

Health Insurance Coverage Options Reference Guide

The Affordable Care Act (ACA) expands access to health insurance coverage for individuals through 400% FPL. Navigators and assisters are responsible for connecting individuals to the appropriate coverage option. To best serve those seeking coverage, navigators should be adequately versed in the ACA coverage continuum, including: (1) subsidized coverage available through the health insurance marketplaces; (2) Medicaid; and (3) the Children's Health Insurance Program.

The following at-a-glance reference details information about coverage options under the ACA. The Center for Health Care Strategies (CHCS) developed this reference tool for the **Charity Care Affinity Group**, a national initiative made possible by Kaiser Permanente Community Benefit. CHCS convenes the 11 affinity group member organizations to address challenges in redefining program roles, delivery systems, and business models for serving the uninsured.

IN BRIEF

This reference tool for charity care organizations offers details about Affordable Care Act health insurance coverage options. This tool is a companion to [*Charity Care Organizations as Navigators: Considerations for Guiding Consumers toward the Best Coverage Options*](#), a detailed guide for charity care programs. For more information, visit www.chcs.org.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

HEALTH INSURANCE COVERAGE OPTIONS	
Health Insurance Marketplaces	
Description	<ul style="list-style-type: none"> • Serves as clearinghouse to purchase affordable private health insurance options with a standardized benefit set. • Provide streamlined eligibility and plan enrollment for Medicaid and subsidized private health insurance.
Financial Eligibility Criteria	<ul style="list-style-type: none"> • Individuals up to 400% FPL (\$45,960) are eligible to receive subsidies to purchase coverage through the marketplace. Individuals above 400% FPL are eligible to obtain marketplace coverage, but are ineligible for APTCs. Those above 400% FPL are referred to brokers to obtain coverage. • If an employee’s premium for single coverage is more than 9.5% of income, the individual may be eligible to receive subsidies through the marketplace. • Eligibility for Medicaid and subsidized health insurance through the marketplaces is calculated using Modified Adjusted Gross Income (MAGI) and household income, which is the sum of the taxpayer’s MAGI plus the MAGI of tax dependents in the family if required to file a tax return. • MAGI is based on federal tax rules for determining adjusted gross income.
Non-Financial Eligibility Criteria	<ul style="list-style-type: none"> • Citizenship – to receive subsidies, individuals must be citizens, nationals, or lawfully present in the United States. • Incarceration – must not be incarcerated, other than pending the disposition of charges. • Residency – must be a state resident.
Plan Options and Covered Services	<ul style="list-style-type: none"> • All options offered through the individual and small group market, including the marketplace, must include 10 Essential Health Benefits (EHBs): <ul style="list-style-type: none"> ○ Ambulatory services (outpatient care received without being admitted to a hospital; i.e., primary care and specialist visits; outpatient surgery; laboratory exams; radiology services, etc.); ○ Emergency services; ○ Hospitalization; ○ Maternity and newborn care; ○ Mental health and substance use disorder services, including behavioral health treatment; ○ Prescription drugs; ○ Rehabilitative and habilitative services and devices; ○ Laboratory services; ○ Preventive and wellness services and chronic disease management; and ○ Pediatric services, including oral and vision care.
Post-Enrollment Requirements	<ul style="list-style-type: none"> • Individuals are required to report any changes affecting eligibility, including: relocation; changes in household income or size; changes in immigration status; becoming incarcerated; or enrollment in other health coverage. Individuals must report changes to their information no later than 30 days after the changes happens, unless otherwise specified by the state. • Eligibility is redetermined annually.

