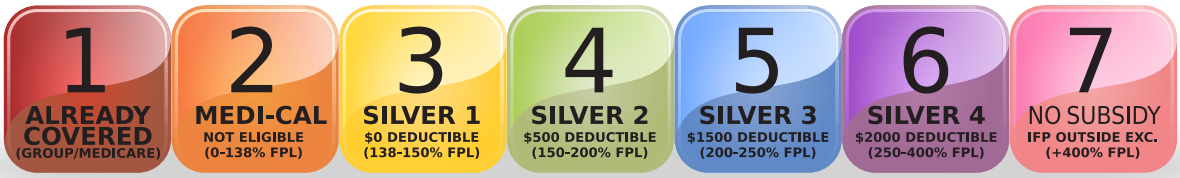
Health Insurance

The reason we have insurance is to help spread the risk so that a medical emergency or a serious illness won't require you to spend yourself into poverty. You pay a premium to the insurance company for a contractual agreement that includes some out-of-pocket maximum exposure, as well as other contractual features like co-payments and coinsurance.

If you're under age 65, then you're covered by social services, individual insurance or group insurance. At 65 we bring you into Medicare as part of our healthcare system for mature Americans.

The **Affordable Care Act** (ACA) has not made health care any cheaper. With all the mandates for minimum essential coverage and first dollar benefits for preventive care, coverage is more expensive. **Premium Assistance** may be available to people starting in 2014 based on their income and the income of their household. We now look to the **Federal Poverty Level** to determine your eligibility for certain programs and benefits. If you fall within certain guidelines, you may be eligible for tax credits that help make your insurance premiums more affordable. If you are eligible for tax credits, then you need to buy your coverage in The Exchange. The Exchange or The Marketplace are terms used to define where you are buying your policy that is eligible for tax credits.



The following article by Garrett Viggers was originally published in the August 2013 issue of California Broker Magazine. Used by permission.

In order to make insurance less of a burden to a family or your household, we look to the Federal Poverty Level (FPL) to see where your income indicates you are. If your income falls between zero and 138% of the FPL, then you should take advantage of the new and improved Medi-Cal system or the Federal Medicaid system. You will need to review the Federal Poverty Level for the size of your household each year. How many people are in your household?

In the ACA, Congress required states to expand Medicaid to all adults, including parents and adults without children, up to 138 percent of the federal poverty line. To ease the fiscal impact on states, the federal government is covering 100 percent of the cost of the newly-eligible adults in the first years of implementation.

Over time, the federal government's share of the cost of covering newly-eligible adults will taper down, but it never falls below 90 percent. As a result of the Supreme Court decision on the ACA, states can decide that they do not want to expand Medicaid. California has opted to implement the expansion to 138 percent of the federal poverty line for adults (previously the ceiling was up to 133 percent). What did your state do? You will need to know what details are specific to your state of residence.

If you are not eligible for tax credits, then you are free to buy your health insurance outside the exchange on the open market. You will find insurance carriers that are selling policies inside the exchange and outside the exchange. Many times their contracts are similar, or even mirror each other.
With the **Affordable Care Act (ACA)** the design of contracts begin to look similar as we refer to the **actuarial value** assigned to each plan in the **metal tiers of Bronze, Silver, Gold or Platinum.** The health insurance plans that cover the greatest percentage of health care expenses also have higher premium expenses. Do you want to pay higher premiums monthly and have fewer medical expenses, or is it better to pay lower premiums now and more out-of-pocket costs when you incur expenses?

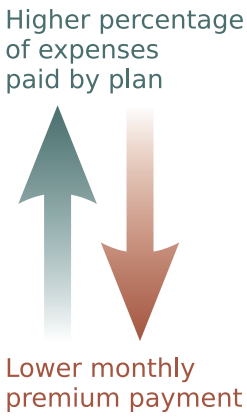
With insurance it is helpful to understand the vocabulary. There are new **Essential Heath Benefits** required in contracts starting in 2014. Insurance policies must cover certain benefits in order to be certified and offered in the marketplace. There are a broad array of services required that include preventive and wellness services. Pediatric dental is now required on medical plans to provide some dental coverage through age 18. We all share in the premiums of this mandate to help our kids be healthier. We hope that our population will take better care of themselves and require less medical care over time as a result of it.

Insurance companies try to contain the cost of care through negotiated rates, fees and services. They use **Preferred Provider Organizations (PPO)** that contract

participating doctors and hospitals to create a network that can help contain costs within the network. Benefits outside the network may require more cost sharing or reduced benefits.

The **Exclusive Provider Organization (EPO)** offer a more exclusive network of providers, and may even exclude coverage outside the network unless there is a life-threatening situation.

Category	Percentage of expenses paid by health plan	Percentage of expenses paid by individual
Platinum	90%	10%
Gold	80%	20%
Silver	70%	30%
Bronze	60%	40%



The **Health Maintenance Organization (HMO)** usually limits coverage to care from doctors who work for or contract with the HMO. You may be required to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and try to focus on prevention and wellness.

Your **Out-of-Pocket Limit (OOP)** or **Out-of-Pocket Maximum** should be when your insurance begins to pay 100 percent of the cost of covered services. It may also be called a Stop Loss, where your losses stop and the insurance pays 100 percent of the costs. This limit seldom includes your premium or charges your insurance plan doesn't cover. Read your contract to see what counts toward your out-of-pocket maximum.

Your insurance company provides you a **Summary of Benefits** or a **Summary of Coverage** which highlights your plan features and coverage details. Take time to review it and familiarize yourself with your plan features.

When a claim is processed you receive your **Explanation of Benefits (EOB)**

that outlines any negotiated discounts, what the plan paid and what is your responsibility.

The **Health Savings Account** is used in conjunction with **special high deductible health insurance plans** designed to meet the guidelines Congress set. First you must purhase the appropriate insurance, and then you can open the Health Savings Account that works along side insurance. Although the insurance has a higher deductible, the premium tends to be lower than the co-pay plans.

The **Health Savings Account** is a tax-deductible contribution on your tax return that is above the line of adjusted gross income. It is like an IRA for health and wellness expenses. Generally, you can purchase anything that is an unreimbursed medical expense with your Health Savings Account dollars, and that includes your office visit, deductibles, prescriptions, eye exams and glasses, dental visits and even some alternative health care services. It is a wonderful opportunity to take wellness into your own hands and it may just inspire you to take better care of yourself.

In the end, insurance is just a tool to help spread the risk so that no one is destroyed financially when there is a medical crisis. Paying a premium today helps bring you peace of mind knowing that you and your family have access to quality care in case you should need it, as well as preventive care to help you stay healthy and well today.

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