people without insurance are designed – in part – to offset the cost of paying for the health care of people without health insurance. And, if you're lower-income, you may be able to qualify for subsidies that make insurance more affordable.

If you understand how the subsidies and tax penalties work you'll be in a better position to purchase the product that suits you best.

Qualifying for Subsidies

The Affordable Care Act determines whether or not you're eligible for subsidies based on the following criteria:

1.

You live in the United States of America

2.

You're a U.S. citizen, U.S. national or otherwise lawfully present in the United States.

3.

You're not incarcerated

4.

Your combined total household income is between 133% and 400% of the Federal Poverty Level (FPL). People with incomes below 133% of FPL will qualify for Medicaid in most states.

Income Requirements for the Affordable Care Act

Household Size	2015 Annual Income Above the Federal Poverty Level (FPL)					
	100% FPL	138% FPL	150% FPL	200% FPL	300% FPL	400% FPL
1	$11,770	$16,243	$17,655	$23,450	$35,310	$47,080
2	$15,930	$21,938	$23,895	$31,860	$47,790	$63,720
3	$20,090	$27,724	$30,135	$40,180	$60,270	$80,360
4	$24,250	$33,465	$36,375	$48,500	$73,750	$97,000
For each additional person add	$4,200 (approx.)	$5,800 (approx.)	$6,250 (approx.)	$7,500 (approx.)	$12,500 (approx.)	$16,640 (approx.)

This table breaks out income levels below 400% of the Federal Poverty Level (FPL).

How Subsidies Work

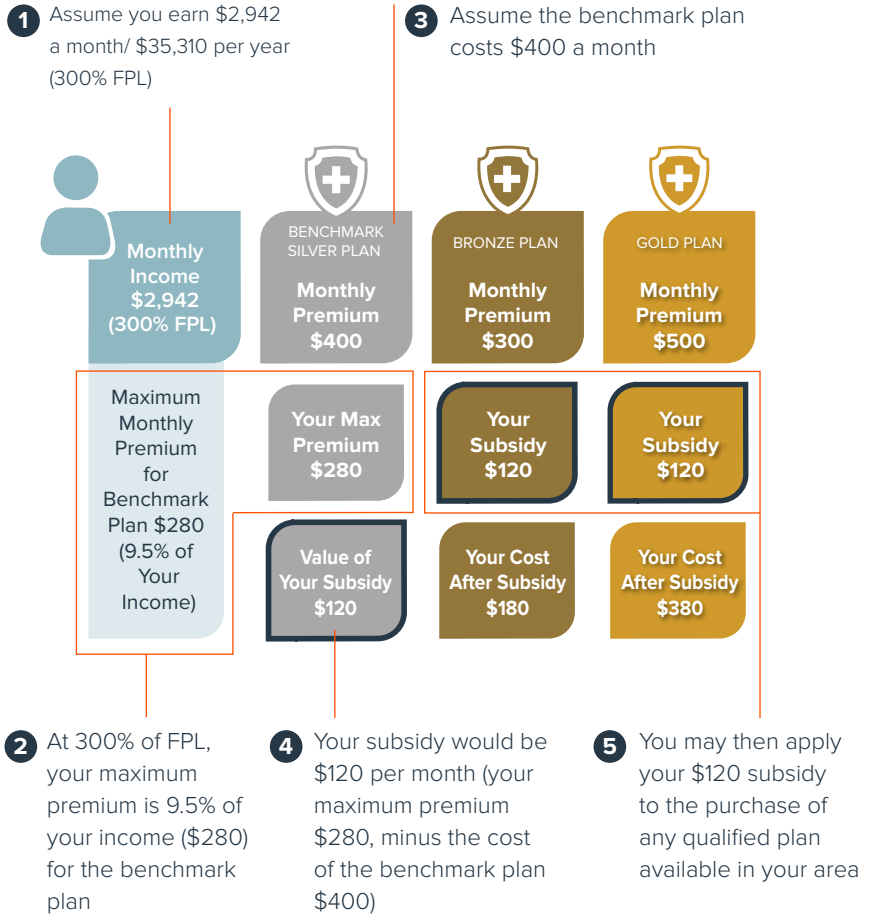
The subsidies (also called Premium Tax Credits) work on a sliding scale that limits your spending on monthly health insurance premiums to a fixed percentage of your annual income if you buy the "benchmark plan," which is the second least expensive plan available in your area.

If that benchmark plan costs more than the fixed percentage of your estimated annual income, you can get a subsidy in the amount of the difference. You may then use that subsidy when you buy a "qualified health plan" (QHP).

Here is the equation that helps you determine your subsidy amount:

1. How much does the "benchmark" plan (the second least expensive "silver-level" plan) cost?
2. Does that benchmark plan cost more than 3% to 9.5% of your modified adjusted gross income (MAGI)?
3. If the benchmark plan costs more than that 3% to 9.5% of your MAGI, the amount over is equal to your subsidy.