HEALTH INSURANCE COVERAGE OPTIONS	
Advance Premium Tax Credits (APTCs)	
Description	<ul style="list-style-type: none"> • Offers tax credits to reduce premium costs for QHP enrollees who meet financial criteria and do not have access to other coverage. • Can be paid in advance to provide immediate help in paying premiums.
Financial Eligibility Criteria	<ul style="list-style-type: none"> • Individuals are eligible for an APTC if they: <ul style="list-style-type: none"> ○ Have a projected income between 100% and 400% FPL (with exception for legal immigrants who are eligible below 100% FPL). ○ Lawfully present individuals below 100% FPL: Immigrants with incomes below 100% FPL who are lawfully present and ineligible for Medicaid because of their immigration status may be eligible for APTC. They must also meet all of the other APTC eligibility criteria that apply to individuals with income >100% FPL. • Tax credit calculation is based on the following: <ul style="list-style-type: none"> ○ The amount that the family is expected to spend on premiums given its income. ○ The cost of the second lowest cost silver plan for the family. This is determined by: <ul style="list-style-type: none"> ▪ Household size ▪ Cost of the plan in the geographic area in which the household resides; ▪ An adjustment to the premium to reflect the age of the individuals enrolling ○ The difference between the family’s expected contribution and the cost of the second lowest-cost silver plan (benchmark plan) determines the amount of the APTC.
Non-Financial Eligibility Criteria	<ul style="list-style-type: none"> • Individuals are eligible for an APTC if they: <ul style="list-style-type: none"> ○ Enroll in a QHP; ○ Lack access to other coverage that meets some basic standards (“minimal essential coverage”); and ○ Meet various tax-based requirements: <ul style="list-style-type: none"> ▪ Plan to file federal tax return or if married, plan to file a joint tax return; and ▪ Not eligible to be claimed as a dependent on someone else’s tax return • It is not necessary for every household member to meet the APTC eligibility criteria. If at least one member qualified, the household can receive tax credits on behalf of the eligible member(s).
Additional Requirements	<ul style="list-style-type: none"> • Those who receive an APTC are obligated to file taxes; when they do, the IRS conducts a “reconciliation” to ensure that the right amount of premium tax credit was received. <ul style="list-style-type: none"> ○ If they received a higher APTC than their income tax data indicates they qualify for, they must repay the excess. This might happen if someone gets a salary increase in the middle of the year and forgets to report it. ○ If they receive a lower APTC than their income tax data indicates they qualify for, they receive a tax refund (or offset to any tax liability). This might happen if someone loses a job in the middle of the year and forgets to report it. • Reducing the risk of repayment for a consumer: <ul style="list-style-type: none"> ○ Provide accurate projections: when applying for an APTC, answer any questions about projected income and family size as accurately as possible. ○ Report changes: promptly report any changes in income or family size that occur in the midst of the year; this allows marketplaces to adjust the APTC to the right level. ○ Take less APTC: consumers can consider taking less than the full APTC that they qualify for and receive any remaining credit at tax time. Alternatively, consumers can wait to receive the credit when they file their tax return but they will have to cover the monthly health

HEALTH INSURANCE COVERAGE OPTIONS	
	insurance premiums without assistance.
Cost-Sharing Reductions (CSR)	
Description	<ul style="list-style-type: none"> • New federal program that helps reduce out-of-pocket costs for enrollees in QHPs. • Payments are made directly to issuers to reduce deductibles, co-insurance, and/or copayments (out-of-pocket) costs.
Financial Eligibility Criteria	<ul style="list-style-type: none"> • Individuals are eligible for a CSR if they: <ul style="list-style-type: none"> ○ Have a projected income below 250% FPL. ○ Lawfully present immigrants with income below 100% FPL who are ineligible for Medicaid because of immigration status may qualify for a CSR. • The level of savings (or tier) for which a family qualifies is based on their income: <ul style="list-style-type: none"> ○ <i>Tier 1</i>: Available to special populations <100% FPL; 100-150% FPL. Covers 94% of the actuarial value of the silver plan. ○ <i>Tier 2</i>: Available to those with income between 150-200% FPL. Covers 87% of the actuarial value of the silver plan. ○ <i>Tier 3</i>: Available to those with income between 200-250% FPL. Covers 73% of the actuarial value of the silver plan.
Non-Financial Eligibility Criteria	<ul style="list-style-type: none"> • Individuals are eligible for a CSR if they: <ul style="list-style-type: none"> ○ Meet the eligibility criteria for APTC; and ○ Enroll in a silver QHP. • In families where members qualify for different levels of CSR (e.g., one American Indian (AI) and one non-AI member), the “least common denominator” rule is used. This means that everyone qualifies only for the CSR variation available to the member who qualifies for the least generous CSR.
Medicaid	
Description	<ul style="list-style-type: none"> • Federal-state health insurance program for low-income people. Minimal out-of-pocket costs.
Financial Eligibility Criteria	<ul style="list-style-type: none"> • MAGI methodology will be used to determine income eligibility for children, pregnant women, family programs, and adults with income below 138% FPL • The following Medicaid eligibility groups do not follow MAGI methodology: <ul style="list-style-type: none"> ○ Aged, blind or disabled individuals; ○ SSI cash recipients; ○ Foster care children; and ○ Individuals receiving long-term care and waiver services.

HEALTH INSURANCE COVERAGE OPTIONS			
Non-Financial Eligibility Criteria	<ul style="list-style-type: none"> • Individuals must meet the following non-financial eligibility criteria: <ul style="list-style-type: none"> ○ Residency—individual must be a resident of the state to be eligible for Medicaid. ○ SSN—a valid SSN or proof of application for a number is required. ○ Incarceration—those who are placed in city, county or state facilities are not eligible for Medicaid coverage while incarcerated. • Non citizens and are unqualified immigrants are not eligible for Medicaid (e.g., undocumented individuals, students, tourists). • Most legal non-citizens are not eligible for Medicaid for five years after they receive legal status. <ul style="list-style-type: none"> ○ Individuals are exempt from the five-year bar if they fall into one of the following categories: refugees, asylees, victims of trafficking, battered spouses and children, Cuban/Haitian entrants. 		
Plan Options and Covered Services	<ul style="list-style-type: none"> • Benchmark coverage is required for the adult expansion group. The selected Alternative Benefit Plan must: <ul style="list-style-type: none"> ○ Offer the 10 EHBs provided under marketplace coverage; ○ Meet mental health parity requirements; ○ Provide EPSDT services for those under age 21; ○ Provide non-emergency transportation, family planning, and U.S. Preventive Services Task Force recommended services; and ○ Cover prescription drugs. • Individuals who are eligible for other Medicaid programs (e.g., pregnant women, aged, blind and disabled) receive a benefit package determined by the state. States are required to cover certain mandatory benefits and can choose to provide other optional benefits, including the following: <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="vertical-align: top; width: 50%;"> <p>Mandatory:</p> <ul style="list-style-type: none"> ○ Inpatient/outpatient hospital services; ○ Early and periodic screening, diagnostic, and treatment services; ○ Nursing facility services; ○ Home health services; ○ Physician services; ○ Rural health clinic services and federally qualified health center services; ○ Laboratory and x-ray services; ○ Family planning services; ○ Nurse midwife services; ○ Certified pediatric and family nurse practitioner services; ○ Freestanding birth center services; and ○ Tobacco cessation counseling for pregnant women. </td> <td style="vertical-align: top; width: 50%;"> <p>Optional:</p> <ul style="list-style-type: none"> ○ Prescription drugs; ○ Clinic services; ○ Physical, occupational, speech, hearing, and language therapy; ○ Respiratory care services; ○ Other diagnostic, screening, preventive and rehabilitative services; ○ Podiatry services; ○ Optometry services; ○ Dental services and dentures; ○ Prosthetics; ○ Eyeglasses; ○ Chiropractic services; ○ Private duty nursing, personal care, hospice services; ○ Case management; ○ Services for those 65 or older in an Institution for Mental Disease; ○ Services in an intermediate care facility for the mentally retarded; ○ State plan home and community based services; ○ Self-directed personal assistance services; ○ Community first choice option; and ○ Inpatient psychiatric services for individuals under age 21. </td> </tr> </table> 	<p>Mandatory:</p> <ul style="list-style-type: none"> ○ Inpatient/outpatient hospital services; ○ Early and periodic screening, diagnostic, and treatment services; ○ Nursing facility services; ○ Home health services; ○ Physician services; ○ Rural health clinic services and federally qualified health center services; ○ Laboratory and x-ray services; ○ Family planning services; ○ Nurse midwife services; ○ Certified pediatric and family nurse practitioner services; ○ Freestanding birth center services; and ○ Tobacco cessation counseling for pregnant women. 	<p>Optional:</p> <ul style="list-style-type: none"> ○ Prescription drugs; ○ Clinic services; ○ Physical, occupational, speech, hearing, and language therapy; ○ Respiratory care services; ○ Other diagnostic, screening, preventive and rehabilitative services; ○ Podiatry services; ○ Optometry services; ○ Dental services and dentures; ○ Prosthetics; ○ Eyeglasses; ○ Chiropractic services; ○ Private duty nursing, personal care, hospice services; ○ Case management; ○ Services for those 65 or older in an Institution for Mental Disease; ○ Services in an intermediate care facility for the mentally retarded; ○ State plan home and community based services; ○ Self-directed personal assistance services; ○ Community first choice option; and ○ Inpatient psychiatric services for individuals under age 21.
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HEALTH INSURANCE COVERAGE OPTIONS	
Post-Enrollment Requirements	<ul style="list-style-type: none"> • Renewals will occur every 12 months, unless there is a change that affects eligibility. • Renewal is based on information in the individual’s record account or other current information available through the Federal data hub: <ul style="list-style-type: none"> ○ If a beneficiary cannot be renewed based on available information, a pre-populated renewal form must be sent with a request for additional information needed to determine eligibility. The individual must complete, sign and return the form. ○ If a beneficiary does not respond to the renewal form, and coverage is terminated; eligibility can be reconsidered if the individual responds within 90 days without being required to submit a new application. • If a beneficiary is ineligible due to an increase in income, the agency will determine potential eligibility for other subsidized and non-subsidized coverage options
Children’s Health Insurance Program (CHIP)	
Description	<ul style="list-style-type: none"> • Federal-state health insurance program for low-and moderate-income children, parents, and pregnant women. Modest out-of-pocket costs at state option. • Most states use CHIP funding to expand Medicaid eligibility levels, though some states have stand-alone CHIP programs.
Financial Eligibility Criteria	<ul style="list-style-type: none"> • Eligibility levels vary by state but coverage ranges from 138%-400%. MAGI-based income calculation. • Income of a child is not counted if the child is not required to file taxes. • Medicaid and CHIP base determination on current monthly income, with State option to consider predictable changes in income at initial determination.
Non-Financial Eligibility Criteria	<ul style="list-style-type: none"> • Requirements are the same as Medicaid except that states may provide Medicaid and CHIP coverage to children and pregnant women who are lawfully residing in the US, including those within their first five years of having certain legal status. • States have the option to implement 12-month continuous eligibility for CHIP enrollees.