How to determine your subsidy amount



Subsidy Amount:

Subsidy amount is based on your household size and income. This table breaks down how the subsidy would be applied:

Household Size	Yearly Income (MAGI)	Monthly Income	Cost of "Benchmark Plan"	Limit on Your Monthly Premium for Benchmark Plan	Amount of Your Subsidy
Single Adult 	138% **$16,234**	**$1,353**	**$400**	**$40** (3% of income)	**$360** ($400-$40=$360)
	150% **$17,655**	**$1,471**	**$400**	**$59** (4% of income)	**$341** ($400-$59=$341)
	200% **$23,540**	**$1,962**	**$400**	**$167** (8.05% of income)	**$233** ($400-$167=$233)
	300% **$35,310**	**$2,943**	**$400**	**$280** (9.5% of income)	**$120** ($400-$280=$120)
	400% **$47,080**	**$3,923**	**$400**	**$373** (9.5% of income)	**$27** ($400-$373=$30)

Tax Penalties

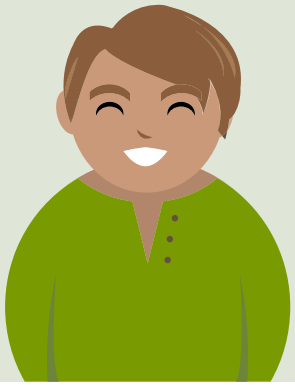
If you don't have major medical health insurance that meets minimum Federal standards for more than three months in a row, you may incur a tax penalty. You'd pay that penalty when you file your income taxes in 2016.

Tax penalties are pro-rated by the number of months your uninsured.

Penalties are also phased in over three years, beginning in 2014 when the penalty is 1.0% of your household income. In 2015 the penalty increases to 2.0% of your income and by 2016 the penalty is calculated at 2.5% of your taxable income.

The maximum tax penalty can't exceed three times the minimum penalty, or the national average price for a bronze level plan, within a given year. Pricing for bronze level plans is not available, so for this table we've used three times the minimum penalty as the maximum.

This table breaks down how the penalty would be applied each year:

Household Size	2014 Annual Income as a Percentage of the Federal Proverty Level (FPL)					
	Yearly Penalty	133% FPL	250% FPL	300% FPL	400% FPL	Above 400%
		$15,521 (-$10,150) = $5,371	$29,175 (-$10,150)=$19,025	$35,010 (-$10,150) = $24,860	$46,680 (-$10,150) = $36,530	$46,681+
Single Adult 	2014 Minimum: **$95 per adult, $47.50 per child.**	**1.0% = Minimum $95**	**1.0% = $190.25**	**1.0% = $248.60**	**1.0% = $365.50**	Up to **$2,448** per adult [1]
	2015 Minimum: **$325 per adult, $162.50 per child.**	**2.0% = 107.42** You pay = Minimum $325	**2.0% = $380.50**	**2.0% = $497.20**	**2.0% = $730.60**	Up to **$3,816** [2]
	2016 Minimum: **$695 per adult, $347.50 per child.**	**2.5% = $134.27** You pay = Minimum $695	**2.5% = $475.64** You pay = Minimum $695	**2.5% = $621.50** You pay = Minimum $695	**2.5% = $913.25**	Up to **$4,045** [2]

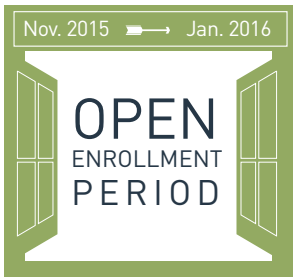
1 (As published by the IRS: http://www.irs.gov/uac/ACA-Individual-Shared-Responsibility-Provision-Calculating-the-Payment)

2 (As projected by the Tax Policy Center: http://taxpolicycenter.org/taxfacts/acacalculator.cfm)

STEP 3

Know When You Can Buy Coverage for 2016, and When You Can't

Though no one can be turned down for health insurance based on their personal medical history, people who buy coverage on their own will need to enroll during an **open enrollment period** or when they've experienced a **"qualifying life event."**



Open Enrollment Period

In 2016 the open enrollment period is scheduled to begin on November 1, 2015 and run through January 31, 2016. During open enrollment your application for health insurance cannot be turned down.

Qualifying Life Events and Special Enrollment Periods

Under the Affordable Care Act (ACA), you typically cannot get major medical health coverage without a qualifying life event. A qualifying life event triggers a **60 day** "special enrollment period" that will allow you to apply for a plan and guarantee your application is approved.

Key Dates:

Today through **11/1/2015;** Only those with QLEs can apply.

11/1/2015 through **1/31/2016;** Anyone can apply.

Here are a few examples of Qualifying Life Events (QLEs):

Loss of essential health coverage:
If you or a dependent lose health coverage that meets government standards.

Change of family structure:
If you get married, divorced, have or adopt a child, or have a death in the family.

Change of citizenship status:
If you become a U.S. citizen or national.

Government error:
If you lose, change or enroll in coverage because of an error committed by an officer, employee or agent of the Exchange or the Department of Health and Human Services as determined by the Exchange.

Change in subsidy eligibility:
If you become eligible or lose eligibility for subsidies (advance payments of the premium tax credit or cost sharing reductions).

Move to a new coverage area:
If you permanently move to a new area.

Conclusion

We hope you learned something about health reform with our Three Steps to Understanding The Affordable Care Act workbook. Please feel free to share it with friends or relatives and when you're ready to explore your health insurance options and enroll in coverage!

eHealth®

eHealth is the nation's first and largest health insurance marketplace for individuals, families and small businesses. This online marketplace can help you research, compare and enroll in the nation's largest selection of individual and family health insurance products. Their customer care center is staffed with licensed health insurance agents and knowledgeable representatives, ready to assist you.

Contact an Allstate Business Insurance Agent for additional details.

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