HEALTH INSURANCE COVERAGE OPTIONS	
Plan Options and Covered Services	<ul style="list-style-type: none"> • Medicaid expansion CHIP programs use the standard Medicaid benefit package, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, which includes all medically necessary services like mental health and dental services. • States can choose to provide benchmark coverage, benchmark-equivalent coverage, or secretary-approved coverage. <ul style="list-style-type: none"> ○ Benchmark coverage based on one of the following: <ul style="list-style-type: none"> ▪ The standard Blue Cross/Blue Shield preferred provider option service benefit plan offered to federal employees; ▪ State employee’s coverage plan; or ▪ HMO plan that has the largest commercial, non-Medicaid enrollment within the state. ○ Benchmark-equivalent coverage must be actuarially equivalent and include: <ul style="list-style-type: none"> ▪ Inpatient and outpatient hospital services; ▪ Physician’s services; ▪ Surgical and medical services; ▪ Laboratory and x-ray services; and ▪ Well-baby and well-child care, including immunizations. ○ Secretary-approved coverage includes any other health coverage deemed appropriate and acceptable by the Secretary of HHS. <ul style="list-style-type: none"> ▪ The ACA requires pediatric oral and vision care. ▪ Dental coverage in CHIP programs is required to include coverage for dental services necessary to prevent disease and promote oral health, restore oral structure to health and function, and treat emergency conditions.
Post-Enrollment Requirements	<ul style="list-style-type: none"> • Requirements are similar to those for Medicaid.